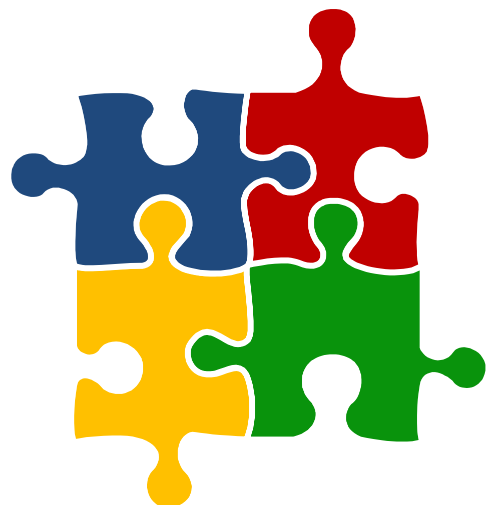
Dun Laoghaire Rathdown LDTF Area
Drug Rehabilitation Pilot Project

Comprehensive Assessment Form



Prior to carrying out this Comprehensive Assessment please ensure that you have copy of Initial Assessment previously completed.

If you did not carry out the Initial Assessment with this client please spend some time with them reading through it as it forms the basis of their Comprehensive Assessment.

GENERAL INFORMATION

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

Assessment date:

Gender: Male ☐ Female ☐

Age: DOB: (dd/mm/yy)

PPS No.:

Address:

County:

CAN WE

Write to you at this address Yes ☐ No ☐

Call in person to the above address Yes ☐ No ☐

:

Telephone No.:

Landline:

Mobile:

CAN WE PHONE YOU ON

Mobile number 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 drug use/ contact with this service: Yes ☐ No ☐

Phone number: Landline: Mobile:

Address:

Assessment commencement date:

Referrer/ referring agency:

Name of referrer & referring agency:	Address of referring agency:	Contact number of referrer / referring agency:

Referral date:

Can you give me some details about the reason for your referral? (What are the issues / difficulties you have been experiencing?)

Client initials: DOB:

Can you outline any services/ agencies that you are currently involved with:

	Name of agency:	**Name of (key) worker in agency:**	**Address of agency:**	**Contact number of agency:**
Substance Use				
Physical Health				
Mental/ Psychological/ Emotional Health				
Family & Current Relationships				
Accommodation & Living Arrangements				
Income & Finance				
Employment				
Education & Training				
Legal issues				
Recreational Activities / Hobbies				
Religious/ Spiritual Matters				
Cultural / Ethnic Matters				

Client initials: DOB:

SUBSTANCE USE

Please insert screening tool score as appropriate (See Initial Assessment):

DUDIT score ☐	AUDIT score ☐

Is there anything you would like to tell me about your current substance use including any current Drug Using Risk Behaviours? (Refer to Current Drug Use & Drug Using Risk Behaviours in Initial Assessment.)

Have you ever received help for your drug or alcohol use in the past?

Drug use: Yes ☐ No ☐	Alcohol Use Yes ☐ No ☐
If yes to above please state where and when you received this help/ treatment:	If yes to above please state where and when you received this help/ treatment:
Please describe the type of help/ treatment you received: (E.g. individuals counselling, residential detox, residential rehabilitation, methadone maintenance, etc)	Please describe the type of help/ treatment you received: (E.g. individual counselling, group counselling, residential rehabilitation, etc)
What did you find most useful about this help/ treatment?	What did you find most useful about this help/ treatment?
What, in your opinion, was the overall outcome for you and your drug use having received this help/ treatment?	What, in your opinion, was the overall outcome for you and your alcohol use having received this help/ treatment?
What type of help/ treatment do you think would be beneficial to you now?	What type of help/ treatment do you think would be beneficial to you now?

Do you experience withdrawal symptoms when you stop taking substances? (Examples may include nausea, vomiting, diahorrea, abdominal discomfort, muscle aches, anxiety, irritability, insomnia, palpitations, shakes, sweating, memory loss, confusion, convulsions or blackouts.) If yes, please give details.

Client initials:	DOB:

SEVERITY OF DEPENDENCE SCALE (SDS)[1, 2]

The following questions are about your substance use prior to commencing treatment. For each of the five questions, please indicate the most appropriate response, as it applied to your **substance use in the month prior to starting treatment**

	Never/ Almost never	Sometimes	Often	Always/ nearly always
Do you think your use of .... (preference substance was out of control?	0	1	2	3
Did the prospect of missing a fix (or dose) ....(preference substance) make you anxious or worried?	0	1	2	3
Did you worry about your use of ....(preference substance)?	0	1	2	3
Did you wish you could stop?	0	1	2	3
	Not difficult	**Quite difficult**	**Very difficult**	**Impossible**
How difficult did you find it to stop or go without ……….(preference substance)?	0	1	2	3

SDS TOTAL: ☐

Severity of Dependence Scale

This table provides guidelines for diagnostic cut-off points for dependence/ problematic use for various substances. They should therefore be interpreted within the context of the overall assessment. Where discrepancies arise in the research regarding the cut-off point for a specific substances the lower cut-off point is indicated below. When assessing an individuals level of dependence, the higher the total score the higher the level of dependence [3]. Assessors are advised to consult referenced research papers for guidance on cut-off points.

Alcohol ≥ 3 [4]	Benzodiazepines ≥ 7 [10]	Cocaine ≥ 3 [7,8]
Amphetamines ≥ 5 [5]	Cannabis ≥ 3 [6]	Opiates ≥ 3 [8,9]

Please identify the goals you have in relation to your substance use in the longer term:

1.

2.

3.

What changes would you like to make in relation to your substance use in the short term?

1.

2.

3.

Client initials:	DOB:

PHYSICAL HEALTH

Is there any additional information about your current or past medical history that you think it would helpful for us to know about? (Refer to Initial Assessment)

Do you have any dental health needs? If 'yes' please give details:	Yes	☐	No	☐
Have you any concerns about your sexual health? If 'yes' to above please give details:	Yes	☐	No	☐
Do you know how you can protect yourself against sexually transmitted infections?	Yes	☐	No	☐
If female have you ever had a smear test? If 'yes' can you give me an estimated date of when you had your last smear?	Yes	☐	No	☐
If 'no' would you like to have a smear test taken?	Yes	☐	No	☐
Do you have any concerns about contraception? If 'yes' please give details?	Yes	☐	No	☐

Have you ever had a:

HIV test	Yes	☐	No	☐	Don't know	☐
Hepatitis B test	Yes	☐	No	☐	Don't know	☐
Hepatitis C test	Yes	☐	No	☐	Don't know	☐

If 'yes' to any of the above are you aware of the test results? Please give details:

If you received a positive Blood Bourne Virus (BBV) test result did you received any treatment? Please give details:

Do you know if you have ever been vaccinated against hepatitis B?

Yes	☐	(If 'yes' please give estimate of date) ____________	No	☐	Don't know	☐

Would you like to have a blood test taken to screen for:

HIV	Yes	☐	No	☐
Hepatitis B	Yes	☐	No	☐
Hepatitis C	Yes	☐	No	☐

Are you aware of the ways in which HIV, hepatitis B & C can be transmitted from one person to another?	Yes	☐	No	☐

Has information been given to you on: (If applicable)

Needle exchange services:	Yes	☐	No	☐
Safer drug using practices:	Yes	☐	No	☐
Safer sex practice:	Yes	☐	No	☐

Client initials:	DOB:

Do you think that there is a connection between your substance use and your physical health?
If 'yes' please give details:

General Practitioner: (Family doctor)

Name of GP:	Address of GP:	Contact number of GP:

Is your GP aware of your substance use and any issues/ difficulties you may have in relation to it?

Yes ☐	No ☐

Do you currently have:

A medical card?	Private health insurance?	Other?
Yes ☐ No ☐	Yes ☐ No ☐	Please specify:

Please identify any goals you have in relation to your general/ dental health in the longer term:

1.
2.
3.

What progress do you want/ supports do you require in relation to your general/ dental health in the short term? (If applicable)

1.
2.
3.

Client initials: **DOB:**

MENTAL/ PSYCHOLOGICAL/ EMOTIONAL HEALTH

Is there any additional information about your past or current mental/ psychological/ emotional health that you think it would be helpful for us to know about? (Refer to initial assessment)

If you are currently receiving help or have in the past received help for mental/ psychological/ emotional health problems can you tell us:

What do/ did you find most useful about this help/ treatment?

If you are/ have been treated for a mental health problem can you tell me what you are/ have been treated for, if known: (your diagnosis)

If you are/ have been treated for a mental health problem can you tell me the name and address of the psychiatrist or doctor that treated you:

Are you aware of any family history of mental health problems? Yes ☐ No ☐
If 'yes' please give details:

Client initials:	DOB:

Have you ever deliberately self-harmed? Yes ☐ No ☐
If 'yes' can you give me more details?

Have you ever considered or attempted suicide? Yes ☐ No ☐
If 'yes' can you give me more details?

Do you think that there is a link between your substance use and your mental/ psychological/ emotional health?
If 'yes' please give details:

Please identify any goals you have in relation to your mental/ psychological/ emotional health in the long term:
(If applicable)

1.
2.

What steps do you think you need to take to achieve your goals in relation to your mental/ psychological/ emotional health in the short term? (If applicable)

1.
2.
3.

Client initials:	DOB:

FAMILY AND CURRENT RELATIONSHIPS

Who do you currently live with? (Refer to Initial Assessment)

Name:	Name:	Name:	Name:
Relationship to you:	Relationship to you:	Relationship to you:	Relationship to you:

Name:	Name:	Name:	Name:
Relationship to you:	Relationship to you:	Relationship to you:	Relationship to you:

Are any of your family members (including your spouse/ partner) aware of your substance use? If 'yes' please give details: Yes ☐ No ☐

Are any of your family members (including your spouse/ partner) aware that you are trying to address your substance use? If 'yes' please give details: Yes ☐ No ☐

Do you think that your family members or friends would support you in addressing your substance use? Yes ☐ No ☐

If yes, who do you think would support you and in what ways?

Do any of your family members (including your spouse or partner) have difficulties with drugs or alcohol or have a history of addiction? If 'yes' please give details: Yes ☐ No ☐

Do you have any children? If 'yes' please complete table below:

Name: Age: If this child does not live with you who do they live with: Do you see this child regularly? (How often?) What area is you child living in: (if known)	Name: Age: If this child does not live with you who do they live with: Do you see this child regularly? (How often?) What area is you child living in: (if known)
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Client initials: **DOB:**

Do you have any concerns about your children's health, welfare or development? Yes ☐ No ☐
If 'yes' please give details:

Have you ever received assistance from any service/ agency to help you with your children's health, welfare or development? If 'yes' please give details: Yes ☐ No ☐

Do you think that you need assistance from any service/ agency to help you with your children's health, welfare or development? If 'yes' please give details Yes ☐ No ☐

Do you think that there is a connection between your substance use and your relationships? If 'yes' in what ways? Yes ☐ No ☐

Please identify what goals you have in relation to your family and relationships in the long term:
(If applicable)

1.
2.

What progress do you want/ supports do you require in relation to your family and relationships in the short term: (If applicable)

1.
2.
3.

Client initials: **DOB:**

ACCOMODATION AND LIVING ARRANGEMENTS

Please refer to initial assessment for:
Living with who: Living where:

Do you currently have any concerns or difficulties with your accommodation or living arrangements? If 'yes' please give details: Yes ☐ No ☐

How many accommodation moves have you had in the past five years? Please give details of where you have lived, with whom and for how long you lived there:

Where:	With whom:	For how long:

Please continue on further information sheet if needed.

Have you ever experienced homelessness? Yes ☐ No ☐
If 'yes' please give details:

If you are currently homeless are you registered with a Local Authority Yes ☐ No ☐
If 'Yes', which Local Authority:

Do you think that there is anything that impacts/ would impact on your capacity to live independently? (E.g. disabilities, mental health problems, etc) Yes ☐ No ☐
If' yes' please give details:

Is there anything about running or maintaining a home that you are concerned about or think you might need help with? If 'yes' please give details: Yes ☐ No ☐

Do you think that there is a link between your drug/ alcohol use and your accommodation and living arrangements? If 'yes' please give details: Yes ☐ No ☐

Please identify any goals you may have in relation to your accommodation and living arrangements in the long term: (If applicable)

1.
2.

What progress do you want/ supports do you require in relation to your accommodation and living arrangements in the short term: (If applicable)

1.
2.
3.

INCOME AND FINANCE

Do you currently have any financial issues/ concerns? Yes ☐ No ☐
If 'yes' please give details:

Do you have a regular income? Yes ☐ No ☐
If 'yes' from where?

Are you currently in receipt of any benefits? Yes ☐ No ☐
If 'yes' what benefits do you receive?

Are there any benefits you think you may be entitled to that you are not receiving? Yes ☐ No ☐
Please give details:

On average how much does your alcohol/ drug use cost you daily?

On average how much does your alcohol/ drug use cost you weekly?

Does you income match your expenditure? Yes ☐ No ☐

If 'no' how do you finance your additional expenditure?

Do you currently have any debts? Yes ☐ No ☐

If 'yes' do you have a plan to manage the payments of your debts? Yes ☐ No ☐

In your opinion, is there a link between your drug/ alcohol use and your financial issues/ concerns? If 'yes' please give details: Yes ☐ No ☐

Please identify what goals you may have in relation to your finances in the long term: (If applicable)

1.
2.

What progress do you want/ supports do you require in relation to your finances in the short term: (If applicable)

1.
2.
3.

Client initials:	DOB:

EMPLOYMENT

Are you?

Employed full-time	☐	Student	☐
Employed part-time	☐	In training	☐
Unemployed	☐	Other (Please state):	☐

What hours of the day and days of the week do you attend work/ college/ training?

Days of week:	
Hours of day:	

Is there any flexibility around the times you attend work/college/ training? (We ask this to see what services operate at times that may suit you)

Yes	☐	No	☐

Have you worked in the past? If 'yes' please give details. Yes ☐ No ☐

Would you like to change your current employment situation? If 'yes' please give details: Yes ☐ No ☐

Do you have any specific employment interests or areas of employment that you would like to pursue? If 'yes' please give details: Yes ☐ No ☐

Do you think that there is a connection between your substance use and your employment situation? Yes ☐ No ☐

Please identify what goals you may have in relation to your employment situation in the long term: (If applicable)

1.
2.

What progress do you want/ supports do you require in relation to your employment situation in the short term: (If applicable)

1.
2.
3.

Client initials:	DOB:

EDUCATION & TRAINING

Can you tell me a bit about your education & training history?

At what age did you leave school?

What is the highest level of education you have attained? (E.g. primary level, secondary level, third level, special needs education, etc)

Can you tell me of any other training or education you have been involved in?

Have you ever been on a CE scheme? Yes ☐ No ☐
If 'yes' can you give details of when this was and where?

Do you have any literacy, numeracy or learning difficulty needs? Yes ☐ No ☐

If 'yes' would you like to address these needs? Yes ☐ No ☐
Please give details:

If you have previously engaged in an education or training course, what did you find most useful or enjoyable about it?

Would you be interested in attending education or training? Yes ☐ No ☐

If 'yes' what are your areas of interest or what particular skills you would like to learn?

Please identify what goals you may have in relation to your education & training in the long term: (If applicable)

1.
2.

What progress do you want/ supports do you require in relation to your education & training in the short term: (If applicable)

1.
2.
3.

Client initials:	DOB:

LEGAL ISSUES

Do you currently have any concerns about legal issues? Yes ☐ No ☐
If 'yes' can you give me details?

Have you in the past ever been:

Charged with an offence?	Yes ☐	No ☐
Been convicted of an offence?	Yes ☐	No ☐
Received a prison sentence?	Yes ☐	No ☐

If 'yes' to any of the above please give details:

Do you have any outstanding warrants or charges? Yes ☐ No ☐
If 'yes' please give details:

Are you currently involved with an agency or individual who is assisting you with you legal issues? (E.g. solicitor, probation service/ officer, Citizen's Advice Bureau) If 'yes' please give details: Yes ☐ No ☐

Do you think there is a connection between your substance use and your legal issues? If 'yes' please give details: Yes ☐ No ☐

Please identify what goals you may have in relation to your legal issues in the long term: (If applicable)

1.
2.

What progress do you want/ supports do you require in relation to your legal issues in the short term: (If applicable)

1.
2.
3.

Client initials:	DOB:

RECREATIONAL ACTIVITES/ HOBBIES

Are there any recreational activities or hobbies that you are involved in? Yes ☐ No ☐

If 'yes' to above please give details:	If 'no' to above, is there any recreational activity you would like to get involved in? Please give details:

Do you think that involvement in recreational activities or hobbies benefits, or would benefit, you and your life? Yes ☐ No ☐
If 'yes' in what ways?

RELIGIOUS & SPIRITUAL MATTERS

Is there anything you think we need to know in relation to providing you a service that is in keeping with your religious beliefs and practices? Yes ☐ No ☐
Please give details:

CULTURAL & ETHNIC MATTERS

Do you have any cultural or ethnic customs or practices that you think we should know about while we are delivering a service to you? Yes ☐ No ☐
If 'yes' please outline what they are:

Please identify what goals you may have in the long term: (If applicable)

Recreational activities / hobbies	Religious & spiritual matters	Cultural & ethnic matters
1.	1.	1.
2.	2.	2.

What progress do you want/ supports do you require in the short term: (If applicable)

Recreational activities / hobbies	Religious & spiritual matters	Cultural & ethnic matters
1.	1.	1.
2.	2.	2.
3.	3.	3.

Client initials: **DOB:**

CHANGE

Throughout this assessment process you have identified that you want to address or make changes to different areas of your life

What are the most important reasons you want to make these changes?

What results/ outcomes do you hope for yourself and your life in making these changes?

Do you feel ready to make these changes now? Yes ☐ No ☐

If 'yes' to above, what do you think you have to do to make these changes happen?

If you do not feel ready to make changes now what do you think would help you make the changes you want?

What do you think will be most difficult for you in making these changes?

Can you identify ways to overcome these difficulties?

Can you identify the main areas that you want to address or change (3- 5areas)? (Please place in order of priority).

1.

2.

3.

4.

5.

Client initials: **DOB:**

ASSESSMENT DETAILS

Date assessment complete:

Assessors observations and comments: (Continue overleaf if required)

Please indicate individual's screening & diagnostic scores:

DUDIT ☐ AUDIT ☐

SDS ☐ (indicate for which substance) __________ SDS ☐ (indicate for which substance) ___________

SDS ☐ (indicate for which substance) __________ SDS ☐ (indicate for which substance) ___________

Interventions recommended and undertaken:

Assessed	**Need identified** (Please tick as appropriate)	**Recommended intervention:**	**Referral made to: (service name & date)**
Substance Use			
Physical / Dental Health			
Mental/ Psychological/ Emotional Health			
Family & Current Relationships			
Accommodation & Living Arrangements			
Income & Finance			
Employment			
Education & Training			
Legal Issues			
Recreational Activities/ Hobbies			
Religious & Spiritual Issues			
Cultural Issues			

Client initials: **DOB:**

ADDITIONAL INFORMATION

Client initials:	DOB:

ADDITIONAL INFORMATION

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