

CHAPTER 4 ASSESSMENT

This Chapter examines and discusses the **process** of assessment and describes the **key principles** of evidence-based, effective assessment placing the service-user at the centre of the process. We have examined and reviewed evidence from a number of sources including research papers, policy guidance and consultation with commissioners, service providers and service users. This includes a questionnaire survey of drug services in Scotland about their use of assessment tools and focus groups conducted by Scottish Drugs Forum with service users in Scotland. The key findings from the focus groups are set out in Appendix 2.

This Chapter sets out:

- the definition of assessment, its rationale and the wider context
- the evidence on the factors that contribute to an effective assessment process
- key principles and elements of practice

It also offers practical advice on selecting assessment tools.

What is assessment?

The purpose of assessment is to identify the needs and aspirations of the individual in order to inform decisions about treatment, care and support for drug users. It usually takes the form of one-to-one discussions between the staff member and the individual. If the assessment process is working effectively, the individual should be a full participant and understand and agree the goals of treatment, care and support.

Effective assessment is an **ongoing process**, not a one-off event. It seeks to identify the range and level of needs of the individual, not only problems with drug misuse but also health, social and economic circumstances. It explores the individual's attributes and aspirations. The outcome should be informed decisions about treatment, care and support that are regularly reviewed and revised as necessary. Ongoing assessment helps both service users and service providers to measure progress against agreed goals and supports transition to another type of service, when appropriate.

As a result of the assessment process, the individual should understand the purpose of assessment and:

- know where he/she is going and why
- receive the 'right' services
- know how and when progress is being made

The Rationale: why is assessment important?

An effective assessment process is at the **core of effective service delivery and co-ordination**. The assessment is the key to establishing with the individual **as complete a picture as possible of their needs and their state of readiness to change** in order to provide the most appropriate service/s likely to promote a positive outcome. Without this information, the individual may be referred to a service that does not match their needs and aspirations, leading to disillusion and drop-out from services.

The Wider Context

In the wider health and social care arena, there is an increasing emphasis on broader assessment to encompass the wide range of health and social needs of individuals. For example, The World Health Organisation (WHO) define it as:

“(Assessment is) a process designed to reach a thorough understanding of a person’s problems in the overall context of his or her life with the object of developing a treatment plan that stands the best chance of being helpful. ”

The development of more effective assessment has been an issue for a number of sectors and services in Scotland in recent years. For example, the Beattie Committee report on post-school education, training and employment for young people who have social, emotional and behavioural problems clearly identified the importance of effective assessment (Scottish Executive 1999). Following the report, the Scottish Executive published a review of assessment for young people who have additional support needs (including disadvantaged and disaffected young people) and a digest of assessment tools (Scottish Executive, 2001). The digest can be downloaded at www.scotland.gov.uk/library3/education/ilsn.pdf. In England, the ConneXions Framework also addresses assessment for this group of young people and has produced guidance and practical tools. More information is available at www.dfes.gov.uk.

Joint Future

One of the key drivers for development of the assessment process for people with drug misuse problems is the Scottish Executive’s Joint Future agenda. As set out in Chapters 1 and 2, the aim of Joint Future is to improve partnership working between agencies (through joint resourcing and joint management) and to secure better outcomes for service users and their carers. <http://www.scotland.gov.uk/health/jointfutureunit/>

A key element of Joint Future is the establishment of locally agreed, **single shared assessment procedures** for all groups within the remit of community care.

In November 2001, the Joint Future Unit of the Scottish Executive issued guidance on single shared assessment. Within this guidance a **minimum standards checklist** was provided in order to ensure that local single shared assessment tools meet a number of specific criteria. The guidance notes, which accompanied this document, confirmed that the minimum standards checklist for single shared assessment **would** apply to all care groups. It states that a core data set is to be established for all community care groups, **including drugs and alcohol** during the course of 2002 to 2003.

The **core data** set currently in use (for elderly services) is divided into 4 sub-sets, as follows:

- personal information core data set
- assessed need core data set (components of need)
- care plan core data set
- important medical conditions guide

What is Single Shared Assessment?

Single Shared Assessment creates a single point of entry to community care services and will lead to better use of resources and more effective outcomes for people in need.

Single shared assessment:

- ensures that agencies adopt a holistic approach to assessing and meeting people's needs, reducing bureaucracy and duplication in assessment and planning care
- should be person-centred and needs led. It should be seen as a continuing process throughout a person's episode of care and relate to the level of need at all times
- is a shared process that supports joint working by seeking information once, co-ordinating all contributions from service providers, clients and people close to them
- has an identified lead professional who co-ordinates documents and shares appropriate information
- actively involves people who use services and their carers
- provides results which are acceptable to all agencies

The **Joint Future Unit** states that in order to achieve this:

'Agencies should put in place single shared assessment processes and a single shared assessment tool. This should be done through the development of joint protocols to ensure agreement locally in the systems for and ownership of assessments and the provision of joint training for staff in assessment practice'.

There are a number of **planned results** of single shared assessment:

- shorter routes to services and faster passage along these routes
- raise assessment practice to new levels
- put people at the centre
- lead professionals to manage process
- information asked for only once
- information shared between professionals appropriately
- outcomes accepted by fellow professionals

The Assessment Process

The development of an effective assessment process at local level for people with drug misuse problems will take place within the wider context of Joint Future and, specifically, single shared assessment. In this Chapter, we set out key areas to address, and principles and elements of effective practice that we have identified from the evidence that we have gathered. We have also produced an outline framework for an assessment process and a draft personal information core data set and an assessed need core data set (Annexes 4A and 4E).

From the evidence, we have identified the following key factors that influence assessment:

- working with the individual
- assessment practices and procedures
- working with other agencies
- transition from assessment to planning and delivery of care

1. Working with the individual

To be effective, the assessment should place the individual at the centre of the process. Assessment should be a process that is done with the individual rather than done to them (EIU consultation workshops 2001, Type 5). The service users' focus groups showed that some clients did not understand what the assessment process was or what it was trying to achieve. Service users often felt assessment was 'done' to them (SDF 2002, Type 4). They saw assessment as an external procedure that must be complied with to get to the next stage of treatment or support.

You mean after your first couple of interviews when you've got to sit through all that cxxp and tell them your life history and what your granny gave you for tea when you were nine and all that. That's what you mean by assessment is it.

SDF Focus Group Respondent 2002

You get what they offer you. They've only got one thing to offer and you get it.

SDF Focus Group Respondent 2002

Assessment should be **needs led**. It should **not** be service-led, resource-focused or unnecessarily time-consuming. The assessment process should be a way of working and an integral **part of the overall care of the drug user**. It may in itself constitute a therapeutic process, allowing the client to explore the wider issues that influence their drug use. This means that the development of a trusting relationship with staff is important. The service users' focus groups suggested that this may be difficult because of the **number of workers** seen during the assessment process.

More recent methods of collecting a broader range of information have moved away from the traditional diagnostic tools that are often performed **on** the individual rather than **with** the individual. This broader approach allows questions to be asked that are fundamental to the ethos of providing **person-centred care**. In recent years there has been a move towards **self-reporting**, which seeks the views, opinions and concerns of the individual.

There are a **number of factors** that impact on the effectiveness of the assessment process:

Time: Both service providers and service users' commented on the sometimes lengthy time taken to complete assessments. The service user focus groups clearly demonstrated that they considered the process to be too long (SDF 2002, Type 4). One group reported that in their area it took eight weeks just for the assessment process to be completed. Others reported four-five weeks and one participant reported three months. This led to further loss of motivation and a view that the process was a 'waste of time'. When deciding the type of assessment (see section 2 below) and the time required for an assessment, it may be felt

necessary to “get an early win for the user”: for example, to secure a prescription for methadone. A broader approach to helping the individual identify the factors associated with their drug misuse problem may have to come later.

Repetition and Duplication: Many drug users will require treatment, care and support from a number of service providers, whether at the same time or serially. One of the main causes of frustration and disillusion was the duplication of assessment and the constant repetition that resulted. This is also an issue for services and the EIU consultation workshops identified the waste of **time and resources** arising from the gathering of the same information through constant re-assessment.

Focus Groups- number of workers

Participants had to see a minimum of three workers during the assessment process. They were asked the same kinds of questions by each and in some cases this felt like the same assessment over again. That lack of information sharing appeared to the individual as frustrating rather than protecting confidentiality.
SDF 2002

Focus Groups- Client involvement in decisions

With one exception participants said that there was no involvement by them in decisions reached because either:

- Participants did not expect to have any say in the decisions reached about them
- Participants agreed totally with the decisions reached, but had no say in it and believed the decision could have been reached a lot quicker
- Participants did not agree with decisions reached but were told that there was no alternative. This appears to be based primarily on disagreement over level of methadone dose or rejected benzodiazepine

Ownership: The service user focus groups on the assessment process also clearly demonstrated that as participants in the assessment process, service users feel a lack of **ownership**, and a lack of **involvement** in the final decisions that were reached about their treatment, care and support. Further, in some cases, users did not necessarily expect to have any say in these decisions either. The key findings from the focus group work on assessment can be found in Appendix 2.

The **key objectives** when working with an individual include:

- to ensure that the individual understands **the purpose of the assessment process and his/her part in it**
- **to identify and agree the individual's needs and problems** and agree realistic goals
- to reach an understanding **about the individual' strengths, skills, attributes and support systems** that will need to be utilised to the full in order to help the person to address the difficulties that they face
- to identify and agree with other service providers **the most appropriate service(s) to match the assessed needs**
- to provide a framework within which to help the individual **to measure their progress in achieving change and reaching their goals**

2. Assessment practices and procedures

Levels of assessment

The EIU consultations emphasised the need for **different levels of assessment**. Drug users frequently come into contact with a wide range of agencies at different stages in their treatment or recovery. A drug user may, for example, present at a Housing Department, Employment Service (New Deal) or benefit office. In those settings, the opportunity to identify the nature and extent of a drug problem is probably limited. The service user focus groups also highlighted the frustration and disappointment that can occur when a first contact is followed by an in-depth, lengthy assessment. During the course of treatment, a referral to a specific service may lead to a more detailed assessment. In line with Joint Future guidance, **three levels of assessment** may be appropriate:

- **simple assessment (or screening)**
- **comprehensive assessment**
- **specialist (or in-depth) assessment**

It may be appropriate to capitalise on the opportunity of a first contact by conducting a **simple assessment (or screening)** to ensure an appropriate referral is made. This first level assessment could be described as the “gateway” into a process of care. It should be a helpful, non-threatening experience designed to encourage the individual to engage in a more in-depth exercise and ultimately promote the development of a therapeutic relationship. The data collected at this stage is likely to be relatively basic, probably socio-demographic information, perhaps cursory information about their drug use and its likely impact on the individual's ability to access services. Simple assessment could allow access to low level services e.g. harm reduction advice and information.

Comprehensive assessment may be used in health and social care settings when the individual has made a direct approach or has been referred by another agency. This assessment could cover more detailed information on drug use and other factors such as housing, employment, health and benefits. This assessment should allow some decisions about treatment, care and support to be made, or whether it is appropriate to refer an individual elsewhere.

Specialist (in-depth) assessment may be appropriate when a client has been referred to a specialist agency, or has moved on from entry-level assessment. This assessment would cover in detail the nature and extent of drug use, physical and psychological health, personal and social skills, social and economic circumstances, previous treatment episodes and assets and attributes of the individual.

Suggested specific content for each level of assessment is laid out in Annex 4A.

Who can Assess?

The Joint Future Unit has produced a useful breakdown of who could undertake an assessment within the three levels. This could be adapted by DATs and partner agencies at a local level.

Simple assessment -	professionally qualified staff in health, housing and social work who are the first contact; vocationally qualified staff; and unqualified staff with training in assessment.
Comprehensive assessment -	professionally qualified staff in social work or health;
Specialist assessment -	professionally qualified staff in social work, health and housing, who may have recognised expertise; vocationally qualified or trained staff in specialist areas where simple specialist assessment is needed; and professionally qualified or trained staff in specialist independent agencies.

(JFU, 2002)

There are some aspects of the role of assessors within the different levels of assessment to consider:

- what kind of referral they can make
- whether they have any decision-making powers in relation to treatment and care
- whether they have any authority to commit resources

The extent to which assessors are engaged in these aspects of assessment and link to the subsequent care planning has implications for their recruitment, selection and training. For example, generic staff will require basic training in the principles of drug-related assessment and in the use of the tool employed while staff in more specialised services would require a higher level of skill and competence. STRADA now offers interdisciplinary training on the principles and function of assessment, followed by local training on jointly agreed protocols. The new STRADA post-graduate Certificate in Addictions will also include an assessment component.

Self-reporting

As noted above, there has been increasing interest in **self-reporting** as an important component of the assessment process. It can help where the client feels constrained by the circumstances and unwilling to talk, promote more participation and add valuable information not gathered through the standard tools. Self assessment tools such as the Rickett Scale may assist but service providers have expressed concern about the lack of scope within some current tools to record clients' views and opinions or to allow individual responses (EIU consultation workshops 2001, Type 5, Rome 2002, Type 2/3).

However, Carroll (1995, Type 2) suggests that there are an immeasurable array of factors that may affect the reliability and accuracy of self-reporting. These include:

- the frequency of the individual's substance use
- the type of drugs being used
- the positive or negative consequences of reporting substance use
- the type and precision of information sought
- whether the behaviour assessed is illicit or socially undesirable
- the length of the interval between the substance use and the assessment
- the individual's treatment status
- the use of corroborating sources such as collateral reports and biological markers
- the way in which information is collected: in face-to-face interview, through questionnaire or through a computerised self-report

There is also a need for some caution in how to interpret statements made by the client. There may be a risk in taking clients self-reports at face value. Wiggins (1973 Type 3) states that accurate measurement requires all four of the following criteria to be met:

- described items (or symptoms) have common meaning among clients and between the client and the assessor
- the client must be able to accurately assess his or her own internal state. Distortions due to defensiveness or insensitive observations must be minimised
- the client must report those internal states honestly to the assessor
- the item or items are in fact related to the concept of the condition as used by the assessor

A study into the assessment of severe mental illness and addictions (Carey 1998, Type 3) stated that self-reporting was an essential tool and the best way to gain access to private information. They suggest four factors that will influence the validity of self-reporting:

- **sobriety:** intoxication at the time of assessment is associated with unreliable and invalid self-reports
- **acute distress:** assessment should take place at a point where the individual is not in acute psychiatric crisis, as under-reporting of recent substance use is likely in acute admission settings
- **cognitive impairment:** it is likely that some people with substance misuse problems experience cognitive deficits sufficient to impair their ability to provide accurate self-reports
- **motivated deception:** concerns about confidentiality can reduce self-reporting accuracy, especially when negative consequences e.g. legal or housing, are contingent upon admitting to using substances.

Errors in reasoning can occur when the assessor can recognise a possible relationship between the symptoms, or situation, which the client describes and the possible effects of drug misuse (Jones 1992, Type 3). While it may be useful and often necessary to believe the client, and to recognise the validity of their reporting, it cannot be assumed that their physical, psychological or social discomforts are drug related or that the client is able to interpret these symptoms in a way which accurately diagnoses the problems. Assessors should consider the possibility that there might be different explanations for the presenting problems, other

than drug misuse: for example, the experience of having flu can sometimes produce symptoms similar to those of opiate withdrawal.

Collateral Sources of Information

There may be useful additional information to be gleaned from family members, friends or other people in close contact with the individual. Wilson & Grube (1994 Type 3) describe collateral sources as including:

- friends and family
- other treatment providers (including community pharmacy)
- official records including results of urinalysis or oral solution drug testing
- reports from legal or other agencies

A study into the use of subject and collateral reports to measure alcohol consumption, (Maistro and Connors 1992, Type 3) states that collateral information sources have long been found to be useful in substance abuse treatment settings.

It is important to recognise that these different sources of information may vary in terms of their relative validity. Information provided through official records regarding recent drug consumption (levels and types of drug used) may provide a higher confidence of accuracy than that provided by the people closest to the individual.

“Particularly with the use of illicit substances, collaterals (significant other informants) may have limited opportunity to directly observe participants using behaviour...and thus their reports are likely to be based on the participant’s reports to them rather than on independent observation.” (Rounsaville 1981, Type 3)

Conversely, family and friends may provide the best source of qualitative information about how a person’s drug use is affecting them and those around them.

Assessment Tools

Assessment tools are used in a range of sectors to aid the assessment process. They are instruments developed by practitioners or academic institutions that facilitate the collection of information in a **systematic** fashion. Outcomes of assessment can be measured, contrasted and compared, in order to assist the practitioner and the client in identifying the nature and extent of problems.

Assessment tools are often used to **help guide and structure dialogue** between worker and client. When used in the assessment of drug users, they commonly collect information on an individual’s:

- drug use
- risk behaviour
- health, social and economic circumstances

Service providers stated that they need assessment tools, which are **tried and tested, fit for purpose and designed to identify the main issues that need to be addressed, and to elicit all the information required to identify individual need** (EIU Consultation workshops, Type 5). Practitioners working with individuals with drug misuse problems will need to be aware of the relative merits of each tool and be able to select tools that will assist them in their practice. A Guide to selecting assessment tools is at Annex 4C.

A Study of Assessment Tools

A study of assessment tools was completed in 2002 (Rome 2002, Type 2/3). The main aim of the study was to **map the use of assessment tools** in drug services in Scotland and to study the nature and extent of their application. The study provides an analysis of the range of assessment tools in use and compares how the circumstances of their actual use differ from the original purpose of the tool. The key objectives of the research were:

- to map and review existing research on assessment tools in the drug misuse field including their purpose, reliability, validity, and service providers' views on their strengths and weaknesses
- to examine service providers' views on the application of the tools, their strengths and weaknesses and the variation in the use of these tools across Scotland
- to investigate the development of a core data set and a standardised assessment tool across drugs services in Scotland.

The research methods included a review of the research literature to identify tools used for assessment, their appropriate application and where the various tools are used both nationally and world-wide. An examination of the tools used in Scottish drug services was investigated using a survey questionnaire. The type of information collated included both qualitative and quantitative data.

The results of this research suggest that there is a wide variation in the use of assessment tools in drug services across Scotland. Significantly, tools are **often not used for their designated purpose** e.g. the SMR 24 Scottish Drug Misuse Database proforma. One of the other key findings was that respondents attached importance to the development of a common or core assessment tool, and core information gathering to facilitate more integration between drug services across Scotland.

The key findings of the study were:

- only five validated tools are being used, primarily for assessment, by drug services in Scotland
- in general, an agency/service provider will use one tool for all client groups
- many of the tools currently used for assessment are not primarily designed for this purpose
- tools take too long to complete and often require additional time to score and input to a database
- many tools are used only once or sporadically rather than as part of planned process of monitoring the effectiveness of care provision.

A summary of the key findings of this study is presented in Annex 4B. EIU will produce a digest of Assessment Tools later in 2002 and it will be available online at <http://www.drugmisuse.isdsotland.org/eiu/eiu.htm>

3. Working with other agencies

Services need to work better together in the interests of the individual, sharing information to avoid duplication of assessment and agreeing common assessment tools, common data sets and referral discharge protocols.

Development of core data sets

As noted above, the Joint Future agenda requires the development of a single, shared assessment and a core data set for people with drug misuse problems. A common assessment that tried to capture all the information needed by key agencies could be lengthy and impractical. However, from our review of the evidence, including the consultations with both service providers and service users, there is support for a **core assessment** to produce an agreed **core set of information or data set** that would be useful to all agencies and service providers. This would cover socio-demographic information, health, housing, employment history, income/benefits as well as the nature of the drug misuse. If such information were available to all the relevant parties, it would benefit clients who would not experience the frustration of answering the same questions on several occasions. It would also offer reassurance that the “system” knows about them and is actively pursuing their care.

The use of a core set of information or data set should also help service providers to do their job better. They will have the basic information and be able to work with the individual on the more detailed assessment necessary to inform decisions about appropriate treatment, care and support within their service. In this way, a core or common assessment could contribute significantly to a **person-centred service**.

In some parts of Scotland, such data sets are already in use (Forth Valley and Aberdeen City). The Study of Assessment Tools (Rome 2002, Type 2/3) included a mapping of tools currently in use in Scotland and, from that information, we have produced a draft core data set.

The core data set consists of the following two sub-sets:

- **Personal information core data set**
- **Assessed need core data set (components of need)**

The two data sets are set out in Annex 4E of this Chapter.

A core data set would also provide consistent information across the area to help DATs with **service evaluation and planning** for the future pattern and provision of services in their area. EIU Evaluation Guide 7, “Using assessment data for evaluation” examines when and how assessment data collected by drug services can be used as part of an evaluation design. It briefly outlines the definitions, purposes and principles of assessment and examines how specific tools can be used in evaluation.

http://www.drugmisuse.isdsotland.org/goodpractice/EIU_evaluationg7b.pdf

In order to facilitate the development of integrated care systems at local level there should be a clear and standardised process across all participating agencies. There may be a case for a **standardised assessment protocol and/or tool**, for simple, comprehensive and specialist assessments to be available to all these agencies in order to ensure consistency in implementation and in the quality of the information obtained. This would require agreement between agencies and training for staff appropriate to the level of assessment.

The development and use of a single shared assessment tool would require **collaboration and co-operation** between agencies/service providers and their staff:

- to agree the core areas/questions
- to agree joint protocols on information sharing
- to develop robust joint working arrangements between agencies and agreement on how resources can be jointly used to provide the appropriate services for the individual

Staff should be able to provide up-to-date information on the nature and availability of **other services**, to enable their client to make informed choices about what services they would wish to access and from which service provider (see Chapter 3). The skills and attributes of staff are vital to building a relationship with the client and in maintaining and enhancing their motivation to change. In order to do this staff should be trained in line with core competencies, where possible through multi-agency training.

As noted above, STRADA has already identified assessment as a topic for modules that are delivered to a range of staff from a range of agencies. DATs should actively encourage their constituent agencies to ensure that staff receive training and support ongoing joint training locally.

Impact of parental or family drug use on children

At the EIU consultation workshops, service providers voiced concerns about **a lack of information about, or involvement of, the family**, in the assessment process and a lack of attention paid to the needs and welfare of children. The consultation document on guidelines for joint working with children and families affected by drug misuse "Getting Our Priorities Right" (Scottish Executive, 2001) reported that there could be improvements in involving family members in the assessment process. Further, the draft guidelines highlighted the importance of addressing children's needs and welfare in the assessment process. By identifying potential or actual, problems affecting the children as a result of drug misuse, the opportunity arises to alert staff in the appropriate agencies. "Getting Our Priorities Right" contains an assessment framework for assessing problem drug use and its impact on parenting.

The final guidelines on inter agency working for those working with children and families affected by drug misuse will be published later in 2002. We have included a specific item on "risk to dependant children" in the Assessed need core data set (see Annex 4E).

Information Sharing

One of the key issues for agencies engaged in the treatment, care and support of drug users is **information sharing**. An effective assessment process requires a commitment from agencies both to share and safeguard client information in order to reduce the risk of inappropriate referrals and to ensure that clients have access to the service that best matches their needs (EIU consultation workshops 2001, Type 5).

While the evidence suggests that there is strong support for information sharing, there is also a recognition that there are potential barriers. Agencies have legitimate concerns about the need for confidentiality but there are also wider concerns that difficulties about the sharing of information are sometimes a result of agencies' own "confidentiality policy" rather than the best interests of the clients themselves (EIU consultation workshops 2001, Type 5).

From our consultations there was a view that the decision about sharing information should be made between the individual worker and the drug user on the understanding that all the factors had been explained and understood between them. The principle of **informed consent** is a key component of single shared assessment and there is now guidance from the Scottish Executive on informing individuals and obtaining consent (CSAGS 2002) 'Protecting Patient Confidentiality : Final Report').

In Chapter 6, **Information Sharing**, we have set out the key elements of 2 major national initiatives on information sharing:

- the principles and protocols for information sharing produced by the Confidentiality and Security Advisory Group for Scotland (CSAGS)
- the eCARE Programme, to develop the technology to support information sharing

The Chapter also contains practical examples from the substance misuse field of how information sharing issues have been dealt with locally.

4. Transition from Assessment to Planning and Delivery of Care

The assessment process is not an end in itself. Its purpose is to inform decisions about treatment, care and support with a view to matching services to the assessed needs of the individual. The completion of the assessment should, therefore, be a clear statement of the type and level of the individual's needs and an agreed set of goals. There could also be value in a profile of the individual that covers needs, circumstance, attributes and aspirations. The outcome of the assessment process can be summarised in a proposed **Action Plan**. Annex 4A sets out key components of an Action Plan. This could include an **initial pathway to be considered** when planning the care to be delivered.

This is the "ideal" process. However, the research and consultation evidence seems to show that in a number of areas the range of available services is limited and may not meet all the needs. Chapter 3 sets out various factors affecting Accessibility and identifies principles and practice that could improve it. This may influence both the conduct and outcome of the assessment process i.e. assessing individuals to see how they fit into the existing services. It could be argued that this is a realistic approach and the service users' focus groups (SDF 2002, Type 4) shows that service users themselves may take that view. However, such an approach would mean that the real nature and extent of the problems faced by drug users would not be recognised and recorded. This would inhibit the potential to compare the needs of drug users with the current level, nature and capacity of service provision. This is an important element of the needs assessment exercise identified in Chapters 2 and 3 and is a key element of service planning.

This potential gap between the "ideal" service(s) for the individual as set out in the Action Plan following assessment and the creation of an integrated care plan that is subject to the constraints of available provision is a difficult issue to address for managers and practitioners. This is discussed in Chapter 5.

Remember Harry?

Having identified a drug service that might suit his needs, Harry's GP has referred him. The first step will be an assessment. The staff will work with Harry to gather information, not just about his problems with drug misuse but about the other things in his life that affect him.

Assessment Pathway

Harry attends his first appointment with the specialist drug service. He has an idea about what he wants and is keen to get started.

Processes

The assessment process gathers information, over a series of visits, on the client's type and level of needs; their attributes and their aspirations

Who gets to know all this?

Service providers should explain to clients with whom their personal data will be shared, the purposes for which it is shared and seek their consent to information sharing.

Outcomes

Harry has had the opportunity to discuss his problems and his needs, including the issues that impact on his family.

Harry understands that other providers can help meet his wider needs. He has a copy of the drug service's information sharing leaflet for service users and has given consent to sharing his personal information

The service provider should be signed up to a local inter-agency information sharing protocol.

Who will you speak to? What other information might you need to share?

With Harry's consent, core information from the assessment is communicated to other service providers who will contribute to his wider treatment, care and support.

What happens next?

The service provider should agree with the client, and other providers as necessary, what services are needed to meet their assessed needs and set appropriate goals.

Harry's assessment produces an Action Plan setting out his needs, the services to meet those needs and an agreed set of goals.



KEY PRINCIPLES AND ELEMENTS OF EFFECTIVE PRACTICE: ASSESSMENT

From our review of the research literature and the evidence that we have gathered through consultation, focus groups and the EIU Working Group, we have identified the following key principles and elements of effective practice:

1. Working with the Individual

An effective assessment process focuses on the individual. It should be:

- needs-led, not service-led, resource-led or unnecessarily time-consuming
- ongoing, not a one-off event
- part of the overall care process

An effective assessment process should encompass:

- the gathering of information about the type and level of needs, attributes and aspirations of the individual
- the development of a profile of the individual
- communication of the assessment outcome to appropriate providers
- an action plan, agreed with the individual and other agencies as necessary that identifies appropriate goals and the services likely to meet the assessed needs
- regular review and monitoring with reassessment at agreed intervals

Annex 4A sets out an outline framework for an assessment process for drug users.

The assessment process should cover the current position and changes in an individual's circumstances and needs. This commonly includes collecting information on personal, family and social circumstances, physical and psychological health, injecting-related risk behaviour and offending behaviour. It should also cover:

- clients' goals
- clients' expectations
- strengths
- support
- boundaries

The process should have a **clear time frame**. The service user needs to be aware of the proposed length of time involved to complete the assessment process as this appears to have an impact on level of motivation and retention in treatment.

Effective assessment requires the **full involvement and participation** of the individual at every stage, as far as possible, through:

The development of a two-way dialogue to ensure that the individual understands the purpose of the assessment and that the assessor has fully understood the information offered by the individual. From the staff's perspective, it is crucial that they are satisfied that they understand the service user's own perceptions about their needs and problems.

Encouraging ownership by the individual: for example, by the use of tools that support **self-assessment**, such as the Rickett Scale. The individual should have at least an equal share in the process and the outcome. There should also be an opportunity to record disagreement and agreements.

Openness to ensure that the individual knows:

who is involved in the assessment

what issues are being discussed and by whom

what judgement is being made about the type and level of their needs

Service users should be able to participate at every stage if they wish. One suggestion is that clients should be offered copies of their assessment summary and/or care plan.

Staff should be trained in the agreed skills and competencies to enable them to build a trusting relationship with the individual and carry out assessment effectively. As far as possible training should be inter agency.

2. Assessment practice and procedures

Drug users come into contact with a wide range of services at different stages of their treatment, care and support. It may be pragmatic and practical to have **different levels of assessment** to meet the presenting needs of the client; to reduce the risk of over long initial assessments; and to make the most effective use of time and resources. **Three levels of assessment** are set out in Annex 4A.

Assessment tools can help to guide and structure discussion between staff and individuals. Such tools commonly collect information on the individual's drug use, risk behaviour and health, social and economic circumstances. There is a need for tools that are **tried and tested and fit for purpose**. Careful consideration should be given to deciding **whether an appropriate tool does not already exist** and could be used with no or minor modification for the task in hand. A Guide to selecting assessment tools is at Annex 4C.

Self-reporting and collateral reporting are important and vital sources of information in assessing the impact of substance misuse on an individual.

3. Working with other agencies

Agencies should agree the core information (see Annex 4E for draft core data sets) that they are willing to transfer to ensure a smooth transition for the drug user and reduce duplication. Guidance on **informed client consent** will need to be observed. There would also have to be agreement about the sharing of **more detailed information** from a third-level or service specific assessment. There may be particular concerns about sharing of information in rural areas where communities are smaller and closer.

The DAT, working with agencies, should draw up **clear, strict protocols** to support sharing of information between agencies, as well as guidance on information sharing for clients (see Chapter 6 on Information Sharing).

4. From Assessment to Planning and Delivery of Care

From the assessment there should be an Action Plan for the individual. This Action Plan should be produced after **discussion and agreement between the individual and staff who have worked with him/her. Where possible, it could include service providers who could provide the appropriate treatment, care and support.** It should draw on the outcome of assessment tool(s), self-assessment by the individual, and the judgement of staff.

The Action Plan should recognise the needs, attributes and aspirations of the individual. It should offer a systematic way to support the individual to make progress towards agreed goals at a pace suitable for him/her; and to enable provider(s) to design and deliver the appropriate treatment, care and support "package". An example of what an Action Plan might contain is at Annex 4A.

Outline Framework for an Assessment Process for Drug Users

This framework has been adapted from the outline framework for assessment set out in the Beattie Report 'Implementing Inclusiveness' (Scottish Executive, 1999). While it covers some of the ground already set out in the main body of the Chapter, its aim is to **provide more detail on the key principles and components of the assessment process. It also sets out the specific items that would be covered in the three levels of assessment set out in Section 2 of the Chapter.**

Principles of Assessment:

- It must be open.
- It must be fair and accurate.
- It must be focused on the individual and not designed to accommodate the organisational structures or administrative practices of an agency.
- It must respect confidentiality.
- It must encourage full participation and ownership by the individual.
- It must aid progression.

It should also:

- Be continuous but not repetitive
- Be given adequate time and care
- Be carried out by competent and well-trained staff
- Be designed to allow the transfer of accurate, relevant and up-to-date information

The objectives of the assessment process:

- Identification of the type and level of need and the attributes and aspirations of the individual.
- Agreement jointly with the individual, and other service providers as appropriate, of an action plan for treatment, care and support.
- Agreed goals and arrangements for review and reassessment.
- Communication of the outcome of the assessment process to the appropriate providers and the arrangement of matching provision.

The elements of the assessment process:

- The assessment exercise.
- The profile.
- The action plan.

An assessment should be carried out:

- At initial contact.
- Regularly - but not too often.
- At every transition between services.
- After critical events.

What should it cover?

Simple assessment should cover:

The 21 items included in the Personal Information core data set.

Comprehensive assessment should cover:

The 12 sub-headings listed under the Assessed Need core data set, including detailed assessment of:

- Presenting problem
- Primary drug profile
- Secondary drug profile
- Injecting behaviour
- Signs and symptoms of oversedation or withdrawal
- Risk to self or others, including dependant children

Specialist assessment should cover

Detailed assessment of all data items included under the 12 sub headings of the Assessed need core data set.

Outcome of the assessment**(a) The Profile**

From the assessment process, a profile of the individual could be created to cover:

- The type and level of needs; drug treatment, social support, life skills
- Particular circumstances e.g. family problems, emotional and behavioural problems, debt, likely to create barriers to progress
- The aspirations and attributes, with particular attention to positive experiences in the past
- Goals – short term and longer term

(b) Action Plan

The Action Plan draws together the outcomes of the various stages of the assessment process. It should be produced after discussion between the individual and staff who have worked with him/her and, where possible service providers who could provide treatment, care and support. It should draw on the outcome of assessment tool(s); self-assessment by the individual; the judgement of staff; and the profile.

The Action Plan should recognise the needs, attributes and aspirations of the individual. It should offer a systematic way to support the individual to make progress towards agreed goals at a pace suitable for him/her; and to enable service provider(s) to design and deliver the appropriate treatment, care and support "package".

The action plan should specify:

- The goals
- The agreed treatment approach for drug use and the service provider
- The actions to address other problems e.g. housing, family support, offending behaviour, personal and social skills, education and training needs
- What will constitute progress and how it will be measured
- Dates for reviewing progress, who will be involved and the format
- The main contact

(c) Ongoing assessment and review

This should cover progress made by the individual towards goals including:

- Improvements in health
- Improvements in family and social functioning
- Reducing criminal behaviour
- Reduction in drug use
- Improvements in self esteem and motivation
- Movement towards employability

The individual should be offered the opportunity for self-assessment where possible as well as taking into account the use of assessment tools and professional judgement (see Chapter 5, Planning and Delivery of Care).

A planned review should take place at regular intervals to ensure that the care plan is revised to take account of changing needs and circumstances and that service providers are meeting needs appropriately and the agreed quality standards.

(d) Training

Staff should have access to regular training in the competencies appropriate to the level of assessment that they are engaged in. There should be opportunities for multi-disciplinary training at national and local level to support the development of joint working and information sharing.

The Use of Assessment Tools by Drug Services in Scotland Study of the Nature and Extent of Application

Rome A.M. (2002)

ABSTRACT

This study explored the use of assessment tools and frameworks in Scottish treatment services working with adults with drug misuse problems. It provides an analysis of the range of assessment tools in use and compares how the circumstances of their actual use differ from the original intentions of the design.

The main aim of the study was to map the use of assessment tools in drug services in Scotland and to study the nature and extent of their application. There were a number of key objectives to the research. The objectives were to map and review existing research on assessment tools in the drug misuse field including their purpose, reliability, validity, strength and weaknesses. Further, research aimed to examine service provider's views on the application of the tools and the variation in the use of these tools across Scotland. A further objective of the study was to examine the reliability and validity of the tools with the aim of investigating the development of a core data set and a standardised assessment tool across drugs services in Scotland.

The research methods incorporate a data analysis of the current literature to identify assessment tools, their appropriate application and where the various tools are used both nationally and world-wide. An examination of the assessment tools used in Scottish Drug Services was investigated using a Survey Questionnaire. The type of information collated included both qualitative and quantitative data.

The results of this research suggest that there is a wide variation in the use of assessment tools. Significantly, the tools are not often used for their designated purpose. Further, respondents seemed to attach importance to the development of a common assessment tool, and core information gathering to develop more integration between drug services across Scotland.

Guide to choosing assessment tools: Factors to consider

- **Primary use:** Ensure that the stated use of the tool matches your requirements. Tools primarily designed for outcome evaluation tend to collect quantitative rather than qualitative information.
- Ensure that the tool has been validated for use with the **target client group**. Some tools have been found to be inappropriate for some client groups such as prisoners or clients with co-existing mental health problems (Rome 2002, Type 2/3). Often tools are too broad in their scope to highlight particular issues synonymous with specific client groups.
- Available assessment instruments for substance users have been designed with different purposes in mind and vary widely in the **time frame** they capture. The assessor will need to be aware of the time frame covered by the instrument.
- Similarly assessors should be careful to select a measure sensitive to the **type of substance use** involved. Many tools have a focus on opiate injecting behaviour: the focus and nature of questions within the tool may have limited relevance to people using non-opiate drugs and who do not inject.
- Many tools provide a **composite measure or score** of the severity of substance use. This formula approach, multiplying **frequency of use** by **amount**, might indicate that, by comparison, using cocaine twice daily is less problematic than using a similar amount of opiate three times in a day. Assessors will need to be aware of the variance in scoring methods and how this affects the resulting care provision.
- Assessors should recognise that **short periods of abstinence** may be more significant for substances associated with steady use for example opiates or methadone than for those characterised by binge or episodic use e.g. cocaine.
- The **time taken to complete** assessment tools ranged from three minutes to four hours for the tools examined in the assessment tool study (Rome 2002, Type 2/3). Brief screening instruments tend to take less time to complete than comprehensive tools. On average, up to 30 minutes appeared to be a reasonable time to spend on a comprehensive assessment. Specialist or specific assessments, for mental state assessment or social enquiry report may take longer.
- **Administration:** tools that require scoring and/or inputting from paper to computer database will provide additional administrative work for frontline workers or require dedicated administrative support. Frontline workers score 61% of commonly used tools. One third of all tools reported in the study are stored on computer databases (Rome 2002, Type 2/3). The additional administrative requirements of each tool should be taken into consideration.
- **Training requirements:** Typically training of one day or less was required on the use of specific tools (Rome 2002, Type 2/3). Service managers should ensure that initial training and updates are available to all staff who would use these tools. Training should include issues regarding the assessment process and specific guidance on the use of selected tools.
- Developers of new instruments must consider carefully their usefulness across a number of potential substance use disorders and settings. Before embarking on developing a new assessment instrument for substance use, **careful consideration should be given to evaluating whether an appropriate one does not already exist and could be used with no or minor modification for the task in hand.**

Examples of tools currently used for assessment

- THE RICKTER SCALE
- CHRISTO INVENTORY FOR SUBSTANCE MISUSE SERVICES (C.I.S.S.)
- PERSONAL LIFESTYLE OUTCOME TRACE (P.L.O.T.)
- MAUDSLEY ADDICTION PROFILE (M.A.P.)
- ADDICTION SEVERITY INDEX
- COMMUNITY CARE ASSESSMENT – DRUGS & ALCOHOL (CCADA)
- SMR24: SCOTTISH DRUG MISUSE DATABASE MONITORING PROFORMA

From the results of the survey of tools currently used for assessment in Scotland (Rome 2002, Type 2/3), a comparison was made between Type A tools (common tool where identified primary use is assessment) and Type C tools (common tool where identified primary use is **not** assessment) and against the published research literature. Two of the tools identified in the mapping exercise do not appear in any published or unpublished studies, the SMR 24 and the CCADA. Information about SMR24 was provided by ISD and about CCADA by the Glasgow City Council Social Work Department. The information was used to create standalone profiles. Where comparisons are being made between the published research literature and the survey results, this is presented in parallel columns.

All information which has been collated from the results of the survey is presented in shaded boxes.

A digest of tools used for assessment will be produced in October 2002 and will be available online at www.drugmisuse.isdscotland.org/eiu/eiu.htm.

THE RICKTER SCALE

Background		
<p>The Rickter scale is a non-paper based tool (a colourful plastic board) that allows clients to explore their circumstances, identify priority areas for support and interventions. This tool is different from the others previously described because the client (with the support of a worker) completes it, so it is a form of self-assessment. The structure enables clients to explore possibilities, set goals and contribute to their own action plans. Evaluation of the Rickter scale suggests that it positively encourages interaction between the client and the worker.</p> <p>A bank of questions is available including personal social development, key skills, drugs and alcohol issues, preparation for work and community safety.</p>		
Where did you find out about this tool	Commissioners of Service 75% Word of Mouth 16.7% In-house staff training 8.3%	
How long have you used this tool	Mean 12 Months Standard Deviation 7.3	
Origin	Original Format 91.7% Modified for agency's use 8.3%	
Comparative Information	Published Research Literature	Survey Results (n=12)
Application		
Primary Use	Self Assessment	Assessment 75% Evaluation 41.7%
Secondary Use	Evaluation	Evaluation 41.7% Audit 16.7% Assessment 16.7% Screening 8.3% Research 8.3%
Client Groups	This tool has been used by projects funded by the New Futures Fund, which aims to support vulnerable groups (including recovering substance misusers) into employment, training and education.	Adult 83% Adolescent 50% Women 41.7% Ethnic Groups 33.3% Prisoners 25%
How often is this tool completed with each client	No information	3 Monthly 50% Initial & End 16.7% Ongoing 16.7% Monthly 8.3% As Required 8.3%
Administrative Issues		
Guidelines/Manual required	No information	Yes 91.7% No Information 8.3%
Approximate time to complete	The tool can be customised depending upon its intended use; thus completion time varies depending upon the number of questions selected.	Mean 40 minutes Standard Deviation 11.1
Time to score	No information	Mean 12.9 minutes Standard Deviation 7.2
Scoring by		

Validation: Rickter has not been formally validated. However, Scottish Enterprise has commissioned a research consultant to examine the utility of Rickter within the New Futures Fund initiative. Further, there are plans to undertake a validation study of Rickter in the future.		
Training requirements	None	Mean 1.3 day
Users Opinion & Comment		
Positive features	Relative Score 55.2% Good evaluation data Can be used for all clients Supports fuller assessment of clients needs Records the clients views / opinions	
Concerns	Relative Score 17.7% Can look like a toy. Some clients feel insulted Only records clients view on day of use Work is progressing for the data input to be easier	

CHRISTO INVENTORY FOR SUBSTANCE MISUSE SERVICES (C.I.S.S.)

Background		
<p>The CISS is a simple, validated, 10-item questionnaire producing a single score of 0 to 20 which is a general index of client problems. It has been used with both drug and alcohol services. CISS was developed to find out workers' impressions of their clients in a quick, standardised and reliable way and outcome areas are scored on a three point scale of problem severity (0 = none, 1 = moderate, 2 = severe). It can be used to monitor client problems at intake and at structured follow-up points. As with the MAP, CISS can be used to establish changes over time. For example, the CISS collects information on HIV risk behaviour that can be compared between first assessment and follow-up assessments, both for individuals and for the population of service users as a whole.</p>		
Where did you find out about this tool	Journal / Research 42% Conference / Seminar 25% Commissioners of Service 25% Word of Mouth 17% Internal 8%	
How long have you used this tool	Mean 7.82 Months Standard Deviation 5.04	
Origin	Original Format 75% Modified for agency's use 8.3% Developed for agency's use 8.3% Developed as joint tool with other agencies 8.3%	
Comparative Information		
Application	Published Research Literature	Survey Results (n=12)
Primary Use	The tool has been validated for outcome monitoring in a practice setting. Outcome measures include physical health, psychological health, drug use, HIV risk and criminal behaviour.	Assessment 83% Evaluation 16.6% Screening 16.6% Audit 8.3% Research 8.3%
Secondary Use	It also measures three areas of client-support interaction: the use of structured support (e.g. AA / NA counselling), compliance (e.g. with treatment requirements), and working relationships (e.g. ease of interviewing).	Evaluation 58.3% Research 33.3% Audit 33.3% Assessment 16.6% Audit 16.6%
Client Groups	All	Adult 100% Adolescent 83% Women 83% Ethnic Groups 83% Prisoners 50%
How often is this tool completed with each client	No information	3 Monthly 50% 6 Monthly 16.6% 12 Monthly 16.6% Monthly 8.3% Once & Review 8.3% As Required 8.3%
Administrative Issues		
Guidelines/Manual required	Guidelines are on form	No 66.6% Yes 33.3%
Approximate time to complete	The author notes that a worker familiar with the tool can complete	Mean 13.6 minutes Standard Deviation

	it in three to five minutes.	12.59
Time to score	No information	Mean 4.8 minutes Standard Deviation 3.6
Scoring by	No information	No information
<p>Validation: A validation study conducted by Christo and his colleagues was positive (Christo et al 2000). The CISS demonstrates good face validity because its items were acceptable to workers and clients. The CISS also scored well against other existing multi-dimensional instruments suggesting that content validity is also good. Further it appears to have good discriminant validity - the spread of scores was good and there were no ceilings on the scores.</p>		
Training requirements	None	Mean 0.7 day
Users Opinion & Comment		
Positive features	<p>Relative Score 60.4%</p> <p>Quick to complete Good evaluation data Tick boxes make information easy to record Can be used for all clients Supports fuller assessment of clients needs Records information in a consistent manner which can be shared with other agencies</p>	
Concerns	<p>Relative Score 16.7%</p> <p>Too simplified Does not record the clients views / opinions</p>	

Christo G, Spurrell S, Alcom R. Christo Inventory for Substance- Misuse Services. Drug and Alcohol Dependence 2000; 59: 189-197.

PERSONAL LIFESTYLE OUTCOME TRACE (P.L.O.T.)

Background		
The PLOT is a five-minute outcomes tool for assessment of behavioural dysfunction in drug misusers developed by the Community Alcohol and Drug Service at Forth Valley Primary Health Care Trust. PLOT is a self-contained, 'self-marking' tool that describes the status of a user at any stage in treatment.		
Where did you find out about this tool	Journal / Research 40% Word of Mouth 60% Member of team developed it 20%	
How long have you used this tool	Mean 9.8 Months Standard Deviation 7.12	
Origin	Modified for agency's use 60% Original Format 20% Developed for agency's use 20%	
Comparative Information		
	Published Research Literature	Survey Results (n=5)
Application		
Primary Use	outcomes tool for assessment of behavioural dysfunction	Assessment 60% Evaluation 60% Screening 20% Audit 20%
Secondary Use	No information	Evaluation 40% Research 20% Assessment 20% Audit 20%
Client Groups	No information	Adult 100% Adolescent 60% Women 100% Ethnic Groups 80%
How often is this tool completed with each client	No information	3 Monthly 80% 2 Monthly 20%
Administrative Issues		
Guidelines/Manual required	No information	Yes 80% No Information 20%
Approximate time to complete	It can be completed in around 5 minutes.	Mean 9.6 minutes Standard Deviation 5.6
Time to score	No information	Mean 5.8 minutes Standard Deviation 3.0
Scoring by	No information	No information
Validity: A three component research study was designed to examine the PLOT's validity, reliability and ability to measure change over time. Firstly PLOT was tested against the ASI and OTI and showed highly significant correlation with both. Secondly, the PLOT was shown to be highly reliable between users. Thirdly, a longitudinal study with 35 subjects showed change in most domains over time.		
Training requirements	None	Mean 1.0 day Standard Deviation
Users Opinion & Comment		

Positive features	Relative Score 77.5% <ul style="list-style-type: none">• Quick to complete• Good evaluation data• Tick boxes make information easy to record• Can be used for all clients• Supports fuller assessment of clients needs• Records information in a consistent manner which can be shared with other agencies
Concerns	Relative Score 14.3% <ul style="list-style-type: none">• Format of data collection does not easily lead itself to audit or evaluation

MAUDSLEY ADDICTION PROFILE (M.A.P.)

Background		
The MAP is a brief, multi-dimensional tool designed for assessing treatment outcome. It was developed at the National Addiction Centre in London. The MAP was developed from the interview instrument used in the National Treatment Outcome Research Study (NTORS). It includes 60 self-reported items and covers four main areas: substance use, health risk behaviour, physical and psychological health, and personal/social functioning. The authors stress the advantages of incorporating (not replacing) the MAP within existing assessment procedures. The MAP can also be extended and amended to suit local conditions (e.g. prevalence of specific drugs and patterns of use) and the recall periods can be adjusted for practical application.		
Where did you find out about this tool	Journal/Research 83% Conference 17% Word of Mouth 50%	
How long have you used this tool	Mean 18.7 Months Standard Deviation 9.7	
Origin	Original Format 33% Modified for agency's use 67%	
Comparative Information	Published Research Literature	Survey Results (n=6)
Application		
Primary Use	Assessing treatment outcome	Assessment 67% Evaluation 50% Screening 17%
Secondary Use	The results generated by using MAP are commonly used for service evaluation. In particular, it can be used to assess treatment outcomes.	Assessment 17% Research 33% Evaluation 33% Audit 33%
Client Groups	All	Adult 100% Adolescent 67% Prisoners 17% Women 67% Ethnic Groups 67%
How often is this tool completed with each client	Can be used routinely	Monthly 17% 3 Monthly 50% 6 Monthly 17% 12 Monthly 17%
Administrative Issues		
Guidelines/Manual required	Yes	Yes 67% No 17% No Information 17%
Approximate time to complete	Field-testing shows that the MAP takes an estimated 12 minutes to administer.	Mean 26.7 minutes Standard Deviation 15
Time to score	No information	Mean 13.3 minutes Standard Deviation 7.6
Scoring by	No information	No information
Validity: A validation study showed that the content of MAP was acceptable to clients and easily comprehended (Marsden et al 1998). Further, Results from the test-retest were highly acceptable and self-report validity was confirmed by the high level of agreement with results of urinalysis in a sub-sample.		
Training requirements	None	Mean 0.7 days Standard Deviation

Users Opinion & Comment	
Positive features	Relative Score 58% <ul style="list-style-type: none"> • Quick to complete • Good evaluation data • Records the clients views / opinions
Concerns	Relative Score 16.7% <ul style="list-style-type: none"> • Too long to input data to computer

- Marsden J, Gossop M, Stewart D, Best D, Farrell M, Lehmann P, Edwards C, Strang J. The Maudsley Addiction Profile (MAP): a brief instrument for assessing treatment outcome. *Addiction* 1998; 93(12): 1857-1868.

ADDICTION SEVERITY INDEX

Background		
<p>Researchers in the United States first developed the Addiction Severity Index (ASI) in the late 1970s. It is one of the most commonly used instruments in the addictions field internationally. The primary use of the ASI is screening. However, a secondary (and not unusual) use of the ASI is for outcome evaluation. The ASI has been used as the primary tool in numerous clinical outcome trials. Further, those commissioning substance misuse services have adopted some ASI items as performance indicators.</p> <p>The ASI collects information on 200 items across seven domains; medical status, employment status, drug use, alcohol use, legal status, family / social status and psychiatric status.</p> <p>Multiple versions of the ASI have been developed, including the Euro-ASI (developed with European funding in the 1990s).</p>		
Where did you find out about this tool	Training & Education 75% Conference 25%	
How long have you used this tool	Mean 23.3 Months Standard Deviation 26.2	
Origin	Original Format 75%	
Comparative Information		
	Published Research Literature	Survey Results (n=4)
Application		
Primary Use	Screening	Assessment
Secondary Use	Service Evaluation	Screening 25% Evaluation 25% Audit 25%
Client Groups	The ASI is most useful for adults who report substance misuse as a major difficulty.	Adult 75% Adolescent 25% Prisoners 25% Women 25% Ethnic Groups 25%
How often is this tool completed with each client	No information	Initially 25% Initially & Review 25% 3 Monthly 25% 6 Monthly 25%
Administrative Issues		
Guidelines/Manual required	The original research team has sought to help standardise the use of the ASI, including the provision of a specification for a standard database and suggestions for uniform coding and storage	Yes 50% No 50%
Approximate time to complete	50 – 60 minutes	Mean 67.5 minutes Standard Deviation 15
Time to score	5 minutes	Mean 18.8 minutes Standard Deviation 13.5
Scoring by	Technician Computer	No information

<p>Validity: It is shown to be reliable and valid (when correctly administered) across a range of clinical populations and treatment settings (McLellan et al 1980; McLennan et al 1985; Kosten et al 1985; Leonhard et al 2000). However, a study examining the reliability and validity of the ASI among clients with severe and persistent mental illness did not produce such positive results. This study showed that inter-observer reliability was satisfactory, but the test-retest results were relatively poor (Zanis et al 1997).</p>		
Training requirements	2 days - Training in the use of the tool and subsequent monitoring of ASI interviewers appears to be associated with increased validity (Alteman et al 2001).	Mean 1.8 days
Users Opinion & Comment		
Positive features	<p>Relative Score 59%</p> <ul style="list-style-type: none"> • Can be used for all clients • Supports fuller assessment of clients needs • Records information in a consistent manner which can be shared with other agencies • Records the clients views / opinions 	
Concerns	<p>Relative Score 14%</p> <p>Comments:</p> <ul style="list-style-type: none"> • Due to format, interview can become quite deep • Some questions quite sensitive 	

References

- Alteman AI, Mulvaney FD, Cacciola JS, Cnaan A, McDermott PA, Brown LS. The validity of the interviewer severity ratings in groups of ASI interviewers with varying training. *Addiction* 2001; 96: 1297-1305.
- Kosten TR, Rounsaville BJ, Kleber HD. Concurrent validity of the Addiction Severity Index. *Journal of Nervous and Mental Disorders* 1985; 171: 606-610.
- Leonhard C, Mulvey K, Gastfield D, Schwartz M. The Addiction Severity Index: A field study of internal consistency and validity. 2000; 18: 129-135.
- McLennan AT, Cacciola J, Kushner H, Peters R, Smith I, Pettinati H. The Fifth Edition of the Addiction Severity Index: cautions, additions and normative data. *Journal of Substance Misuse Treatment* 1992; 9(5): 461-480.

COMMUNITY CARE ASSESSMENT – DRUGS & ALCOHOL (CCADA)

Background		
<p>The development of the CCADA arose from addiction workers' views that the Community Care (CC1) Assessment Form was not appropriate (e.g. only 1 section on "nature of any dependencies") to record all the relevant elements within an addiction assessment. Thus, a group of Senior Addiction workers determined that an addiction assessment tool was required to cover</p> <ul style="list-style-type: none"> • Nature of Drug Use (Past and Present) • Treatment History, including current medication • Nature of Dependency, including any symptoms arising • Legal Issues • Potential for Change (positive and negative indicators) • Future Community Support <p>The CCADA was first used in Maryhill ADAPT in 1993. It is presently used within all Social Work Community Addiction Services and by some generic social workers</p>		
Where did you find out about this tool	Internal Development 44% Commissioners of Service 22% Community Care 11% Don't Know 11%	
How long have you used this tool	Mean 83.5 Months Standard Deviation 34.57	
Origin	Original Format 56% Modified for agency's use 11% Developed for agency's use 33%	
Comparative Information	Published Research Literature	Survey Results (n=9)
Application		
Primary Use	Assessment	Assessment 100% Screening 22% Evaluation 11% Audit 11%
Secondary Use	None	Screening 22% Research 11% Evaluation 11%
Client Groups	All except Prisoners	Adult 100% Adolescent 56% Prisoners 44% Women 89% Ethnic Groups 78% Residential 11%
How often is this tool completed with each client	Initially then as client's situation changes a new assessment is carried out.	Once 33% As Required 22% 6 Monthly 22% Once & Review 11%
Administrative Issues		
Guidelines/Manual required	No	Yes 11% No 78% Don't Know 11%
Approximate time to complete	45 minutes	Mean 123 minutes Standard Deviation 72.25
Time to score	No scoring	No Information
Scoring by	No scoring	
Validity: No studies undertaken		
Training requirements	None	Mean 0.6 days

Users Opinion & Comment		
Positive features	Relative Score 33.3% <ul style="list-style-type: none"> • Can be used for all clients • Records the clients views / opinions 	
Concerns	Relative Score 23.8% <ul style="list-style-type: none"> • Too long to complete • Format of data collection does not easily lead itself to audit or evaluation Other Comments: <ul style="list-style-type: none"> • Being replaced by longer version & questions • Impossible to extract useful information • Piloting new assessment Tool for Glasgow City Council 	

SMR24

Background		
<p>The SMR24 monitoring form was one of the most commonly identified assessment tools from the questionnaire survey, however it is not designed to be used as an 'assessment tool'.</p> <p>The SMR24 is the data collection tool for the Scottish Drug Misuse Database, which offers a profile of drug misuse in Scotland based on anonymous information on new problem drug misusers in contact with services.</p> <p>Established in 1990 at ISD Scotland on behalf of the Scottish Executive, the Database gathers information from most specialist drug services in Scotland and from a number of general practitioners, providing a unique source of information on drug misuse in Scotland. Statistics from the Database are published in the annual Drug Misuse Statistics Scotland publication, available via the Drug Misuse In Scotland website at: http://www.drugmisuse.isdsotland.org/index.shtml</p> <p>The information presented on the SMR24 form relates to new patients/clients. As such, the statistics do not reflect the total number of drug misusers seen by services during any period.</p> <p>The SMR24 form has been in use since April 2001. Prior to that date there were two forms in use: the SMR22 for prescribing services and SMR23 for non-prescribing services.</p> <p>For further information on providing information to the Scottish Drug Misuse Database, contact ISD Scotland at: http://www.drugmisuse.isdsotland.org/sdmd/sdmd.htm</p>		
Where did you find out about this tool	Commissioners of Service 42% National tool 25% Conference / Seminar 8.3% Developed In-house 8.3%	
How long have you used this tool	Mean 16.6 Months Standard Deviation 18.1	
Origin	Original Format 75% Developed for agency's use 16.6% Developed as joint tool with other agencies 8.3%	
Comparative Information	Published Research Literature	Survey Results (n=12)
Application		
Primary Use	Audit: It offers a profile of drug misuse in Scotland, based on anonymous information on 'new' problem drug users in contact with services.	Assessment 66.7% Research 25% Evaluation 16.6% Screening 8.3% Audit 8.3%
Secondary Use	Research	Audit 50% Evaluation 33.3% Screening 33.3% Assessment 25% Research 16.6%
Client Groups	All – although for the purpose of compilation of reports, excludes penal establishments inmates, to improve validity of comparisons between areas (as limited coverage)	Adult 100% Women 83% Adolescent 75% Ethnic Groups 75% Prisoners 66.7%

How often is this tool completed with each client	Initial contact, or if it has been at least 6 months since last attendance at the service.	Initial Contact 66.7% 6 Monthly 16.6% 3 Monthly 8.3% Initially & 6 Mthly 8.3%
Administrative Issues		
Guidelines/Manual required	Yes, there is a detailed manual and service providers have a copy.	Yes 66.7% No 25% No Information 8.3%
Approximate time to complete	No information	Mean 22 minutes Standard Deviation 16.8
Time to score	Not applicable	Mean 15 minutes Standard Deviation N/A
Scoring by	No scoring	N/A
Validity: No studies undertaken		
Training requirements	Less than, or equal to, one day. Training was provided in conjunction with introduction of the new SMR24 form.	Mean 0.75 day
Users Opinion & Comment		
Positive features	Relative Score 60.4% <ul style="list-style-type: none"> • Quick to complete • Good evaluation data • Tick boxes make information easy to record • Can be used for all clients 	
Concerns	Relative Score 16.7% <ul style="list-style-type: none"> • Tick boxes do not allow individual responses to questions • Format of date collection does not easily lead itself to audit or evaluation • Does not record the clients views / opinions 	

Development of Core Data Sets

Sources of Information

In order to construct an initial **Personal Information** and **Assessed Need** core data set, four existing data sets were examined:

- SSA Personal Information core data set (Elderly services)
- SMR24 form
- Christo G., "Common data set", Druglink May/June 2001
- Forth Valley Substance Action Team core data set (Draft)

Using the SSA core data set as a template, the four sets were integrated to produce a 21-item draft Personal Information core data set and the Assessed Need core data set.

Comparison with existing Assessment tools

Through the initial mapping exercise, 26 assessment tools were returned by drug services with the questionnaires.

One of these tools, the SMR24, has already been used to construct the draft core data sets. The remaining 25 tools were used to measure the extent to which the draft core data sets matched with the information currently collected by drug services.

A record was made of how often the items in the two draft data sets appeared in the 25 assessment tools.

KEY FINDINGS:

Comparison of Assessment tools

- Two of the 21 data items in the **Personal Information core data set** were found in over 75% of the 25 Assessment tools studied.
- Four items appeared in 50-75% of tools, 9 items in 25-50% and 6 in less than 25% of the 25 Assessment tools studied.
- 7 of the 12 sub-headings identified in the **Assessed Need core data set** appeared as either sub-headings or data items in one or more of the 25 Assessment tools studied
- One (Employment) of the 82 data items in the **Assessed Need core data set** were found in over 75% of the Assessment tools studied.
- Four items appeared in 50-75% of tools, 11 items in 25-50% and 47 in less than 25% of the 25 Assessment tools studied.

19 of the core data items in the **Assessed Need core data set** did not feature in any of the 25 Assessment tools studied.

The following core data sets were developed in collaboration with the Joint Future Unit drawing on the information gained from this study. These data sets should be used as a basis for the development of single shared assessment protocols and documentation for people with drug problems.

1. Personal Information core data set

- Family name and forename
- Present address and postcode
- Unique identifier
- Date of birth
- Gender
- Ethnicity

- Referral Source
- G.P Name
- G.P Address
- Other professionals/agencies involved
- Next of kin
- Dependant children at home
- Previously known
- Previous Interventions

- Presenting problem
- Primary drug profile
- Secondary drug profile
- Injecting
- Signs and symptoms of over sedation and/or withdrawal

- Consent to assessment
- Signed permission to share information with other agencies

2. Draft Assessed Need core data set

Drug Use

- Other problem drug profile
- Alcohol use
- Prescribed drugs/medication
- Effects on user (positive and negative)
- Problems/concerns
- Drug history including alcohol

Living Arrangements

- Household composition
- Status of residency
- Accommodation type
- Carer/cared for
- Other drug user(s) in household
- Housing support needs
- Benefits
- Heating

Physical Health

- Past medical history
- Permanent or long-standing health condition or disability
- Current care provision
- Seen by GP in last 18 months
- Current medical condition
- Current medication
- Current treatments
- Registered disabled

Disease Prevention

- Sleep patterns
- Diet and food preparation
- General physical state
- Body Mass Index
- Injecting practices/techniques
- Wound management
- Oral health
- Vaccination history

- History of cervical or breast screening

Mental Health

- Past psychiatric history
- Current signs and symptoms
- Risk assessment
- Current medication
- Seen by psychiatric services in last 18 months
- Current diagnosis

Social Functioning

- Relationships
- Family contacts
- Social contacts
- Spiritual and religious matters
- Cultural and ethnic matters
- Leisure/hobbies
- Employment, past and current
- Learning

Legal Situation

- Current offending behaviour
- Previous convictions
- Outcomes
 - Prison
 - Other

Service User's Perspective

- Problems and issues perceived and conveyed by the person
- Person's motivation
- Advocacy required?

Collateral Information

- Carer/significant others' perspective
- Other service provider

Biological Measures

- Biochemistry
- Virology
- Hepatitis B
- Hepatitis C
- HIV
- Pregnancy

Readiness to Change

- Stage of change
- Motivational state
- Strengths
- Barriers to change
- Support system
- Self-efficacy

Risk and Safety

- Needle sharing/exchange/cleaning
- Sharing of injecting paraphernalia including filters, water and spoons
- Sexual risk
- Blood borne virus
- Sexually transmitted diseases
- Personal safety- Risk from self
- Personal safety- Risk from other
- Risk to dependant children
- Public Safety