NEBRASKA STANDARD REPORTING FORMAT
FOR SUBSTANCE USE AND CO-OCCURRING EVALUATIONS
FOR <u>ALL</u> JUSTICE REFERRALS

A. DEMOGRAPHICS

B. PRESENTING PROBLEM / PRIMARY COMPLAINT

    1. External leverage to seek evaluation
    2. When was client first recommended to obtain an evaluation
    3. Synopsis of what led client to schedule this evaluation

C. MEDICAL HISTORY

D. WORK / SCHOOL / MILITARY HISTORY

E. ALCOHOL / DRUG HISTORY SUMMARY

    1. Frequency and amount
    2. Drug and/or alcohol of choice
    3. History of substance-induced/use/disorder
    4. Use patterns
    5. Consequences of use (physiological, legal, interpersonal, familial, vocational, etc.)
    6. Periods of abstinence / when and why
    7. Tolerance level
    8. Withdrawal history and potential
    9. Influence of living situation on use
    10. Other addictive behaviors (e.g., gambling)
    11. IV drug use
    12. Prior substance use evaluations and findings
    13. Prior substance use disorder treatment

F. LEGAL HISTORY (Information from Criminal Justice System)

    1. Criminal History and other information
    2. Substance testing results
    3. Simple Screening Instrument (SSI) results
    4. Risk Assessment Reporting Format for Substance Abusing Offenders (SRARF) results

G. FAMILY / SOCIAL PEER HISTORY

H. BEHAVIORAL HEALTH HISTORY

1. Previous mental health diagnosis
2. Prior mental health treatment

I. COLLATERAL INFORMATION (Information from Family/Friends/Criminal Justice/Other)

1. Report any information about the client's use history, pattern, and/or consequences learned from other sources.

J. OTHER DIAGNOSTIC / SCREENING TOOLS – SCORE AND RESULTS

1. Report the results and score from any other substance abuse assessment tool used that is not the ASI or CASI.

K. ASAM Multidimensional Assessment

1. Dimension 1: Acute Intoxication and/or Withdrawal Potential
    a. Intensity:
    b. Justification:

2. Dimension 2: Biomedical Conditions and Complications
    a. Intensity:
    b. Justification

3. Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications
    a. Intensity:
    b. Justification:

4. Dimension 4: Readiness to Change
    a. Intensity:
    b. Justification:

5. Dimension 5: Relapse, Continued Use, or Continued Problem Potential
    a. Intensity:
    b. Justification:

6. Dimension Recovery/Living Environment
    a. Intensity:
    b. Justification:

L. CLINICAL IMPRESSION

1. Summary of evaluation
    a. Behavior during evaluation (agitated, mood, level of cooperation)
    b. Motivation to change
    c. Level of denial or defensiveness

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      d. Personal agenda
      e. Discrepancies of information provided

2. Substance use or substance use disorder diagnostic impression (including justification)
      a. Identify the substance use and substance use disorder diagnostic impression

3. Needs identified (for the client and the family)

4. Problems identified

M. RECOMMENDATIONS

1. Primary / ideal level of care recommendation
      a. Identify the substance use or substance use disorder level of care and service(s) that would best meet the need of the client.

2. Available level of care / barriers to ideal recommendation
      a. If the substance use or substance use disorder level of care and service(s) are not available or there is some other reason the client cannot receive that service, identify those reasons. Include the next best substance use level of care and service that the client can be referred to.

3. Client / family response to recommendation
      a. Document the client's response to the level of care and service recommendation.
      b. Include the family's response to the level of care and service recommendation.

ATTACHMENT A: PERTINENT BIOPSYCHOSOCIAL INFORMATION

	YES	NO	Notes
1. MEDICAL / HEALTH STATUS			
a. Eating disorders issues			
b. Infectious diseases present			
c. Head trauma history			
d. Organ disease (liver, heart, other)			
e. Pregnancy			
f. Medication status and history			
g. Other pertinent medical problems			
h. Nutritional			
2. EMPLOYMENT / SCHOOL / MILITARY	YES	NO	
a. Employment history			
b. Financial responsibility problems			
c. Work ethic / goal setting problems			
d. Military history			
e. Attendance issues			
f. Performance / goal setting problems			
g. Learning disabilities present			
h. Cognitive functioning difficulties			
3. FAMILY / SOCIAL DESCRIPTION	YES	NO	
a. History of use / treatment			
b. Family communication issues			
c. Family conflict evident (domestic, sexual, physical, neglect, etc.)			
4. DEVELOPMENTAL	YES	NO	
a. Abandonment issues			
b. Significant childhood experiences			
5. SOCIAL COMPENTENCY / PEER RELATIONSHIPS			
a. Authority issues present			
b. Assertiveness issues present			
c. Submissiveness issues present			
d. Social support network			
e. Substance-using peers prominent			
f. Isolation issues			
g. Use of free time / hobbies			
h. Group v. individual activities			
i. Gang membership / affiliation			
6. BEHAVIORAL HEALTH	YES	NO	
a. Need for mental health treatment evident			
b. Danger to self or others present			
c. Legal issues past or present			
d. Violence by history			
e. Impulsivity by history			
f. High risk behaviors by history			
7. INDIVIDUALIZED NEEDS	YES	NO	
a. Spirituality			
b. Cultural issues impacting AOD use			
c. Anti-social values / beliefs			

Co-Occurring Evaluations

The co-occurring evaluation will contain all the elements found within the substance use evaluation, with the exception of Section M Recommendations, which will be implemented into Section O- Recommendations of the Co-Occurring Evaluation.

M. MENTAL STATUS EXAMINATION

1. Appearance
   a. Age
   b. Gender, Race, Ethnicity
   c. Body build
   d. Position
   e. Posture
   f. Eye contact
   g. Dress
   h. Grooming
   i. Manner
   j. Attentiveness to examiner
   k. Distinguishing features
   l. Prominent physical abnormalities
   m. Emotional facial expression
   n. Alertness

2. Motor
   a. Agitation
   b. Abnormal movements

3. Speech
   a. Rate
   b. Volume

4. Affect
   a. Appropriateness
   b. Observation
   c. Mood

5. Thought Content
   a. Suicidal Ideation
   b. Homicidal ideation
   c. Paranoid ideation
   d. Delusions
   e. Other major themes discussed by client

6. Thought Process
   a. Associations
   b. Coherence
   c. Logic
   d. Stream
   e. Attention

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7. Perception
    a. Hallucinations
    b. Illusions

8. Global Evaluation of Intellect

9. Insight

10. Mini-Mental State Exam

N. DIAGNOSIS

O. CO-OCCURRING RECOMMENDATIONS

1. Primary/Ideal level of care (what would best meet client needs)
    a. Identify the level of care and service(s) that would best meet the need of the client.

2. Available level of care/barriers to ideal recommendation
    a. If the level of care and service(s) are not available or there is some other reason the client cannot receive that service, identify those reasons. Include the next best level of care and service that the client can be referred to.

3. Client/Family response to recommendations
    a. Document the client's response to the level of care and service recommendation.
    b. Include the family's response to the level of care and service recommendation

4. Identification of who needs to be involved in the client's treatment
5. Treatment plan including transitioning to lower levels of care and discharge planning
6. A means to evaluate the client's progress throughout their treatment and outcome measures at discharge
7. Recommended linkages with community resources