The "Car Game" Interactive Exercise
Letters A-E

Letter	Negative Aspects of Tx Planning	Positive Aspects of Tx Planning
A		
B		
C		
D		
E		

The "Car Game" Interactive Exercise
Letters F-J

Letter	Negative Aspects of Tx Planning	Positive Aspects of Tx Planning
F		
G		
H		
I		
J		

The "Car Game" Interactive Exercise
Letters K-O

Letter	Negative Aspects of Tx Planning	Positive Aspects of Tx Planning
K		
L		
M		
N		
O		

The "Car Game" Interactive Exercise
Letters P-T

Letter	Negative Aspects of Tx Planning	Positive Aspects of Tx Planning
P		
Q		
R		
S		
T		

The "Car Game" Interactive Exercise

Letters U-Z

Letter	Negative Aspects of Tx Planning	Positive Aspects of Tx Planning
U		
V		
W		
X		
Y		
Z		

ADDICTION SEVERITY INDEX NARRATIVE REPORT

JOHN B. SMITH
444 MAIN STREET
PHILADELPHIA, PA. 19444

Date of Birth:	07/30/1959	ID#	101
Social Security Number:	444 33 2211	Site Id #	101001
Date of Interview:	08/26/2004	Time Int. Began:	10:51:21
Type of Interview:	Intake	Time Int. Ended:	11:25:21
Interviewer Name:	Deni Carise	Interviewer Id #:	01

GENERAL INFORMATION SECTION

The following is a clinical summary based on an in-person interview with John Smith, on 08/26/2004. This summary is based on the client's self report regarding lifetime and recent Medical, Employment, Alcohol, Drug, Legal, Family/Social and Psychiatric involvement and/or problems. Included in each of these sections is the interviewer's severity rating, suggesting the client's need for treatment (or additional treatment beyond what he's already receiving). This is based on the information provided by the client.

John is a 40 year old, white (non Hispanic), male. He states his religious preference is Catholic. John reports he actively practices his faith and attends church every Sunday. He feels his spirituality will be a big part of his recovery. He has lived at his current address for approximately 3 years. Neither he nor his family owns this residence. John reports paying $600.00 month rent. John reports spending 2 of the past 30 days in a Jail or Prison facility in which his freedom was restricted and/or prohibited. This could have limited his ability to use alcohol or drugs, as well as his interactions with family and others. Client was arrested for driving under the influence and spent 2 nights in jail.

ALCOHOL & DRUG SECTION

Lifetime and Recent Alcohol Use:

In his lifetime, John drank regularly for a period of 15 years. For 7 years, his drinking was regular and heavy (generally defined as 5 or more drinks in one day). In the past 30 days, he drank 20 days, and has drank heavily, having more than five drinks per day, on each of those days. He reports having spent $100 on alcohol in the past 30 days. He has never experienced alcohol delirium tremens.

Lifetime and Recent Drug Use:

John has a history of ongoing heroin use for a period of 4 years, he also used methadone regularly for one year. John appears to have no lifelong problems with other opiates, additionally he reports no periods of ongoing barbiturate use. He has used sedatives, hypnotics, or tranquilizers regularly (generally defined as three times per week or more), for a period of 2 years. John reports using Xanax for several years in the early 1980's, not prescribed. John has used cocaine regularly or problematically for a period of 8 years, he has no history of ongoing amphetamine use. John has a 15 year history of ongoing, regular cannabis use, he has no history of ongoing use of hallucinogens. He

has no history of regular or ongoing use of inhalants. John has a history of using multiple substances, on an ongoing basis, for a period of 15 years. He has never overdosed, either intentionally or unintentionally, on drugs.
In the past 30 days, John has used heroin 8 days and methadone on 2 days. He has been buying methadone on the street for past 6 months. John has not used any other opiates, barbiturates, or sedatives in the past 30 days. John has used cocaine 3 days in the past 30, he has not used amphetamines during this time. John has used cannabis 10 days in the past 30, he has not used any hallucinogens. He has not used any inhalants in the past month. John has used two or more drugs together (or drugs and alcohol) on 20 days in the past month. In the past 30 days, John reports that he spent $100 on alcohol and $300 on other drugs.

Alcohol and Drug Treatment History:

John has received treatment 2 times for alcohol problems. None of these were brief "detoxification" treatments. He attended outpatient programs 2 times in 1994. John has received treatment 2 times for drug problems, none were limited to detoxification. These occurred at the same time he was treated for alcohol use. John's last period of continuous abstinence from alcohol and drugs lasted for 6 months, ending approximately 60 months ago. He attended four outpatient sessions for drug or alcohol problems in the past 30 days. This may include AA, NA, or CA attendance. John's outpatient sessions were limited to 4 AA meetings in past month.

Client Perception of Severity of Alcohol and Drug Problems and Desire for Treatment:

John experienced alcohol related problems on 30 of the past 30 days, and is bothered considerably by these problems. Obtaining alcohol treatment is extremely important to John. John experienced problems on 10 of the past 30 days related to drug use, and is bothered considerably by these problems. Obtaining drug treatment is extremely important to John.

Interviewer Impressions and Recommendations - Alcohol and Drugs:

It is my impression that John understood all of the questions, and that he did not deliberately misrepresent information about his drug or alcohol use and history. It is the interviewer's belief that both alcohol and drugs are his most significant substance abuse problem. He has an alcohol problem of substantial concern, and help obtaining appropriate treatment is vital at this time. John has a drug problem of substantial concern, and help obtaining appropriate treatment is necessary at this time.

Additional Alcohol and Drug Comments:

Client appears sincerely motivated to attain treatment for his alcohol and drug problems. He would like to be a better father to his children and resume friendship with his wife. He believes his use of alcohol and drugs is responsible for his problems with his family members.

FAMILY / SOCIAL SECTION

Marital and Living Situation for Majority of the Past Three Years:

John is currently divorced, and is generally satisfied with this situation. He has been divorced for about 4 years. John has lived alone for most of the past three years, and appears to feel fairly indifferent to this circumstance. He has been in this living arrangement for about 4 years.

Recovery Environment and Social Contacts:

No one residing with him has problems with alcohol or drugs. John currently spends most of his free time alone, and is generally dissatisfied with this situation. He would like to establish better relationships with children and ex-wife. He reports having 4 close friends on whom he can rely.

Relationship Problems Lifetime:

John reports that he has had close, long lasting relationships with family and friends in his lifetime. In his lifetime, he has had significant problems getting along with his partner, but not with his children. In his lifetime, he has not had any serious problems getting along with either his mother or father. He has not had serious problems getting along with other significant family members in his lifetime. He has not had any significant problems getting along with either siblings or close friends. He has not had any serious problems getting along with either neighbors or co-workers. John reports no history of emotional, physical, or sexual abuse in his life.

Relationship Problems Past Thirty Days:

In the past 30 days, he has had significant problems getting along with his partner, but not with his children. In the past 30 days, he has not had any serious problems getting along with his mother. He has not had significant problems getting along with either his siblings or close friends. He has not had any serious, recent problems getting along with co-workers. John has not experienced any recent emotional, physical, or sexual abuse.

Client Perception of Severity of Family and Social Problems and Desire for Treatment:

Overall, John reports having 10 days of family related problems in the past 30, and is considerably troubled by these problems. He considers his problems with ex-wife to be most pressing. Obtaining treatment for family difficulties is profoundly important to John. He reports experiencing no problems with others and is not troubled or bothered by social issues. Consequently, help obtaining treatment for social related difficulties is not important to John.

Interviewer Impressions and Recommendations - Family and Social:

It is my impression that John understood all of the questions, and that he did not deliberately misrepresent this information. John has family or social problems of substantial concern, and help is necessary at this time.

Additional Family & Social Comments:

John is considerably bothered by the lack of involvement in his children's lives. He and his ex-wife argue over the children and he does not see them as often as he would like. During this section of the interview, John's affect was sad and he had difficulty maintaining composure.

PSYCHIATRIC SECTION

Serious Emotional and Psychological Problems - Lifetime:

John does not have a significant past history of psychiatric problems. He does not have a history of being prescribed psychotropic medications. He does not have a history of treatment for psychological or emotional problems. He does not receive any financial compensation for a psychiatric disability.

Recent Serious Emotional and Psychological Problems:

John has had serious problems with depression in the past 30 days, he was not obviously depressed at the
time of the interview. John acknowledges serious problems controlling violent behavior in the past 30 days, he was not hostile at the time of the interview. John reports he has trouble controlling his rage and anger toward ex-wife when she blocks his visits with children.

Client Perception of Severity of Emotional and Psychological Problems and Desire for Treatment:

John experienced psychological or emotional problems on 4 of the past 30 days, and is bothered by them. Obtaining psychological or emotional treatment is slightly important to him.

Interviewer Impressions and Recommendations - Psychiatric:

It is my impression that John understood all of the questions, and that he did not deliberately misrepresent his psychological/emotional information. He appears to have a moderately severe psychological or emotional problem, treatment is needed.

Additional Psychiatric Comments:

Client states he has concerns that one day he is not going to be able to control himself if his wife continues to withhold the children from seeing him.

LEGAL SECTION

History of Charges and Arrests:

John's participation in this substance abuse evaluation was suggested by a representative from the criminal justice system. He was referred as a consequence of his recent DWI arrest. John reports being arrested and charged once with driving while intoxicated twice, and twice for drug crimes. The drug related crimes were 1991 and 1995 possession charges, both reduced and dropped. His most recent charge was 3 weeks ago and the case is still pending. He was charged with burglary, larceny, or breaking and entering on one occasion, he has no robbery charges. This charge was in 1985 and he was convicted, served 3 months in jail and paid a fine. John was charged with disorderly conduct, vagrancy, or public intoxication on one occasion (public intoxications, 1990), he has never been charged with contempt of court. He was convicted on at least 1 of these charges. John has a history of being incarcerated for 3 months. His incarceration lasted about 3 months and was for burglary/ larceny/breaking and entering.

Current Legal Involvement:

In the past 30 days, John was detained/incarcerated on 2 days, he did not engage in any illegal activities for profit. He is awaiting either charges, trial, or sentencing for driving while intoxicated. He is not on probation or parole.

Client Perception of Severity of Legal Problems and Desire for Treatment:

John is slightly bothered by his legal problems, nevertheless, he feels that counseling for his legal problems is not important.

Interviewer Impressions and Recommendations - Legal:

It is my impression that John understood all of the questions, and that he did not deliberately misrepresent his legal information. He appears to have a minor legal problem or concern, but counseling does not look as though it is necessary. John has legal counsel for his current charges.

Additional Legal Comments:

No comment.

MEDICAL SECTION

Medical History:

John was hospitalized once for medical problems. This hospitalization was 5 years ago. He reports this hospitalization was for a routine appendectomy in the summer of 1994. He has a chronic medical problem (asthma) and is prescribed medications (inhaler) for this problem. He does not receive any financial compensation for physical disabilities.

Client Perception of Severity of Medical Problems and Desire for Treatment:

John does not report any medical problems in the past 30 days, and is not bothered by medical problems. Help obtaining treatment is not important to him at this time.

Interviewer Impressions and Recommendations - Medical:

It is my impression that John understood all of the questions, and that he did not deliberately misrepresent his medical information. He appears to have no need for medical treatment at this time.

Additional Medical Comments:

Client reports his overall health is very good. His asthma has been under control for several years now. He has expressed some concern regarding his alcohol and drug use and how that is affecting him physically.

EMPLOYMENT SECTION

Employment History:

John has worked full time for most of the past three years. John's longest full time job lasted for 14 years. He works for a construction company. The majority of his employment in the past few years has been skilled manual work.

Current Financial Resources:

John reports working 24 days and making $7200 income in the past month. He reports he usually works a six day week. He did not receive any income from either unemployment compensation, welfare, pensions, benefits, or social security in the past month. He has not received any money from family or friends in the past month. John says that he has not made any money illegally in the past month. John has 4 dependents for whom he is financially responsible. John pays support to wife and three children. No one contributes any cash, food, housing, etc. for his support.

Education, Training and Resources:

He completed 14 years of traditional schooling obtaining a high school diploma and taking some college level courses as well as receiving 12 months of technical or vocational training. John has the skill base necessary to acquire a job. He does carpentry and masonry work, and completed training in these areas. He has a valid driver's license, but does not have use of a car for employment purposes.

Client Perception of Severity of Employment Problems and Desire for Treatment:

Overall, he reports experiencing no problems related to obtaining or maintaining employment and is not troubled or bothered by employment related difficulties. Consequently, help obtaining treatment for employment related difficulties is not important to John.

Interviewer Impressions and Recommendations - Employment:

It is my impression that John understood all of the questions, and that he did not deliberately misrepresent this information. He appears to have no need for employment counseling at this time.

Additional Employment Comments:

Client has had a very stable work history for the past fourteen years. He is very satisfied with this status and has no desire to pursue training or additional education.

Interviewer Comment

The above information is based on John Smith's responses to questions from the Addiction Severity Index interview, and was completed on 08/26/2004. This information will be used to guide John's placement into treatment and to develop his specific treatment care plan.

(Interviewer's Name)

ASI Master Problem List

Client: John Smith

Date Identified	Problem Code	Problem Statement	Status	Date Resolved
	M1	Has a chronic medical problem that interferes with her/his life		
	A/D 1	Reports several or more episodes of drinking alcohol to intoxication in the past month		
	A/D 2 A/D 3	Reports regular, lifetime use of alcohol “to intoxication” Reports using heroin in past month		
	A/D 4	Reports lifetime, regular use of heroin		
	A/D 5	Reports lifetime, regular use of sedatives, hypnotics, or tranquilizers		
	A/D 6 A/D 7	Reports using cocaine in past month Reports lifetime, regular use of cocaine		
	A/D 8 A/D 9	Reports using marijuana in past month Reports lifetime, regular use of marijuana		
	A/D 10 A/D 11	Reports simultaneous use of multiple substances in past month Reports lifetime, regular use of multiple substances		
	A/D 12	Reports having problems with alcohol in past month Is troubled by alcohol problems and is interested in treatment		
	L1	The admission was prompted or suggested by someone in the criminal justice system		
	L2	Is awaiting charges, trial, or sentencing		
	L3	Has been detained or incarcerated within past 30 days		
	F1 F2	Not satisfied with how she/he spends her/his free time Reports having serious problems w/ family members in past month		
	F3	Is troubled by family problems and is interested in treatment		
	P1 P2	Has had significant problems with depression in past month Has had trouble controlling violent behavior in past month		
	P3 P4	Has experienced psychological or emotional problems in past month Is troubled by psychological or emotional problems in past month		
	P5	Is troubled by psychological or emotional problems and is interested in treatment		

Status Code

D = Deferred R = Resolved T = Transferred

Client Name **John Smith**

ID # 000000000

ASI Treatment Plan Template

Drug & Alcohol Plan

(ASI/DENS Format)

Client Name: John Smith **Counselor Name: Exercise Handout**

Date	Problem Statement

Goals

D/C Criteria	Objectives *What will the client say or do? Under what circumstances? How often will he/she say or do this?*

Interventions *What will the counselor/staff do to assist client? Under what circumstances?*	Service Codes	Target Date	Resolution Date

Participation in Treatment Planning Process

Participation by Others in the Treatment Planning Process

Note: All participants may not have participated in every area.

Client Signature/Date
Counselor Signature/Date

Service Codes

I=Individual	G=Group	F=Family	C=Couples	P=Psychoeducational	H=Homework
R=Reading	M=Media	V=Videotape	A=Audiotape	R=Referral	

ASI Treatment Plan Template **Medical Plan**

(ASI/DENS Format)

Client Name: John Smith **Counselor Name: Exercise Handout**

Date	Problem Statement

Goals

D/C Criteria	Objectives *What will the client say or do? Under what circumstances? How often will he/she say or do this?*

Interventions *What will the counselor/staff do to assist client? Under what circumstances?*	Service Codes	Target Date	Resolution Date

Participation in Treatment Planning Process

Participation by Others in the Treatment Planning Process

Note: All participants may not have participated in every area.

Client Signature/Date
Counselor Signature/Date

Service Codes

I=Individual	G=Group	F=Family	C=Couples	P=Psychoeducational	H=Homework
R=Reading	M=Media	V=Videotape	A=Audiotape	R=Referral	

ASI Treatment Plan Template

Family Issues Plan

(ASI/DENS Format)

Client Name: John Smith **Counselor Name: Exercise Handout**

Date	Problem Statement

Goals

D/C Criteria	Objectives *What will the client say or do? Under what circumstances? How often will he/she say or do this?*

Interventions *What will the counselor/staff do to assist client? Under what circumstances?*	Service Codes	Target Date	Resolution Date

Participation in Treatment Planning Process

Participation by Others in the Treatment Planning Process

Note: All participants may not have participated in every area.

Client Signature/Date
Counselor Signature/Date

Service Codes

I=Individual	G=Group	F=Family	C=Couples	P=Psychoeducational	H=Homework
R=Reading	M=Media	V=Videotape	A=Audiotape	R=Referral	

Sample: Program-Driven Treatment Plan **"Old Method"**

(ASI/DENS Format)

Client Name: John Smith Date of Interview: 08/26/1998 Counselor Name: B. Vague

Date	Problem Statement
08/26/1998	John has a severe medical condition.
08/26/1998	John is alcohol dependent.
08/26/1998	John's low self-esteem contributes to regular depressive episodes.

Goals
John will seek medical services and comply with all medical recommendations.
John will refrain from alcohol use now and in the future.
John needs to work on his self-esteem.

D/C Criteria	Objectives *What will the client say or do? Under what circumstances? How often will he/she say or do this?*
Required	John will take advantage of outpatient program services.
Required	John will complete Steps 1, 2, and 3.
Required	John will attend Social-Skills Group.

Interventions *What will the counselor/staff do to assist client? Under what circumstances?*	Service Codes	Target Date	Resolution Date
Challenge John's denial around alcohol use and the impact of drinking on his medical and legal problems.	**G**	**11/01/98**	
Review Steps 1, 2, and 3 with John.	**I**	**11/01/98**	
Explore how John is co-dependent on his children.	**I**	**11/01/98**	
Counselor will discuss with John how his cognitive distortions disrupt his ability to engage with significant others.	**I**	**11/01/98**	

Participation in Treatment Planning Process
[blank]

Participation by Others in the Treatment Planning Process
[blank]

Note: All participants may not have participated in every area.

Client Signature/Date
Counselor Signature/Date

Service Codes

I=Individual	G=Group	F=Family	C=Couples	P=Psychoeducational	H=Homework
R=Reading	M=Media	V=Videotape	A=Audiotape	R=Referral	

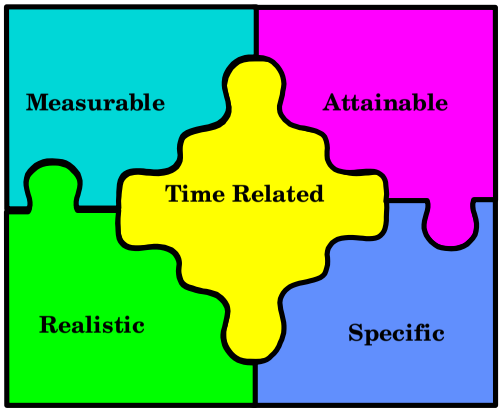
Treatment Planning M.A.T.R.S. Checklist

Problem Statements	**Check if addressed**
1. Do problem statements reflect the 6 problem domains? (e.g., 1. Medical status; 2. Employment and support; 3. Drug/Alcohol Use; 4. Legal status; 5. Family/social status; 6. Psychiatric Status)	
2. Are problem statements written in behavioral terms?	
3. Are problem statements written in a non-judgmental and jargon free manner?	
4. Are problem statements based on priority needs?	
Goals *What does the client want to achieve during treatment?*	
5. Do goals address the problem statements?	
6. Are the goals attainable during the active treatment phase?	
7. Would the client be able to understand the goals as written?	
8. Would both the client and the treatment program find these goals acceptable?	
9. Has the client's stage of *readiness to change* been considered in the goal statements?	
Objectives *What will the client say or do? Under what circumstances? How often will he/she say or do this?*	
10. Do objectives address the goals?	
11. **M**easurable—Can change or progress toward meeting the objectives be documented/ evaluated?	
12. **A**ttainable—Can the client take steps toward meeting the objectives?	
13. **T**ime-Limited—Is the time frame specified for the objectives?	
14. **R**ealistic—Can the client meet the objectives given their current situation?	
15. **S**pecific—Are specific activities included? Could the client understand what is expected?	
16. Has the client's stage of *readiness to change* been considered in the objectives?	
Interventions *What will the counselor/staff do to assist client? Under what circumstances?*	
17. Do interventions address the objectives?	
18. **M**easurable—Will the counselor/treatment program be held accountable for the service(s)?	
19. **A**ttainable—Do interventions reflect the level of care available or are outside referrals used when needed?	
20. **T**ime-limited—Is the time frame specified for the interventions?	
21. **R**ealistic—Do the interventions reflect the level of functioning or functional impairment of the client?	
22. **S**pecific—Are specific staff persons responsible for assisting client/providing service?	
23. Has the client's stage of *readiness to change* been considered in the interventions?	
General Checklist	
24. Is this treatment plan individualized to fit the client based on their unique abilities, goals, lifestyle, socio-economic status (SES), work history, educational background, and culture?	
25. Are client strengths incorporated in the treatment plan?	
26. Has the client (and significant others) participated in developing this treatment plan?	
27. Is the plan dated and signed by all who participated in developing this treatment plan?	

THE THESAURUS OF TREATMENT PLANNING

The Goal is to . . .

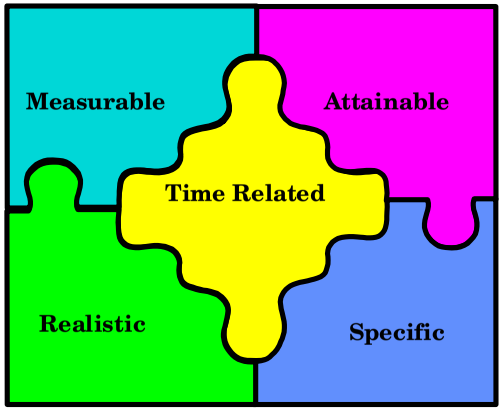
INCREASE	Awareness of	Statements about	Ability to	Understanding of
RECEIVE	Redirection from	Feedback from		
IDENTIFY	Target of	Triggers of	Consequences of	Pain related to
ACCEPT	Responsibility for	Consequences of	Need to	
DEVELOP	Strategies to	Non-self-defeating ways to	Awareness of	Better control of
COMPLETE	Homework by	Chores when		
DECREASE or REDUCE	Intensity of	Frequency of	Number of	Duration of
COMPLY WITH or FOLLOW	Need to	Rules about	Limits of	Prescription of
Treatment Planning "M.A.T.R.S." EXPRESS or VERBALIZE	Acceptance of	Awareness of	Desire to	Feelings about
DEMONSTRATE	Feelings of	Motivation to	Awareness of	
MISCELLANEOUS	Report	Participate	Engage in	Cooperate with
	Practice	Acknowledge	Become	Communicate
	Implement	Achieve		



Treatment Planning "M.A.T.R.S."

"Thesaurus of *ACTION* Words"											
Describe	Demonstrate	Respond	Complete	Attend	Dress	Brushes	Talk	Go	Express	Drink	Watches
Joins	Participates	Sit	Make known	To shave	Arise	Interpret	Ventilate	Plan	Explain	Accept	Wash
Repeat	Send	Take care of	Write	Ask	Match	Defend	Cease	Will exhibit	Delay	Perform	Drive
List	Use	Identify	Be able to	Verbalize	Tell	Speaks	Has/has not	Come	Approach	Refrain	Dial
Increase	Decrease	State	Answer	Contribute	Choose	Make	Decide	Walk	Request	Arrange	List

"Thesaurus of *THERAPEUTIC* Objectives/Interventions"					
Bibliotherapy	Role playing	Coping skills	Coping strategies	Role reversal	Desensitization
Relaxation techniques	Genograms	Anger management	Reframing	Written exercises, lists	Journals, written letters
Assertiveness training	Living skills training	Positive self-talk	Reality testing	Stress reduction	Questionnaires, scales
Didactic lectures	Attend self-help groups	Specialty group	In-home therapy	Recreation therapy	Occupational therapy
Communication skills	Modeling	Participation	Individual counseling		



Treatment Planning
"M.A.T.R.S."

THE THESAURUS OF CLIENT STRENGTHS & LIMITATIONS

EXAMPLES OF CONSUMER STRENGTHS OR LIMITATIONS				
SOCIAL	Accepts feedback	Accepts responsibility	Assertive	Aware of how behavior impacts others
	Friendly	Fun-loving	Genuine	Good hygiene
	Long-term relationships	Respectful	Supportive of others	Listens to others
OCCUPATIONAL/EDUCATIONAL	Bright	Creative	Goal-oriented/focused	Independent
	Learns quickly	Works hard	Writes well	Good team player
	Dependable	Good attention span	Organized	Good follower
FEELINGS/AFFECT	Accepts feelings in self	Emotions appropriate	Expresses emotions	Range of feelings available
	Aware of feelings	Tolerates emotional discomfort	Empathic with others	Integrates feelings and thinking
THINKING/COGNITION	Abstract thinker	Attention/Concentration	Good reality testing	Thinks through behavior
	Logical thinker	Insight into own behavior	Insight into others behavior	Intelligent
PHYSICAL	Eats well	Healthy	Maintains normal weight	Good sleep habits
	Exercises regularly	Good personal grooming	Cares about appearance	Good dental hygiene

Sample: Individualized Treatment Plan **"New Method"**

(ASI/DENS Format)

Client Name: John Smith Date: July 7, 2007 Counselor Name: B. Smart

Date	Problem Statement
07/07/2007	John reports having a chronic medical problem that requires ongoing care.
07/07/2007	John reports regular use of alcohol "to intoxication" during his lifetime.
07/07/2007	John reports that he had significant problems with depression during the past month.

Goals
Ensure John is obtaining medical care and taking necessary medications.
John will examine his recent drinking patterns and how those patterns may have contributed to his current legal problems and family problems (or other presenting problems).
John will explore his options and motivation for treatment of his depression.

D/C Criteria	Objectives *What will the client say or do? Under what circumstances? How often will he/she say or do this?*
Required	John will visit a medical center/clinic for assessment and treatment of his medical problems.
Required	John will complete the "Drinking Pattern Checklist" and share his answers in group therapy session on (date).
Required	John will talk about how his alcohol and drug use has helped and hurt his mood and energy level.
Optional	John will invite his children to participate in family education sessions within 3-4 weeks.

Interventions *What will the counselor/staff do to assist client? Under what circumstances?*	Service Codes	Target Date	Resolution Date
Staff will assist John in calling the Jones Medical Clinic to make an appointment for necessary medical services.	**R**	07/10/2007	
Counselor will review John's "Drinking Pattern Checklist" and discuss John's comfort level in sharing with peers	**G**	07/12/2007	
Counselor will educate John on co-occurring conditions of depression and alcohol dependence and provide referral information on mental health clinics accepting sliding scale fees.	**I**	07/25/2007	
Counselor will check-in weekly with John to ask how he feels about involving his children in his treatment	**I**	09/07/2007	

Participation in Treatment Planning Process
John reports that he did contribute to this plan, but it is unclear if he agrees with it.

Participation by Others in the Treatment Planning Process
Family members participated and agreed with this plan.
Significant others were invited to participate in the treatment planning process but were unable to do so.

Note: All participants may not have participated in every area.

Client Signature/Date
Counselor Signature/Date

Service Codes

I=Individual	G=Group	F=Family	C=Couples	P=Psychoeducational	H=Homework
R=Reading	M=Media	V=Videotape	A=Audiotape	R=Referral	

Documenting Client Progress Using S. O. A. P. Method

S = Subjective or summary statement by the client. Usually, this is a direct quote. The statement chosen should capture the theme of the session.

1. If adding your own explanatory information, place within brackets [ ] to make it clear that it is not a direct quote.
   - *Example of session theme:* "When he raises his voice, I just . . . what do I do? . . . Yes, I'll talk more in group."

2. If client refers to someone else's name, indicate that other person by initials. This makes it clear that the client is the focus, not the person the client is talking about. It also guards against any breeches in confidentiality. This is especially true when a client refers to another client.
   - *Example of client using someone else's name:* "She really made me mad . . . You think I should make an appointment to talk to her? I don't like dealing with this stuff [case worker S.P.].

3. If the client didn't attend the session or doesn't speak at all, use a dash on the "S" line.
   - *Example:* S: ---

O = Objective data or information that matches the subjective statement. Descriptions may include body language and affect.

- *Example:* 20 minutes late to group session, slouched in chair, head down, later expressed interest in topic.

A = Assessment of the situation, the session, and the client, regardless of how obvious it might be based on the subjective and/or objective statements.

- *Example:* Needs support in dealing with scheduled appointments and taking responsibility for being on time to group.
- *Example:* Needs referral to mental health specialist for mental health assessment.
- *Example:* Beginning to own responsibility for consequences related to drug use.

P = Plan for future clinical work. Should reflect interventions specified in treatment plan including homework assignments. Reflect follow-up needed or completed.

- *Example:* Begin to wear a watch and increase awareness of daily schedule.
- *Example:* Complete Tx Plan Goal #1, Objective 1.
- *Example:* Consider mental health evaluation referral.
- *Example:* Contact divorce support group and discuss schedule with counselor at next session.

Adapted from work by Larry T. Mark and presented by Donna Wapner, Diablo Valley College. Handout included in materials produced by the Pacific Southwest Addiction Technology Transfer Center, 1999.

Case Note Scenario

You are a case manager in an adult outpatient drug and alcohol treatment program. The center you work for provides only intensive outpatient and outpatient services. As a case manager for the outpatient component, you have an active caseload of 25 patients. You primarily work with young adults between the ages of 18 and 25 who have some sort of involvement with the adult criminal justice system. Jennifer Martin is your patient. She attends both group and individual therapy sessions. For the past three weeks she has missed two group sessions, one individual session and has been 15 minutes late to another individual session. Jennifer is on probation for possession of a controlled substance and grand larceny. She has been in treatment for approximately two months. You, as her case manager, have asked her to attend this session after missing her last individual appointment.

Case Manager: "I am glad to see you made it today, Jennifer. I am starting to get worried about your attendance for the past two weeks."

Jennifer: "I've just been really busy lately. You know, it is not easy staying clean, working, and making counseling appointments. Are you really worried about me or are you just snooping around trying to get information about me to tell my mom and probation officer?"

Case Manger: "You seem a little defensive and irritated. Are you upset with me or your mom and your probation officer, or with all of us?"

Jennifer: "I don't know...it just feels like everyone is on my case. I am tired of having to report to everyone where I am going, what I am doing, why I am doing things, and not doing others. I am just so tired of everyone watching me. I guess that includes you too."

Case Manager: "So I am included on this list of people who watch over you. How did I get on this list?"

Jennifer: "You told my probation officer that I had missed group and individual sessions before you talked to me."

Case Manager: "And that makes you feel..."

Jennifer: "Pissed off. I thought you were different. I thought I could trust you, but you are just like everyone else in my life."

Case Manager: "Just like everyone else, meaning?"

Jennifer: "You go over my head, treat me like a child, don't talk with me first. I hate when people do that. Why did you have to talk to my probation officer before talking with me?"

Case Manager: "It sounds like I hurt your feelings and broke some kind of trust with you."

Jennifer: "Yeah, it feels like that." (Jennifer stops talking and looks at the ground, wiggling her leg back and forth.)

Case Manager: "Have you felt this way before, Jennifer? Hurt, and like the person you trusted has let you down?"

Jennifer: (Jennifer slowly raises her head and nods.)

Case Manager: "When did you feel like this, Jennifer?"

Jennifer: "When my dad divorced my mom, about two years ago. He promised he would stay in contact with me. Oh, he did for a while, about six months after the divorce, but his calls and visits got more and more sporadic. I didn't hear from him until I got arrested and put on probation. I hate talking about this stuff!"

Case Manager: "I know it is hard talking about this and it brings up a lot of strong feelings for you, but we need to do this. How are the feelings you have regarding trust related to your use of methamphetamine?"

Jennifer: "I don't want to talk about this; its too painful!"

Jennifer grabs her backpack and walks out of the counseling room. The Case Manager attempts to get her to return, but Jennifer keeps walking.

Example S.O.A.P. Note

TYPE OF NOTE

IND	INDIVIDUAL SESSION
GRP	GROUP SESSION
FAM	FAMILY SESSION
COL	COLLATERAL SESSION

Note: Standardized Abbreviations

01/03/00: IND:

S: "I wanted to talk to my kids about how guilty I feel about my drinking."

O: Tearful at times; gazed down and fidgeted with shirt buttons

A: Client has gained awareness in how drinking behavior has embarrassed and hurt his teenage children. He expresses intense feelings related to his drinking and appears to assume responsibility for his past behaviors.

P: Completed Tx Plan Goal 1, Obj 1. Continue with Goal 1, Obj 2 in next 1:1 session.

Sally Jones, CAC

NOTE: Try using one of the *Checklist* tools when completing the documentation practice exercise.

S.O.A.P. Note	S=Subjective	O=Objective	A=Assessment	P=Plan
D.A.P. Note	D=Data	A=Assess	P=Plan	
B.I.R.P. Note	B=Behavior	I=Intervention	R=Response	P=Plan

S.O.A.P. Progress Note Checklist

S ***Subjective*** ***Client statement capturing the theme of the session***	***Check if Addressed***
1. Subjective data about the client—what are the client's observations, thoughts, direct quotes?	
2. Does the client's direct quote summarize the theme of the session?	
O ***Objective*** ***Objective, often observable data or information supporting the subjective statement***	
3. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
4. Does objective data or information match the theme expressed in the subjective statement?	
A ***Assessment*** ***Counselor's assessment of the situation, the session, and the client's condition or prognosis*** ***Client's response to intervention and progress made in achieving tx plan goals / objectives***	
5. What is the counselor's understanding about the problem?	
6. What are the counselors' working hypotheses?	
7. What was the general content and process of the session?	
8. Was homework reviewed (e.g., journal, reading assignments – if any)?	
9. What goals, objectives, interventions were addressed this session?	
10. What is the client's current response to the treatment plan?	
P ***Plan*** ***Document what is going to happen next***	
11. What in the treatment plan needs revision?	
12. What is the counselor going to do next?	
13. When is the next session date?	
General Checklist	
14. Does this note connect to the client's individualized treatment plan?	
15. Are client strengths/limitations in achieving goals noted and considered?	
16. Is this note dated, signed, and legible?	
17. Is the client name and identifier included on each page?	
18. Has referral information been documented?	
19. Does note reflect changes in client status (e.g., GAF Scale, measures of functioning)?	
20. Are any abbreviations used standardized and consistent?	
21. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
22. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	
22. Did counselor/supervisor sign note?	

D.A.P. Progress Note Checklist

Data	**Check if addressed**
1. Subjective data about the client—what are the client's observations, thoughts, direct quotes?	
2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
3. What was the general content and process of the session?	
4. Was homework reviewed (if any)?	
Assessment	
5. What is the counselor's understanding about the problem?	
6. What are the counselors' working hypotheses?	
7. What are the results of any testing, screening, assessments?	
8. What is the client's current response to the treatment plan?	
Plan	
9. Based on client's response to the treatment plan, what needs revision?	
10. What goals, objectives were addressed this session?	
11. What is the counselor going to do next?	
12. When is the next session date?	
General Checklist	
13. Does this note connect to the client's individualized treatment plan?	
14. Is this note dated, signed, and legible?	
15. Is the client name and identifier included on each page?	
16. Has referral information been documented?	
17. Are client strengths/limitations in achieving goals noted and considered?	
18. Are any abbreviations used standardized and consistent?	
19. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
20. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	

B.I.R.P. Progress Note Checklist

B *Behavior* ***Counselor observation, client statements.***	***Check if Addressed***
1. Subjective data about the client—what are the client's observations, thoughts, direct quotes?	
2. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
I *Intervention* ***Counselor's methods used to address goals and objectives, observation, client statements.***	
3. What is the counselor's understanding about the problem?	
4. What are the counselors' working hypotheses?	
5. What was the general content and process of the session?	
6. Was homework reviewed (e.g., journal, reading assignments – if any)?	
7. What goals, objectives were addressed this session?	
R *Response* ***Client's* response to intervention and progress made toward tx plan goals and objectives**	
8. Client's response to the treatment plan, what needs revision?	
9. What is the client's current response to the treatment plan?	
P *Plan* ***Document what is going to happen next***	
10. What in the treatment plan needs revision?	
11. What is the counselor going to do next?	
12. When is the next session date?	
General Checklist	
13. Does this note connect to the client's individualized treatment plan?	
14. Are client strengths/limitations in achieving goals noted and considered?	
15. Is this note dated, signed, and legible?	
16. Is the client name and identifier included on each page?	
17. Has referral information been documented?	
18. Does note reflect changes in client status (e.g., GAF Scale, measures of functioning)?	
19. Are any abbreviations used standardized and consistent?	
20. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
21. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	
22. Did counselor/supervisor sign note?	

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Drug Evaluation Network System (DENS) – Software Overview

The DENS Software Suite is an electronic ASI data collection system created with substance abuse treatment providers in mind. It automates administration of the ASI through an intuitive, time-saving interface used mainly by counselors at treatment facilities. The software takes very little time to learn and has a host of benefits unavailable to states and/or programs currently using paper and pencil instruments.

To schedule a DENS training or more information on the public domain DENS Software System, contact Meghan Love, Treatment Systems Section Coordinator, at MLove@tresearch.org**.**

Comprehensive intake assessment

The DENS Suite is a vehicle for the collection of the ASI, the most widely used substance abuse assessment instrument in the world. Mandated by numerous state governments as well as the Veteran's Administration, it is a standardized, semi-structured, multi-focused screening and assessment tool collecting client information in many different areas of the client's life (General Information, Medical, Employment, Alcohol/Drug, Legal, Family/Social, and Psychiatric). Every question on the ASI form is included in the software, which uses the same semi-structured format as the original ASI instrument to ensure questions are posed in the order intended. With the click of a button, interviewers can administer either the complete ASI interview or a shortened interview called the ASI-Lite. Less personally sensitive questions are asked toward the beginning, with more invasive items and sections appearing toward the end. This allows a counselor to build rapport before posing questions regarding intimate details to their clients.

Advanced functionality with little or no learning curve

The software was designed to be as easy to use as possible, especially for those with little or no previous experience with computers. All major functions are accessed through point-and-click button pressing, and all frequently used buttons have graphics to provide a visual aid. In addition, there are no menus, or "options" screens to configure. After a brief initial sign-in and registration process (completed by either TRI or site staff), every aspect of the DENS Suite is configured and available for immediate use by counselors, who can perform all software functions without the need to memorize commands or complex procedures. On-screen help is present at all times (for both software functions and the ASI interview), and there is room within the title bar of the program to enter a telephone number users may call should they have a question or require further assistance.

DENS software training is normally an inherent part of the TRI ASI training protocol. We have found consistently that even those with the most elementary level of computer literacy feel more comfortable using the DENS Suite once they are properly trained and have spent some time practicing using the software.

Coding, Crosschecks, and Defaults

The DENS Suite contains a number of embedded quality assurance measures to assure the data collected is as accurate as possible. Most visible among these is a series of Crosschecks and Defaults within the ASI portion of the software.

Sample Crosscheck:
Drug and Alcohol section – If a counselor codes a client with more days "drinking to intoxication" than the number of days coded for "drinking" at all, a pop-up message will appear warning the counselor that this situation is not possible, prompting them to recode either "days drinking" or "days drinking to intoxication". The computer will automatically send the counselor to the item to be recoded.

Sample Default:
Legal Section – If a counselor codes a client as not awaiting trial or sentencing for any criminal charges, the software will automatically code the next item (asking for the specific charge for which they are awaiting trial or sentencing) with a zero (0).

Crosschecks and Defaults guard against contradictory responses throughout the course of a client's intake assessment and ensure the counselor is coding consistently and according to standardized ASI coding conventions. In addition to these safeguards, each text field within the DENS Suite is set to accept only a particular set of characters as a response (i.e., a "how many days in the past 30" question will only accept a numerical answer between 0-30). This feature guards against typographical errors, and ensures the counselor is attuned to the specific information being requested in each field.

Hints and Comments

Each ASI item within the DENS software is displayed along with a "hint" at the bottom of the screen. These hints provide information on the intent of the item, any special coding rules, and recommended additional probes to provide clinicians with more detailed information. The content of the hint box changes each time the counselor clicks on a new item within the ASI, assuring that the display is always relevant to the question being asked.

Also included in the software is a text box for entering comments. This is available for each item on the ASI and allows a counselor to enter additional information and detail for each question. The content of the comments box refreshes as the counselor moves from item to item (similar to the hints), and all comments are automatically integrated in understandable text and logical sequence into the ASI Print-Out and Narrative Summary alongside their related items. Finally, there is a place at the end of each ASI section for counselors to write additional comments or note information gathered beyond the standard ASI items.

1. Automated Reports (Client-Level and Aggregate)

The DENS Suite produces two types of reports, Client Level and Aggregate reports. Client-Level reports are summaries of an individual case, and are available in three formats – the ASI Print-Out, the ASI Narrative Report and the Treatment Care Plan Problem List. These are useful in treatment planning, creating a biopsychosocial report of the client's case, tracking changes in a client over time, etc. Aggregate reports summarize all of the cases on a particular computer, and are available from various perspectives (male compared to female clients, clients receiving welfare vs. those who are not, etc.). These are typically used for tracking trends in a client population, performing program evaluation, submitting responses to data requests, etc.

Client-Level Reports

- *ASI Print-Out*
  This patient-level report lists all questions in the ASI along with the client's responses. Any comments entered by the counselor related to a specific question will appear in the print-out immediately following the response to the item.

- *ASI Narrative Summary*
  The narrative is a ten (10) page report suitable for use as an intake summary. It converts the client's ASI responses into sentences and paragraphs, in effect "telling the story" of the client's intake interview. As with the ASI Print-out, any interviewer comments are automatically inserted within the narrative following the question item to which they refer. This allows the report to be customized for each client, allowing reporting of information observed but not necessarily collected through the ASI questions. Many facilities involved in the DENS research study use this stand-alone report as their biopsychosocial assessment.

- *Treatment Care Plan Problem List*
  This is a list of potential problem statements derived from items on the ASI to which the client responds above or below a certain threshold. The statements include such details as "The client reports lifetime, regular use of heroin," or "The client is troubled by psychological or emotional problems and is interested in treatment." Included with this report is a blank treatment care plan template, used by counselors to construct a full treatment plan based on the provided problem list.

- *Treatment Care Planning (Coming Soon!)*
  Although not yet available, a full treatment care planning module is currently under development. This module will include suggested problem statements, goals, objectives and interventions for every ASI section and question as well as space for counselors to enter problem statements of their own, objectives, goals, diagnosis codes, etc. This software should be available by winter 2004.

Aggregate Reports

These reports summarize the entire database on a particular computer, providing an overall look at the clients at a particular facility. They compare each of the following pairs of groups to each other, listing averages for nearly all items included on the ASI.

a. Male vs. female client data
b. Clients entering treatment last year vs. this year
c. Welfare vs. non-welfare-receiving clients
d. Criminal Justice System (CJS) vs. non-CJS-involved clients

2. Additional Questions (for agencies [e.g. state or local governments] that will be collecting data on their own SQL server from a group of distinct treatment programs)

In addition to providing an electronic means of collecting ASI data, the DENS Suite has the capability of incorporating additional questions of current interest. Up to five additional questions can be inserted into each section of the ASI (a total of 40 questions). With the proper training, inserting additional questions to the software is a relatively simple process for provider or state IT staff. The questions will be automatically uploaded into each remote site computer the next time those machines connect to the server to transmit ASI data. The result is a system allowing an agency to quickly gather new information from their sites without needing to budget large amounts of time and finances to roll out and collect data from an addendum to a pre-existing paper instrument. Examples of "additional questions" inserted for other studies includes collection of data on club drug use, OxyContin use, homelessness issues, increased use or psychiatric problems after 9/11, trauma issues, spirituality questions, etc.

3. Security

Several security features are built into the software to guard against client information being accessed by an unauthorized party. The entire client database is password protected, making it difficult for someone to simply copy the file from a facility computer and view it outside the DENS software environment. Within the software itself, there is a password protected login screen, preventing access by anyone other than users sanctioned by a treatment program. Further, when adding usernames to the software a system administrator can decide whether or not to grant new users "administrative access," which gives them permission to add and delete users themselves. This feature helps administrators limit access (if desired) to only those counselors who have passed the required ASI competency measures.

Another security feature embedded in the DENS software protects a treatment facility from transferring identifying information about their clients to TRI via modem or the internet. When data is exported, the software automatically strips the database of any and all client identifying information. This feature allows DENS to be in compliance with HIPAA requirements and protects the security of client information.

4. Training and Competency

It is important to ensure that counselors using the software within a treatment program are competent and comfortable with its operation before they attempt to utilize it during an assessment. To this end, there is a "practice" section within the software program which allows counselors to complete mock interviews just as they would if a client were present. The screens in this portion of the software function exactly the same as the normal ASI screens, but the data entered is only stored temporarily, and in a separate location than actual client data. Counselors can do as many practice ASIs as they want, and TRI offers a series of competency measures should an organization wish its staff to become officially certified in ASI administration.

5. Administrative Functions

In the administrative functions of the software, users will find all the tools necessary to maintain the software and manage their data. Here, counselors can backup their client database so no data is lost in the event of a computer malfunction. They can also use these screens to transmit their non-identifying data, or export it to a floppy disk for manual transmission. Aggregate reports are generated from the administrative area of the DENS Suite, and counselors can batch printed client narrative summaries from here as well. In addition to being able to print multiple narratives at once, counselors can use the batch printing feature to customize the order in which ASI sections appear within the narrative report. This feature is useful for facilities that report to a specific agency that only requests certain information about clients (i.e. only Legal and Alcohol/Drug data).

6. DENS Data Export Software

Available along with the DENS Suite intake software is a program called DENS Data, which allows a facility to export its client database to a statistical analysis package such as SPSS or SAS. The program can also convert a DENS database to Microsoft Excel spreadsheets. DENS Data is a useful utility for performing more advanced analyses on your site's data than the DENS Suite software is capable of completing on its own. Further, if you have more than one computer at your site running DENS, this data export utility offers a way of merging the data from several machines into one database, allowing you to get an overall picture of your site's clientele.

All DENS software programs are in the Public Domain.

DENS Software Treatment Plan Template

(Adapt for Agency Need)

Client Name: **Counselor Name:**

Date	**Problem Statement**
Goals	
D/C Criteria	**Objectives** *What will the client say or do? Under what circumstances? How often will he/she say or do this?*

Interventions *What will the counselor/staff do to assist client? Under what circumstances?*	**Service Codes**	**Target Date**	**Resolution Date**

Participation in Treatment Planning Process

Participation by Others in the Treatment Planning Process

Note: All participants may not have participated in every area.

Client Signature/Date
Counselor Signature/Date

INSTRUCTIONS

1. Leave No Blanks - Where appropriate code:
   X = question not answered
   N = questions not applicable
   Use only one character per item.
2. Item numbers circled are to be asked at follow-up. Items with an asterisk are cumulative and should be rephrased at follow-up (see Manual).
3. Space is provided after sections for additional comments.

ADDICTION SEVERITY INDEX

SEVERITY RATINGS

The severity ratings are interviewer estimates of the patient's need for additional treatment in each area. The scales range from 0 (no treatment necessary) to 9 (treatment needed to intervene in life-threatening situation). Each ratings is based upon the patient's history of problem symptoms, present condition and subjective assessment of his treatment needs in a given area. For a detailed description of severity ratings' derivation procedures and conventions, see manual. **Note:** These severity ratings are optional.

Fifth Edition

SUMMARY OF PATIENTS RATING SCALE

0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

G1. I.D. NUMBER [ ][ ][ ][ ]

G2. LAST 4 DIGITS OF SSN [ ][ ][ ][ ]

G3. PROGRAM NUMBER [ ][ ][ ]

G4. DATE OF ADMISSION [ ][ ][ ][ ][ ][ ]

G5. DATE OF INTERVIEW [ ][ ][ ][ ][ ][ ]

G6. TIME BEGUN [ ][ ] : [ ][ ]

G7. TIME ENDED [ ][ ] : [ ][ ]

G8. CLASS: [ ]
1 - Intake
2 - Follow-up

G9. CONTACT CODE: [ ]
1 - In Person
2 - Phone

G10. GENDER: [ ]
1 - Male
2 - Female

G11. INTERVIEWER CODE NUMBER [ ][ ]

G12. SPECIAL: [ ]
1 - Patient terminated
2 - Patient refused
3 - Patient unable to respond

GENERAL INFORMATION

NAME _____

CURRENT ADDRESS _____

_____

_____

G13. GEOGRAPHIC CODE [ ][ ][ ]

G14. How long have you lived at this address? [ ][ ] [ ][ ]

G15. Is this residence owned by your or your family? [ ]

G16. DATE OF BIRTH [ ][ ][ ][ ][ ][ ]

G17. RACE [ ]
1 - White (Not of Hispanic Origin)
2 - Black (Not of Hispanic Origin)
3 - American Indian
4 - Alaskan Native
5 - Asian or Pacific Islander
6 - Hispanic - Mexican
7 - Hispanic - Puerto Rican
8 - Hispanic - Cuban
9 - Other Hispanic

G18. RELIGIOUS PREFERENCE [ ]
1 - Protestant
2 - Catholic
3 - Jewish
4 - Islamic
5 - Other
6 - None

G19. Have you been in a controlled environment in the past 30 days? [ ]
1 - No
2 - Jail
3 - Alcohol or Drug Treatment
4 - Medical Treatment
5 - Psychiatric Treatment
6 - Other

G20. How many days? [ ][ ]

ADDITIONAL TEST RESULTS

G21. Shipley C.Q. [ ][ ][ ]

G22. Shipley I.Q. [ ][ ][ ]

G23. Beck Total Score [ ][ ]

G24. SCL-90 Total [ ][ ][ ]

G25. MAST [ ][ ]

G26. [ ][ ][ ]

G27. [ ][ ][ ]

G28. [ ][ ][ ]

SEVERITY PROFILE

	PROBLEMS	MEDICAL	EMP/SUP	ALCOHOL	DRUG	LEGAL	FAM/SOC	PSYCH
9								
8								
7								
6								
5								
4								
3								
2								
1								
0								

MEDICAL STATUS

M1. How many times in your life have you been hospitalized for medical problems? (Include o.d.'s, d.t.'s, exclude detox.) ☐☐

M2. How long ago was your last hospitalization for a physical problem? ☐☐ Years ☐☐ Months

M3. Do you have any chronic medical problems which continue to interfere with your life? ☐

M4. Are you taking any prescribed medication on a regular basis for a physical problem? 0 - No 1 - Yes ☐

M5. Do you receive a pension for a physical disability? (Exclude psychiatric disability.) ☐
0 - No
1 - Yes _____
Specify

M6. How many days have you experienced medical problems in the past 30 days? ☐☐

FOR QUESTIONS M7 & M8 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

M7. How troubled or bothered have you been by these medical problems in the past 30 days? ☐

M8. How important to you now is treatment for these medical problems? ☐

INTERVIEWER SEVERITY RATING

M9. How would you rate the patient's need for medicaltreatment? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

M10. Patient's misrepresentation ? ☐
0 - No 1 - Yes

M11. Patient's inability to understand ? ☐
0 - No 1 - Yes

COMMENTS

_____

_____

_____

EMPLOYMENT/SUPPORT STATUS

E1. Education completed ☐☐ Years ☐☐ Months

E2. Training or technical education completed ☐☐ Months

E3. Do you have a profession, trade or skill? ☐
0 - No
1 - Yes _____
Specify

E4. Do you have a valid driver's license ? ☐
0 - No 1 - Yes

E5. Do you have an automobile available for use? (Answer No if no valid driver's license.) ☐
0 - No 1 - Yes

E6. How long was your longest full-time job? ☐☐ Years ☐☐ Months

E7. Usual (or last) occupation ? ☐

_____
Specify in detail

E8. Does someone contribute to your support in any way? ☐

E9. (ONLY IF ITEM 8 IS YES) Does this constitute the majority of your support? ☐

E10. Usual employment pattern , past 3 years. ☐
1 - full time (40 hrs/wk)
2 - part time (reg. hrs.)
3 - part time (irreg., daywork)
4 - student
5 - service
6 - retired/disability
7 - unemployed
8 - in controlled environment

E11. How many days were you paid for working in the past 30? (include "under the table" work.) ☐☐

How much money did you receive from the following sources in the past 30 days?

E12. Employment (net income) ☐☐☐☐

E13. Unemployment compensation ☐☐☐☐

E14. DPA ☐☐☐☐

E15. Pension, benefits or social security ☐☐☐☐

E16. Mate, family or friends (Money for personal expenses) ☐☐☐☐

E17. Illegal ☐☐☐☐

E18. How many people depend on you for the majority of their food, shelter, etc.? ☐

E19. How many days have you experienced employment problems in the past 30? ☐☐

FOR QUESTIONS E20&E21 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

E20. How troubled or bothered have you been by these employment problems in the past 30 days? ☐

E21. How important to you now is counseling for these employment problems? ☐

INTERVIEWER SEVERITY RATING

E22. How would you rate the patient's need for employment counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

E23. Patient's misrepresentation ? ☐
0 - No 1 - Yes

E24. Patient's inability to understand ? ☐
0 - No 1 - Yes

COMMENTS

_____

_____

_____

_____

\	PAST 30 DAYS	LIFETIME YEARS	USE (Rt of admin)
D1. Alcohol - any use at all			
D2. Alcohol - to intoxication			
D3. Heroin			
D4. Methadone			
D5. Other opiates/ analgesics			
D6. Barbiturates			
D7. Other sed/ hyp/tranq.			
D8. Cocaine			
D9. Amphetamines			
D10. Cannabis			
D11. Hallucinogens			
D12. Inhalants			
D13. More than one substance per day (include alcohol)			

Note: See manual for representative examples for each drug class

*Route of Administration: 1 = Oral, 2 = Nasal, 3 = Smoking, 4 = Non IV inj., 5 = IV inj.

D14. Which substance is the major problem? Please code as above or 00-No problem; 15-Alcohol & Drug (Dual addiction); 16-Polydrug; when not clear, ask patient. ☐☐

DRUG/ALCOHOL USE

D15. How long was your last period of voluntary abstinence from this major substance? (00 - never abstinent) ☐☐ Months

D16. How many months ago did this abstinence end? (00 - still abstinent) ☐☐

How many times have you:

D17. Had alcohol d.t.'s ? ☐☐

D18. Overdosed on drugs ? ☐☐

How many time in your life have you been treated for:

D19. Alcohol Abuse : ☐☐

D20. Drug Abuse : ☐☐

How many of these were detox only?

D21. Alcohol : ☐☐

D22. Drug : ☐☐

How much would you say you spent during the past 30 days on:

D23. Alcohol ? ☐☐

D24. Drugs ? ☐☐

D25. How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days? (Include NA, AA). ☐☐

How many days in the past 30 have you experienced:

D26. Alcohol Problems? ☐☐

D27. Drug Problems ? ☐☐

FOR QUESTIONS D28-D31 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

D28. Alcohol Problems ? ☐

D29. Drug Problems ? ☐

How important to you now is treatment for these:

D30. Alcohol Problems ? ☐

D31. Drug Problems ? ☐

INTERVIEWER SEVERITY RATING

How would you rate the patient's need for treatment for:

D32. Alcohol Abuse ? ☐

D33. Drug Abuse ? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

D34. Patient's misrepresentation ? 0 - No 1 - Yes ☐

D35. Patient's inability to understand? 0 - No 1 - Yes ☐

COMMENTS

LEGAL STATUS

L1. Was this admission prompted or suggested by the criminal justice system (judge, probation/parole officer, etc.) 0 - No 1 - Yes

L2. Are you on probation or parole ? 0 - No 1 - Yes

How many times in your life have you been arrested and charged with the following:

L3. - shoplifting/vandalism
L4. - parole/probation violations
L5. - drug charges
L6. - forgery
L7. - weapons offense
L8. - burglary, larceny, B&E
L9. - robbery
L10. - assault
L11. - arson
L12. - rape
L13. - homicide, manslaughter
L14. - prostitution
L15. - contempt of court
L16. - other

L17. How many of these charges resulted in convictions?

How many time in your life have you been charged with the following:

L18. Disorderly conduct, vagrancy, public intoxication

L19. Driving while intoxicated

L20. Major driving violations (reckless driving, speeding, no license, etc.)

L21. How many months were you incarcerated in your life? Months

L22. How long was your last incarceration? Months

L23. What was it for? *(Use codes 3-16, 18-20. If multiple charges, code most severe)*

L24. Are you presently awaiting charges, trial or sentence? 0 - No 1 - Yes

L25. What for? (If multiple charges, use most severe).

L26. How many days in the past 30 were you detained or incarcerated?

L27. How many days in the past 30 have you engaged in illegal activities for profit?

FOR QUESTIONS L28 & L29 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

L28. How serious do you feel your present legal problems are? (Exclude civil problems)

L29. How important to you now is counseling or referral for these legal problems?

INTERVIEWER SEVERITY RATING

L30. How would you rate the patient's need for legal services or counseling?

CONFIDENCE RATINGS

Is the above information signficantly distorted by:

L31. Patient's misrepresentation ?

L32. Patient's inability to understand ?

COMMENTS

FAMILY HISTORY

Have any of your relatives had what you would call a significant drinking, drug use or psych problem - one that did or should have led to

	Mother's Side			Father's Side			Siblings		
	Alc	**Drug**	**Psych**	**Alc**	**Drug**	**Psych**	**Alc**	**Drug**	**Psych**
H1. Grandmother				H6. Grandmother			H11. Brother		
H2. Grandfather				H7. Grandfather					
H3. Mother				H8. Father			H13. Sister		
H4. Aunt				H9. Aunt					
H5. Uncle				H10. Uncle					

Direction: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relatives from that category. Code most problematic relative in cases of multiple members per category.

FAMILY/SOCIAL RELATIONSHIPS

F1. Marital Status ☐

1 - Married
2 - Remarried
3 - Widowed
4 - Separated
5 - Divorced
6 - Never Married

F2. How long have you been in this marital status? (If never married, since age 18). ☐☐ Years ☐☐ Months

F3. Are you satisfied with this situation ? ☐
0 - No
1 - Indifferent
2 - Yes

F4. Usual living arrangements (past 3 yr.) ☐
1 - With sexual partner and children
2 - With sexual partner alone
3 - With children alone
4 - With parents
5 - With family
6 - With friends
7 - Alone
8 - Controlled environment
9 - No stable arrangements

F5. How long have you lived in those arrangements? (If with parents or family, since age 18). ☐☐ Years ☐☐ Months

F6. Are you satisfied with these living arrangements? ☐
0 - No
1 - Indifferent
2 - Yes

Do you live with anyone who: (0 - No 1 - Yes)

F7. Has a current alcohol problem ? ☐

F8. Uses non-prescribed drugs ? ☐

F9. With whom do you spend most of your free time: ☐
1 - Family
2 - Friends
3 - Alone

F10. Are you satisfied with spending your free time this way? ☐
0 - No
1 - Indifferent
2 - Yes

F11. How many close friends do you have? ☐

Direction for F12-F26: Place "0" in relative category where the answer is clearly no for all relatives in the category; "1" where the answer is clearly yes for any relative within the category; "X" where the answer is uncertain or "I don't know" and "N" where there never was a relative from that category.

Would you say you have had close, long lasting, personal relationships with any of the following people in your life:

F12. Mother ☐
F13. Father ☐
F14. Brothers / Sisters ☐
F15. Sexual Partner / Spouse ☐
F16. Children ☐
F17. Friends ☐

Have you had significant periods in which you have experienced serious problems getting along with:

	PAST 30 DAYS	IN YOUR LIFE
F18. Mother	☐	☐
F19. Father	☐	☐
F20. Brothers/Sisters	☐	☐
F21. Sexual partner/spouse	☐	☐
F22. Children	☐	☐
F23. Other signficant family	☐	☐
F24. Close friends	☐	☐
F25. Neighbors	☐	☐
F26. Co-Workers	☐	☐

Did any of these people (F18-F26) abuse you:

	PAST 30 DAYS	IN YOUR LIFE
F27. Emotionally (make you feel bad through harsh words)?	☐	☐
F28. Physically (cause you physical harm)?	☐	☐
F29. Sexually (force sexual advances or sexual acts)?	☐	☐

How many days in the past 30 have you had serious conflicts:

F30. With your family ? ☐☐

F31. With other people ? (excluding family) ☐☐

FOR QUESTIONS F32-F35 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

How troubled or bothered have you been in the past 30 days by these:

F32. Family problems ☐

F33. Social problems ☐

How important to you now is treatment or counseling for these:

F34. Family problems ☐

F35. Social problems ☐

INTERVIEWER SEVERITY RATING

F36. How would you rate the patient's need for family and/or social counseling? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

F37. Patient's misrepresentation ? ☐
0 - No 1 - Yes

F38. Patient's inability to understand ? ☐
0 - No 1 - Yes

COMMENTS

PSYCHIATRIC STATUS

P1. How many times have you been treated for any psychological or emotional problems?

In a hospital ☐☐

As an Outpatient or Private patient ☐☐

P2. Do you receive a pension for a psychiatric disability? 0 - No 1 - Yes ☐

Have you had a significant period, (that was not a direct result of drug/alcohol use), in which you have:

	PAST 30 DAYS	IN YOUR LIFE
P3. Experienced serious depression	☐	☐
P4. Experienced serious anxiety or tension	☐	☐
P5. Experienced hallucinations	☐	☐
P6. Experienced trouble understanding, concentrating or remembering	☐	☐
P7. Experienced trouble controlling violent behavior	☐	☐
P8. Experienced serious thoughts of suicide	☐	☐
P9. Attempted suicide	☐	☐
P10. Been prescribed medication for any psychological emotional problem	☐	☐

P11. How many days in the past 30 have you experienced these psychological or emotional problems? ☐☐

FOR QUESTIONS P12 & P13 PLEASE ASK PATIENT TO USE THE PATIENT'S RATING SCALE

P12. How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days? ☐

P13. How important to you now is treatment for these psychological problems? ☐

THE FOLLOWING ITEMS ARE TO BE COMPLETED BY THE INTERVIEWER

0 - No 1 - Yes

At the time of the interview, is patient:

P14. Obviously depressed/withdrawn ☐

P15. Obviously hostile ☐

P16. Obviously anxious/nervous ☐

P17. Having trouble with reality testing , thought disorders, paranoid thinking ☐

P18. Having trouble comprehending, concentrating, remembering ☐

P19. Having suicidal thoughts ☐

P20. How would you rate the patient's need for psychiatric/psychological treatment? ☐

CONFIDENCE RATINGS

Is the above information significantly distorted by:

P21. Patient's misrepresentation ? 0 - No 1 - Yes ☐

P22. Patient's inability to understand ? 0 - No 1 - Yes ☐

COMMENTS