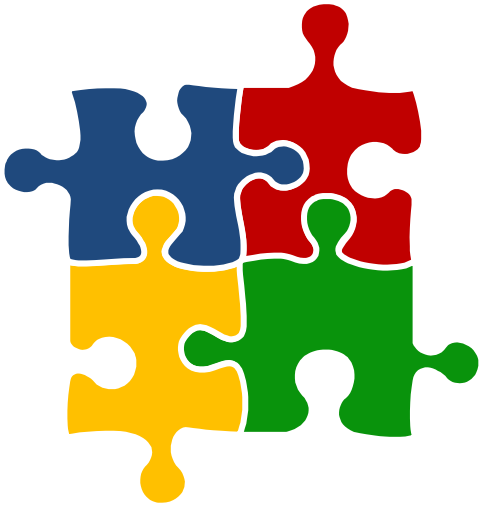
Dun Laoghaire Rathdown LDTF Area
Drug Rehabilitation Pilot Project

Initial Assessment Form



Please enquire if individual has recently completed an Initial Assessment form.
All sections indicated by the symbol ★are also required for NDTRS forms.

GENERAL INFORMATION

★ Surname: ★ Forename(s): ★ Nickname(s):

★ Gender: Male Female

★ Age: ★ DOB: (dd/mm/yy)

★ PPS No.:

★ Address: ★ Telephone number:

County: Landline: Mobile:

CAN WE			**CAN WE PHONE YOU ON**		
Write to you at this address	Yes ☐	No ☐	Mobile number	Yes ☐	No ☐
Call in person to the above address	Yes ☐	No ☐	Landline number	Yes ☐	No ☐

IN CASE OF AN EMERGENCY

Name of next of kin: Relationship to you:

Is this person aware of your substance use/ contact with this service: Yes ☐ No ☐

Phone number: Landline: Mobile:

Address:

★ Referral date:

Date assessment commenced:

★ Source of referral: *(Please circle as appropriate)*

Self ☐	Family ☐	Friends ☐	GP ☐
Outreach Worker ☐	Employer ☐	School/College ☐	Harm Reduction Programme ☐
Prison ☐	Other drug treatment centre ☐	Social/ community service	Accident & Emergency ☐
Acute hospital service (excluding A&E) ☐	Mental Health Service including psychiatrist ☐	Court/ probation/ police ☐	Mental Health Nurse at A&E ☐
Not Known ☐	Other (please identify)		

★ Where do you live: *(Please circle as appropriate)*

Stable accommodation ☐	Institution ☐	Homeless ☐	Other unstable accommodation ☐

★ Who do you live with: *(Please circle as appropriate)*

Alone ☐	Parents/family ☐	Friends ☐	Partner (alone) ☐	Partner & children ☐
Foster care ☐	Alone with children ☐	Not known ☐	Other (please identify)	

★ Nationality – Country on passport:

★ Ethnic origin: *(Please circle as appropriate)*

Do not wish to answer question ☐	White Irish ☐	White Irish traveller ☐	Other white background ☐
Black African background ☐	Other black background ☐	Chinese background ☐	Other Asian background ☐
Other: (Please specify)			

★ Age left primary or secondary school: *(or circle below as appropaite)* _____

Never went to school ☐	Still at school ☐	Not known ☐

★ Highest level of educational attainment: *(Please circle as appropaite)*

Primary level incomplete ☐	Primary level ☐	Junior cert. ☐	Leaving cert. ☐	Third level ☐
Never went to school ☐	Special needs education ☐	Still in education ☐	Not known ☐	

★ Employment status: *(Please circle as appropaite)*

In paid employment ☐	Unemployed ☐	FÁS training course ☐	Student ☐
Retired/ unable to work ☐	Not known ☐	Other (Please specify)	

Client Initials:	DOB:

CURRENT SUBSTANCE USE

Current Drug Use refers to substances used for non-medical purposes over the past 30 days.

★ **Drug type** Please rate in order of preference/ regularity of use in the brackets e.g. 1, 2, 3, etc.	★ **Age at first use**	★ **How often used** 1. Daily or almost daily. 2. Several times a week. 3. At least once a week. 4. Less than once a week. 5. Not known.	★ **Amount used**	★ **Route of transmission** 1. Inject. 2. Smoke 3. Eat/ drink. 4. Sniff/ snort. 5. Sublingual. 6. Rectal. 7. Topical.	★ **Harm reduction awareness** Discuss harm reduction issues. Y/N
Alcohol (__)					
Heroin (__)					
Methadone (non-prescribed or not taken as prescribed) (__)					
Other opiates (including codeine) (__)					
Benzodiazepines (__)					
Amphetamines (Crystal Meth) (__)					
Cocaine powder (__)					
Crack Cocaine (__)					
LSD (__)					
Ecstasy (__)					
Magic Mushrooms (__)					
Solvents (__)					
Cannabis (__)					
Steroids (__)					
Tobacco (__)					
Other medicines (__)					
Other (Please specify) (__)					

SUBSTANCE USE ASSESSMENT

For assessor.
Please explain that you are going to ask some questions about the persons use of substance (drugs and/ or alcohol, as appropriate). Explain that these questions are asked to determine if the person is experiencing risky or problematic use.

Explain that substance use can affect many areas of a persons life and it is important to know how much and the ways/ patterns in which substances are consumed and whether any problems have been experienced in relation to use.

Also explain that some questions asked in the screening tools/ assessment may repeat other questions asked in the course of the interview but are necessary to obtain a clear picture of potential difficulties experienced.

Client Initials:	DOB:

ALCOHOL USE

The Alcohol Use Disorder Identification Test (AUDIT)[1]

Please ensure questions are read as written. Record answers carefully. Begin the AUDIT by saying 'Now I am going to ask you some questions about your use of alcohol beverages during this past year'. Explain what is meant by 'alcoholic beverages' by showing examples of Irish standard drinks. Code answers in terms of Irish 'standard drinks'. Place the correct answer number in the box at the right. **(See overleaf for standard drinks.)**

1. How often do you have a drink containing alcohol?

   (0) Never **(skip to Qs 9 – 10)**
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have six or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

   Skip to Questions 9 and 10 if Total Score for Questions 2 & 3 = 0

4. How often during the last year have you found that you were not able to stop drinking once you had started?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

9. Have you or someone else been injured as a result of your drinking?

   (0) No
   (2) Yes, but not in the last year
   (4) Yes, during the last year

10. Has a relative or friend or a doctor or another heath worker been concerned about your drinking or suggested you cut down?

    (0) No
    (2) Yes, but not in the last year
    (4) Yes, during the last year

Record total score here

For guidance and reference please refer to
AUDIT The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (WHO, 2001)[1]

Client Initials:	DOB:

Standard Drinks Information

A "standard drink" in Ireland is approximately 10 grams of alcohol. This is not to be confused with a "unit of alcohol" which is a UK measurement and contains 8 grams of alcohol. Below is a rough guide to how many standard drinks are contained in Irish measures of alcohol [2].

BEVERAGE TYPE	SERVING SIZE DESCRIPTION	SERVING SIZE MLS
Beer	Half pint/ glass	(284mls)
Cider	Half pint/ glass	(284mls)
Alcopops/ RTD	Long neck bottle	(275mls)
Wine	Small glass	(100mls)
Liqueurs	Glass	(71mls)
Spirits	Single measure	(35.5mls)

AUDIT SCORING AND INTERPRETATION OF SCORES[1]

Total scores of 8 or more are recommended as indicators of hazardous & harmful alcohol use as well as possible alcohol dependence. (A cut-off score of 10 will provide greater specificity but at the expense of sensitivity.)

Since the effects of alcohol vary with average body weight and differences in metabolism, establishing the cut-off point for all women and men over the age of 65 one point lower at a score of 7 will increase sensitivity for these population groups.

Professional judgement should be exercised in cases where the individual's score is not consistent with other presenting evidence or if the individual has a prior history of alcohol dependence.

It may also be instructive to review responses to individual questions dealing with dependence symptoms (Q4, 5, & 6) and alcohol related problems (Q 9 & 10). Provide the next highest level of intervention to individuals who score 2 or more on Q 4, 5, & 6, or 4 on Q 9 or 10.

AUDIT SCORE	RISK LEVEL	INTERVENTION
0 - 7	**Low risk** drinking or abstinence.	Provide individual with appropriate **alcohol education** materials to reinforce low-risk drinking.
8 - 15 (**NOTE:** 7 is cut-off point for all women and men over aged 65)	**Risky or hazardous** drinking. Moderate level of risk.	Undertake **brief intervention** using simple **advice** and appropriate **alcohol education** materials which focus on the reduction of hazardous drinking.
16 - 19	**High-risk, harmful & hazardous** drinking.	Simple **advice**, **brief counselling** and **continued monitoring** should be undertaken. Further **diagnostic evaluation** should be undertaken if the individual does not respond to interventions or alcohol dependence is suspected.
20 - 40	**High-risk.** **Alcohol dependence likely.**	**Referral** should be made to o specialist services for diagnostic evaluation and possible treatment of alcohol dependence.

Please obtain a brief relevant alcohol case history: (Continue on back page if required)

★ Please specify the main type of alcohol you consume:

Beer ☐	Spirits ☐	Wine ☐	Fortified wine ☐	Cider ☐	Alcopops ☐	Other (specify) ☐

★ How many drinks would you have consumed over a typical drinking session over the last month: (If none put 0)

★ On how many days did you drink alcohol over the past month: (If none put 0)

Please categorise the extent of drinking problem (as per tool):

Low risk drinking/ abstinence ☐	Hazardous drinking ☐	Harmful drinking ☐	Dependent drinker ☐

★ Have you ever previously been treated for problem alcohol use:

Never treated ☐	Previously treated ☐	Not known ☐	Not applicable ☐

Client Initials:	DOB:

DUDIT

Drug Use Disorders Identification Test

Here are a few questions about drugs. Please answer as correctly and honestly as possible by indicating which answer is right for you.

☐ **Man** ☐ **Woman** **Age** ☐☐

1. How often do you use drugs other than alcohol? (See list of drugs on back side.)	Never ☐	Once a month or less often ☐	2-4 times a month ☐	2-3 times a week ☐	4 times a week or more often ☐
2. Do you use more than one type of drug on the same occasion?	Never ☐	Once a month or less often ☐	2-4 times a month ☐	2-3 times a week ☐	4 times a week or more often ☐
3. How many times do you take drugs on a typical day when you use drugs?	0 ☐	1-2 ☐	3-4 ☐	5-6 ☐	7 or more ☐
4. How often are you influenced heavily by drugs?	Never ☐	Less often than once a month ☐	Every month ☐	Every week ☐	Daily or almost every day ☐
5. Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?	Never ☐	Less often than once a month ☐	Every month ☐	Every week ☐	Daily or almost every day ☐
6. Has it happened, over the past year, that you have not been able to stop taking drugs once you started?	Never ☐	Less often than once a month ☐	Every month ☐	Every week ☐	Daily or almost every day ☐
7. How often over the past year have you taken drugs and then neglected to do something you should have done?	Never ☐	Less often than once a month ☐	Every month ☐	Every week ☐	Daily or almost every day ☐
8. How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never ☐	Less often than once a month ☐	Every month ☐	Every week ☐	Daily or almost every day ☐
9. How often over the past year have you had guilt feelings or a bad conscience because you used drugs?	Never ☐	Less often than once a month ☐	Every month ☐	Every week ☐	Daily or almost every day ☐
10. Have you or anyone else been hurt (mentally or physically) because you used drugs?		No ☐	Yes, but not over the past year ☐		Yes, over the past year ☐
11. Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?		No ☐	Yes, but not over the past year ☐		Yes, over the past year ☐

Turn the page to see the list of drugs

LIST OF DRUGS

(Note! Not alcohol!)

Cannabis	Amphetamines	Cocaine	Opiates	Hallucinogens	Solvents/inhalants	GHB and others
Marijuana Hash Hash oil	Methamphetamine Phenmetraline Khat Betel nut Ritaline (Methylphenidate)	Crack Freebase Coca leaves	Smoked heroin Heroin Opium	Ecstasy LSD (Lisergic acid) Mescaline Peyote PCP, angel dust (Phencyclidine) Psilocybin DMT (Dimethyltryptamine)	Thinner Trichlorethylene Gasoline/petrol Gas Solution Glue	GHB Anabolic steroids Laughing gas (Halothane) Amyl nitrate (Poppers) Anticholinergic compounds

PILLS – MEDICINES

Pills count as drugs when you take

- more of them or take them more often than the doctor has prescribed for you
- pills because you want to have fun, feel good, get "high", or wonder what sort of effect they have on you
- pills that you have received from a relative or a friend
- pills that you have bought on the "black market" or stolen

SLEEPING PILLS/SEDATIVES

Alprazolam	Glutethimide	Rohypnol
Amobarbital	Halcion	Secobarbital
Apodorm	Heminevrin	Sobril
Apozepam	Iktorivil	Sonata
Aprobarbital	Imovane	Stesolid
Butabarbital	Mephobarbital	Stilnoct
Butalbital	Meprobamate	Talbutal
Chloral hydrate	Methaqualone	Temesta
Diazepam	Methohexital	Thiamyal
Dormicum	Mogadon	Thiopental
Ethcholorvynol	Nitrazepam	Triazolam
Fenemal	Oxascand	Xanor
Flunitrazepam	Pentobarbital	Zopiklon
Fluscand	Phenobarbital	

PAINKILLERS

Actiq	Durogesic	OxyNorm
Coccilana-Etyfin	Fentanyl	Panocod
Citodon	Ketodur	Panocod forte
Citodon forte	Ketogan	Paraflex comp
Dexodon	Kodein	Somadril
Depolan	Maxidon	Spasmofen
Dexofen	Metadon	Subutex
Dilaudid	Morfin	Temgesic
Distalgesic	Nobligan	Tiparol
Dolcontin	Norflex	Tradolan
Doleron	Norgesic	Tramadul
Dolotard	Opidol	Treo comp
Doloxene	OxyContin	

Pills do NOT count as drugs if they have been prescribed by a doctor and you take them in the prescribed dosage.

Client Initials:	DOB:

DUDIT SCORING AND INTERPRETATION OF SCORES[3]

Scoring for each DUDIT item:

ITEMS	SCORING
1-9	0,1,2,3,4
10 - 11	0,2,4

Sum up all the points for the 11 items. The maximum score is 44.

It is suggested that **men** with drug– related problems be identified at a cut-off score of **6 points or more** (≥ 6).
Women with drug- related problems are identified at a cut– off score **2 points or more** (≥ 2).
An individual with **25 points or more** is probably heavily dependent on drugs.

Record total DUDIT score here ❑

DRUG USING HISTORY

Please obtain a brief and relevant drug using history:

★ What has been your type of contact with this programme/ service:

First treatment ☐	One or more treatment periods ☐	Not known ☐

What is the number of times you started treatment in this programme/ service this year (Jan – Dec) :

★ Have you ever previously been treated for problem drug use:

Never treated ☐	Previously treated ☐	Not known ☐	Not applicable ☐

If previously treated please state for which drug(s):

★ If you previously received opioid replacement treatment, please specify age first received opioid substitution treatment:

★ Please specify the first drug you used (excluding alcohol):	★ What age were you when you first used:

Client Initials:	DOB:

DRUG USING RISK BEHAVIOURS

Please obtain a brief history of possible drug using risk behaviours:

★ History of injecting:

Never injected ☐	Has injected ☐	Not known ☐

★ What age were you when you first injected (if applicable) : Not known ☐

★ Frequency of injecting (if applicable):

Injected in the last 30 days ☐	Injected in the last year but not in the last 30 days ☐	Ever injected but not within The last 12 months ☐

If you are currently injecting, which sites do you use?

Are you experiencing any problems or difficulties with your injection sites? Yes ☐ No ☐
If 'yes' to above please elaborate.

★ History of sharing needles & syringes:

Never shared needles & syringe ☐	Has shared ☐	Not known ☐

★Frequency of sharing needles & syringes (if applicable)**:**

Has shared in the last 30 days ☐	Shared needle or syringe in the last 12 months (but more than 30 days ago) ☐	Shared needles or more than 12 months ago ☐	Don't know/ don't want to answer ☐

History of sharing other drug using equipment (spoons, sterile water, citric acid, tourniquet, swabs, snorting equipment.):

Never shared equipment ☐	Has shared equipment ☐	Not known ☐

Frequency of sharing equipment (spoons, filters, mixing tools, sterile water, citric acid, tourniquet, swabs, snorting equipment.):

Has shared in the last 30 days ☐	Shared equipment in the last 12 months (but more than 30 days ago) ☐	Shared equipment more than 12 months ago ☐	Don't know/ don't want to answer ☐

Have you ever experienced an overdosed?

Yes ☐	No ☐

If 'yes' to above can you tell me what happened and when it happened?

Client Initials:	DOB:

HEALTHCARE

PHYSICAL HEALTH:

Are you currently receiving medical treatment for any health condition? Yes ☐ No ☐	If yes, please give details:
Have you experienced any ill health in the past that required medical treatment? Yes ☐ No ☐	If yes, please give details:
Do you currently have any concerns about your physical health? Yes ☐ No ☐	If yes, please give details:

Are you currently taking any prescribed medications?

NAME	DOSE/ FREQUENCY	PRESCRIBED BY	COMMENTS: e.g. why prescribed.

Do you have any physical access requirements/ physical disabilities? Yes ☐ No ☐	If yes, please give details:

IF FEMALE:

Are you pregnant?	Yes ☐	No ☐	Don't know ☐
If yes, do you know which date your baby is due? (Please insert expected due date if known)			
Is the Drug Liaison Midwife involved in your pregnancy care?	Yes ☐	No ☐	
If other healthcare workers are involved in your pregnancy care please give details: (E.g. General Practitioner, Obstetrician, Hospital Midwife, Social Worker, etc)			

MENTAL HEALTH:

Are you currently receiving any help for mental health difficulties? Yes ☐ No ☐	If yes, please give details:
Have you received help for mental health difficulties in the past? Yes ☐ No ☐ Don't know ☐	If yes, please give details:
Do you currently have any concerns about your mental health? Yes ☐ No ☐	If yes, please give details:

Client Initials:	DOB:

ONGOING CARE

Please identify any services/ workers you have been in contact with over the past year. (This may include: addiction treatemt service, housing /homeless services, GP, counsellor, children's support services, employment services, education & training agencies, etc.)

N.B. We will not contact any service you are or have been in contact with without discussing it with you first and obtaining your consent to do so.

Service/ organisation	Workers name	Contact details: phone number +/- address

Do you currently have a care plan to help you with any needs you may have?

Yes ☐	No ☐	Not Known ☐

If 'yes' to above and you have a Case Manager can you please identify the worker (Case Manager), the organisation and their contact details?

Can you identify any goals you may have in relation to your substance use in the long term?

1.
2.
3.

Please identify any goals you may have in relation to your substance use in the short- term?

1.
2.
3.

Please indicate any of the areas below that you think you would like help/ support with:

Physical / dental health ☐	Mental / psychological health ☐	Housing/ living arrangements ☐	Family/ relationships ☐
Income & finance ☐	Education & training ☐	Hobbies / recreational activities ☐	Legal issues ☐

Client Initials:	DOB:

ASSESSMENT DETAILS – For office use only.

★ Date initial assessment completed (dd/mm/yy):

★ Assessment outcome:
Is this person suitable for substance use treatment?

Yes ☐	No ☐

Is this person being referred for comprehensive assessment:

Yes ☐	No ☐

If 'yes' to above to which agency/ service is this person being referred to for comprehensive assessment?

★ Has this centre (to which person is being referred) assessment criteria being fulfilled:

Yes ☐	No ☐	Pending ☐

★ Date assessment criteria fulfilled, if applicable (dd/mm/yy):

Date of referral:

Assessors observations and comments:

Please outline any interventions carried out or advice/ information given:

1.	4.
2.	5.
3.	6

Please outline any service this person has been referred to:

1.	4.
2.	5.
3.	6.

Has the confidentiality policy been explained to individual?

Yes ☐	No ☐

Has a 'Consent to share information' form been signed?

Yes ☐	No ☐

Assessment completed by:

Name:	Service/ organisation:

Client Initials:	DOB:

ADDITIONAL INFORMATION

References:

[1] Babor, T., Higgins-Biddle J., Saunders, J. & Monteiro, M. (2001). *AUDIT The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (2nd Ed.).* World Health Organisation.

[2] Hope, A. (2009). *A Standard Drink in Ireland: What strength?* Health Service Executive—Alcohol Implementation Group.

[3] Berman, A., Bergman, H., Palmstierna T. & Schlyter, F. (2003). DUDIT (Drug Use Disorders Identification Test) Manual. Stockholm: Karolinska Institutet.