

DIRECTIONS FOR PREPARING THE WRITTEN CASE STUDY

PLEASE TYPE THE CASE STUDY AND FOLLOW THESE DIRECTIONS

1. Use, as the subject of your written case study, an actual and typical client from your closed case files. Use one who has completed alcohol or substance use/dependency treatment or is no longer obtaining your services. Use a fictitious name for the client, and use care to protect the identity of the client. Do not use the client's initials or abbreviations of the client's real name.
2. Complete the form for demographic information and treatment circumstances.
3. Provide the information for items A through K, following alphabetical order. Use one of the lettered headings and a numbered subheading as the title for each section and write the narrative for that section. **Please be sure to address each item even if it is not pertinent to your case.** You may use as many sheets of paper as you need, numbering them consecutively.
4. Sign and date the Applicant's Statement.
5. Give the completed written case study to the person who was your supervisor at the time you served the client, and ask the supervisor to date and sign the Supervisor's Statement after he or she has completed review of the case study.
6. Mail the case study, demographic information and treatment circumstances page, and the original certifications page to the Board of Licensing for Alcohol and Other Drug Use Professionals, 121 South Fruit Street, Philbrook Building, Concord, NH 03301. Keep a copy of the materials for your files.

DEMOGRAPHIC INFORMATION AND TREATMENT CIRCUMSTANCES

Name of Applicant: _____

DEMOGRAPHIC INFORMATION ON ACTUAL AND TYPICAL CLIENT

Client's fictitious name: _____

Age when he/she became applicant's client: _____

Race:

American Indian or Alaska Native _____

Asian _____

Black or African American _____

Hispanic or Latino _____

Native Hawaiian or other Pacific Islander _____

White _____

Other _____

Gender: _____ Relationship Status: _____

Occupation: _____

TREATMENT CIRCUMSTANCES

Reason client was referred or reason for treatment: _____

Referral source, if any: _____

Date applicant's services began: _____

Date services ended: _____

Treatment Setting:

Residential _____

Outpatient _____

Intensive Outpatient _____

Detoxification Maintenance _____

Opioid Replacement Therapy (ORT) _____

Other (specify) _____

OUTLINE FOR WRITTEN CASE STUDY

Please organize the information about the client under the headings shown.

A. SUBSTANCE USE HISTORY

1. Substances used
2. Frequency of substance use
3. Progression of substance use
4. Severity of substance use or the amount of each substance used
5. Approximate date or age when substance use began
6. Primary substance used
7. Route of substance administration
8. Effects on the client of substance use, whether blackouts, tremors, tolerance, seizures, medical complications (may be included in physical history) or other (specify)

B. PSYCHOLOGICAL FUNCTIONING

1. Corroborating past mental status and mental status at time of treatment whether oriented, hallucinating, having delusions, suicidal, homicidal, or other (specify)
2. Quality of client's judgment
3. Quality of client's insight into his or her problems

C. EDUCATIONAL, VOCATIONAL AND FINANCIAL HISTORY

1. Education level and history
2. Work history
3. Any disciplinary action taken at school
4. Any disciplinary action taken at work
5. Reason for client's termination of education, if terminated
6. Reason for client's termination of work, if terminated
7. Client's financial status, as indicated by: Living arrangements, manner in which client supports self, and other indicators
8. Financial status of the client's family of origin, as indicated by similar indicators

D. LEGAL HISTORY (Even if not associated with substance use)

1. Past criminal charges and those pending at time of treatment
2. Arrests
3. Findings of juvenile delinquency
4. Criminal convictions

E. SOCIAL HISTORY

1. Influence of parents on client
2. Number, gender and rank order of client's siblings
3. Influence of siblings on client
4. Influence of children on client
5. Influence of significant other on client
6. Psychological health of the client's family with respect to any mental health, psychiatric and emotional problems
7. Description of any substance use by members of the client's family
8. History of the client's level(s) of mental health and actual behavior, both adaptive and maladaptive, in social settings
9. History of relationships, including the number, type and relative level of normality within family, intimate, and other social relationships

F. PHYSICAL HISTORY

1. Past major medical problems and those at time of treatment whether or not related to substance use
2. Past disabilities and those at time of treatment whether or not related to substance use
3. Past pregnancies and those at time of treatment

G. TREATMENT HISTORY

1. Summary of client's history of treatment, if any, for psychological conditions and substance use disorders
2. Client's participation in self-help group(s)

H. ASSESSMENT

1. Identification of and evaluation of client's personal strengths and weaknesses
2. Formulate diagnosis using the most current version of the Diagnostic & Statistical Manual of Psychiatric Disorders (DSM)

I. TREATMENT PLAN

1. Identification and ranking of the problems requiring resolution
2. Immediate goals and long-term goals agreed to by the client
3. Course of treatment including:
 - a. Frequency
 - b. Duration
 - c. Objectives

- d. Counseling theory or theories utilized
- e. Interventions utilized
- f. Treatment setting, whether inpatient, intensive, outpatient, group therapy, detoxification, or other (specify)
- g. Any adjunct support such as self-help, community resources, family members and significant others

J. COURSE OF TREATMENT

- 1. Counseling approaches applicant used with client
- 2. Applicant's rationale for their use
- 3. Any revisions in counseling approaches made in response to the client's specific problems and responses to treatment

K. DISCHARGE SUMMARY

- 1. Concise description of the client's overall response to treatment including substance use at the time treatment ended
- 2. Continuing care plan