

## SOUTHAMPTON SUBSTANCE USE COMPREHENSIVE ASSESSMENT

SERVICE USER NAME .....

ASSESSOR.....ASSESSMENT DATE.....

(7) Comprehensive Assessment Agency .....

(23) What was the date of the triage? 

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(6) What was the date of the referral? 

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What RECENT CHANGES, if any, have there been since the triage?

CURRENT SUBSTANCE USE(Non prescribed in last 4 weeks)

	Substance †	Frequency	(19) Route	Amount/units	Score*
(17)FIRST					
(20)SECOND					
(21)THIRD					
(21)FOURTH					
(21)FIFTH					

Describe social/other triggers (eg peers; anxiety)

(12)TREATMENT HISTORY (most recent first)

Date – from / to	Treatment provider	Treatment provided	Reason for closure

SIGNIFICANT DRUG FREE PERIODS

From	To	What was going on at that time in the persons life?

**PERSONAL/FAMILY/SOCIAL HISTORY**

Early life issues—any abuses, any separation from parents/siblings – experience of the care system/adoption or fostering. Current family circumstances and contact with/support of birth family. How did substance use develop?

**FAMILY HISTORY OF SUBSTANCE USE**

**SUPPORT/CARER**

Do you have anybody who supports or helps you?

**YES/NO**

.....  
Do you have a carer?

**YES/NO**

If YES, who is the carer?.....

Do you mind if I contact your carer?

**YES/NO**

Are you a carer?

**YES/NO**

If YES, for whom are you the carer?.....

Have you or the carer been offered a carers assessment ?

**YES/NO**

Do you want a carers assessment to be arranged?

**YES/NO**

Has the assessor (today) completed a carers assessment ?

**YES/NO**

Do you need support/help with childcare?

**YES/NO**

Action taken.....  
.....  
.....

**STRENGTHS/RESOURCES/MOTIVATION**

Include work skills, occupations, leisure activities, hobbies

Is there a LEGAL HISTORY eg criminal matters/civil matters/CCJs/anything outstanding/offences of arson, serious violence, sexual or offences against children.

**MENTAL HEALTH ASSESSMENT**

SERVICE USER ..... DOB .....

If there are any **mental health symptoms** or concerns disclosed, please give details (eg deliberate self harm; suicide attempts; suicidal ideation; auditory or visual hallucinations; unexplained low mood or anxiety; anger or aggressive thoughts or behaviour). (Is there any relevant prescribed medication?)

If there is a **history** please give details (eg psychiatric admissions; psychosis;self medicating drug/alcohol use)

If there is a **diagnosis**, please give details .....

Name and location of MH key worker.....

Has there been a **dual diagnosis**? **YES/NO**

If there is a MH diagnosis but no actual dual diagnosis and/or no allocated MH key worker, what are your plans for a joint MH/submis assessment?

What actions (where necessary) have you taken to arrange a joint assessment?

If there are any specific risks of harm to self or harm to others, please complete a **Specific DICE**. Please summarise the risks and outline your risk management plan

Send a copy of this page to the relevant MH agency/worker.

To whom did you send it ..... Date .....

Signed ..... Assessing agency .....

Are there any current **physical health** problems? Any history? Please include details of any DISABILITY.

Appetite	
Sleep pattern	
When was clients last period?	

Please ✓ where applicable

Abscesses		DVT		High/Low Blood Pressure	
Asthma		Epilepsy/Fitting		Liver/Jaundice	
Blood Poisoning		Gastro-intestinal		Stroke	
Diabetes		Heart		other	

**PREVIOUSLY TESTED FOR ANY BLOOD BORNE VIRUS?**

BBV Type	YES/NO	If YES, when?	If YES, where?	Pos	Neg	Refused
Hep B				(41)		
Hep C		(26)		(42)		
HIV						

IF SERVICE USER WANTS TO BE TESTED FOR ANY BLOOD BORNE VIRUS PLEASE INDICATE ✓

Hep B		Hep C		HIV	
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IF SERVICE USER HAS EVER HAD ANY HEP B VACCINATIONS , PLEASE INDICATE IF THE PROGRAMME WAS COMPLETED OR PARTIALLY COMPLETED.

(27) If completed, when....., if partial, how many in the series 1 / 2 / 3 / completed\*

(28) DO YOU WANT AN (HEP A)/HEP B VACCINATION?

**YES/NO/ALREADY IMMUNISED**

DO YOU REQUIRE INFORMATION ABOUT

Hep B/HepC/HIV

**YES/NO**

Safe sex

**YES/NO**

Contraception

**YES/NO**

Safer Injecting

**YES/NO**

What follow up action have you taken? What is planned? (eg vaccination, referral to hepatology)

(46) IS THERE ANY EVIDENCE OR DISCLOSURE OF SEX WORKING?

\*(Delete where inapplicable)

If YES, is service user aware of any specialist agencies?

**YES/NO**

If appropriate, pass on relevant details.

**SUBSTANCES TESTED**

Testing method used ..... Date .....

OPIATES	Pos/Neg/NT	METHADONE	Pos/Neg/NT	SUBUTEX	Pos/Neg/NT
BENZODIAZEPINES	Pos/Neg/NT	AMPHETAMINES	Pos/Neg/NT	COCAINE	Pos/Neg/NT
MDMA	Pos/Neg/NT	CANNABIS	Pos/Neg/NT	other	Pos/Neg/NT
METHAMPHETAMINE	Pos/Neg/NT	other	Pos/Neg/NT	ALCOHOL.....units/NT	

(sdat/pm/110506)

**ASSESSORS OBSERVATIONS**

(Interaction, non-verbal communications, insight, motivation, in withdrawal)

**CLIENT GOALS**

**CARE PLAN (include plans for education, training and employment (ETE))**

IDENTIFIED NEED	OBJECTIVE	INTERVENTION	PLANNED REVIEW DATE

- (33) TYPE OF TREATMENT MODALITY .....
- (35) DATE OF FIRST APPOINTMENT OFFERED TO START MODALITY .....
- (24) (36) DATE TREATMENT (MODALITY) ACTUALLY STARTED .....
- 29) DATE OF DRUG TREATMENT HEALTH CARE ASSESSMENT .....

Service User Signature .....

\*Copy of assessment given to/declined by service user.

RISK ASSESSMENT (Use **Specific DICE** and attach a copy to assessment)

Have you completed a DICES Risk Management Plan

YES/NO/NA

Please note, when a brief DICE identifies a specific risk, a specific DICE and Risk Management Plan must be completed at the comprehensive assessment.

RISK MANAGEMENT PLAN (See DICES guidance)

Describe the risk Identify all significant risks posed to or by service user to self or to others. Give evidence.

Identify the options List all options for risk management, including those you reject.

Choose your preferred option(s) Whichever you select will become your risk management plan. Details may be expanded; include those who will undertake task(s). You may select alternative plans.

Explain your choice Give reasons for your plan and for those rejected options.

Share the thinking Include those with whom you have consulted and shared the decision making. Say also where copies of the risk assessment have been sent, where filed and with whom further discussions are planned.

***Risk assessments should be reviewed and renewed as the degree of risk changes.***

ASSESSED BY..... &.....

OFFICE USE  
Recorded By..... (8)Client ref..... Date.....