

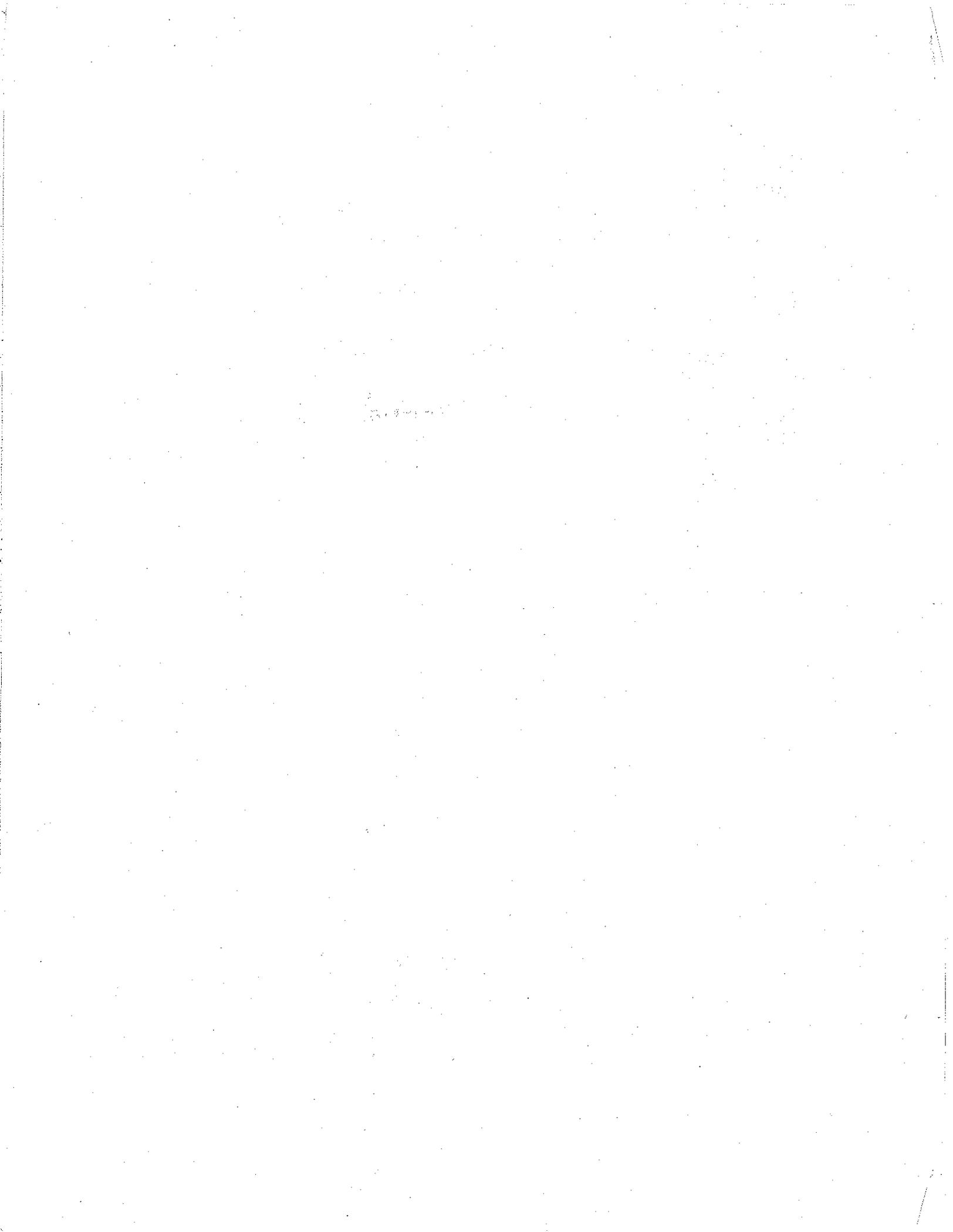


**Standardized Model
For Assessing
Substance Abuse
Among Offenders**

Training Manual

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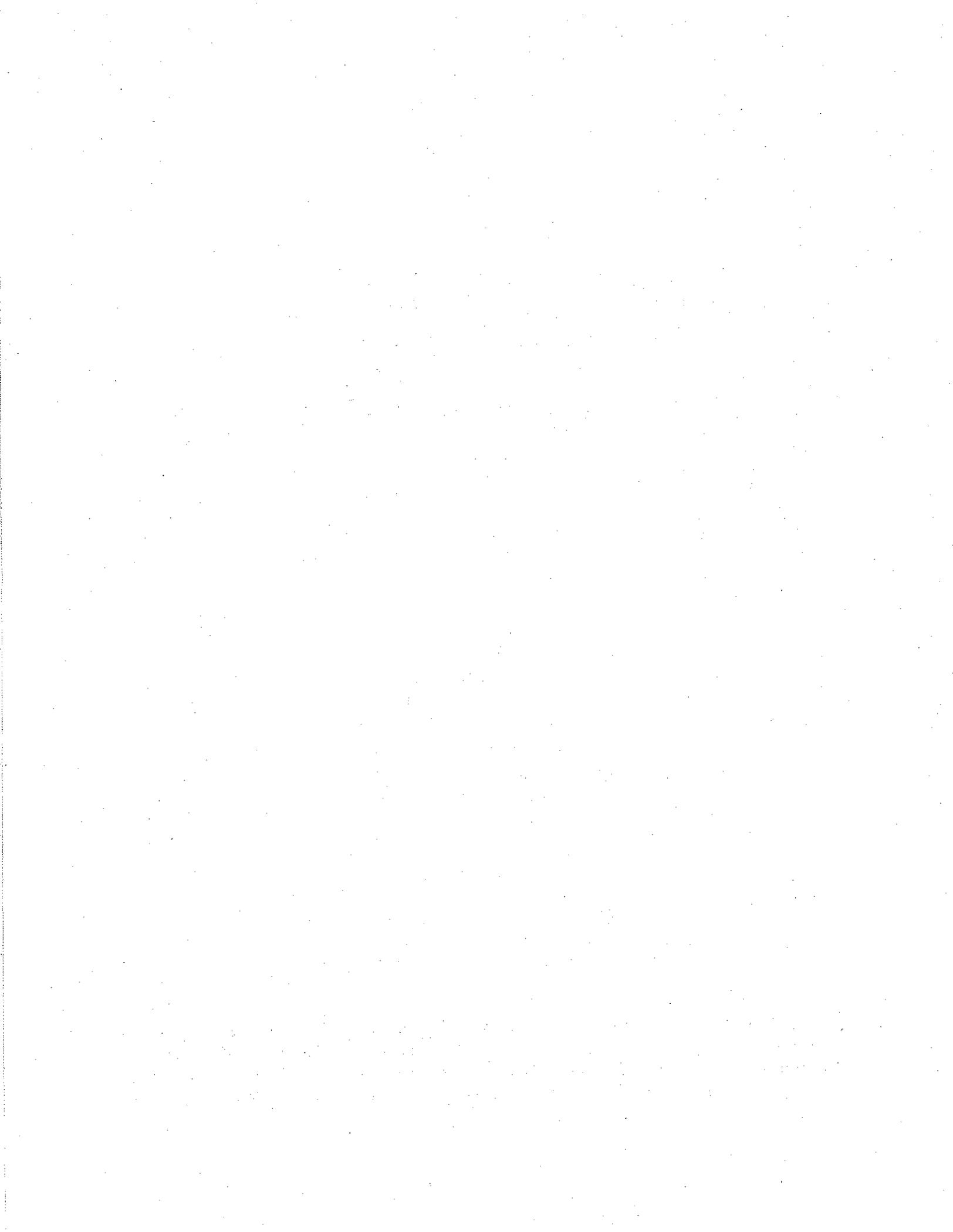
**STANDARDIZED MODEL FOR ASSESSING SUBSTANCE
ABUSE AMONG OFFENDERS**

TRAINING MANUAL

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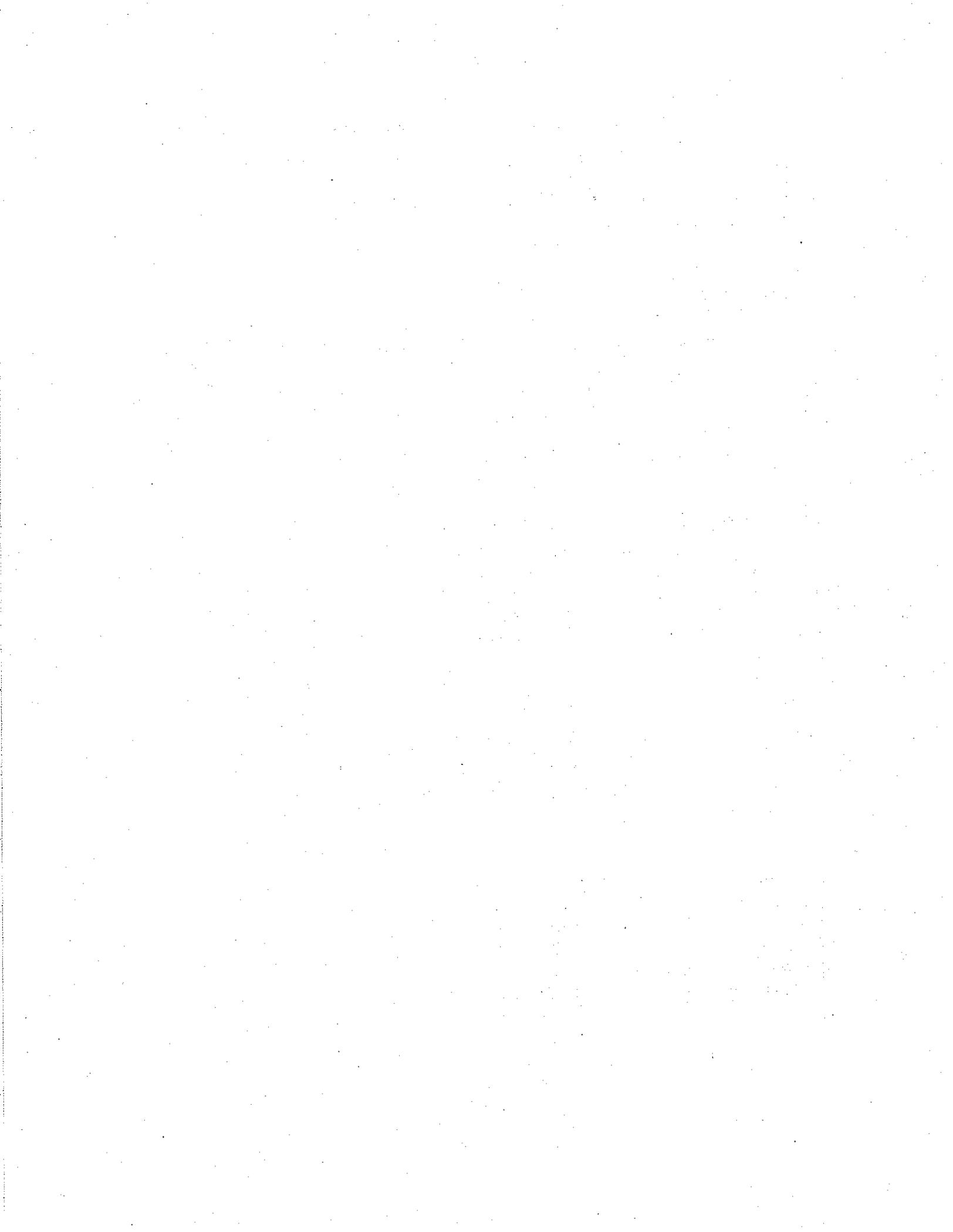


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INTRODUCTION

Substance abuse and crime are often coexistent factors. Over the last decade several state and national reports have documented the need to address substance abuse among adult and juvenile offenders in order to enhance public safety and promote healthy communities (2000, 1). The state of Nebraska is no exception in its observance of crime and substance abuse. Successful reduction of the problem requires a working relationship between justice officials and substance abuse treatment providers. Problems, however, seem to exist in ameliorating the substance abuse among adults and juveniles. A 1993 technical review prepared for the Department of Public Institutions concluded, "The relationship between probation and treatment systems was 'ad hoc' and dependent on the good will and energy of each individual probation officer and each individual treatment provider" (Herz, 2001).

Recognizing the problem, a group of justice practitioners began meeting in 1996 to address problems related to substance abuse treatment. In 1997, this group named itself the Criminal Justice Coordinated Response and worked to:

- Identify gaps in the criminal justice system related to treatment;
- Eliminate fragmentation in services through the criminal justice continuum;
- Identify effective treatment modalities for offenders; and
- Integrate predictors of recidivism into substance abuse treatment (Herz, 2001)

Problems existed beyond the justice system. There was also fragmentation or gaps in the relationship between criminal justice and substance abuse providers. Included among these inconsistencies are:

- Inconsistent coordination and communication
 - Lack of cross-training
 - Lack of information sharing
- Lack of criteria and accountability
 - Selecting offenders for evaluations (Justice)
 - Producing quality evaluations (Providers)
- Need to reexamine and update treatment approaches for offenders
- Limited system resources to pay for treatment
- Limited number of treatment & Certified Alcohol/Drug Abuse Counselors (CADAC)
 - 1 CADAC/3,068 NE Residents
 - 1 CADAC/12,500 Western NE Residents

Recognizing these issues, the Nebraska Unicameral passed LB 865 (1999) which required the Governor to create a Task Force to examine the adult and juvenile offenders' need for access to substance abuse treatment. The Nebraska Substance Abuse and Treatment Task Force was then created. The Task Force was required to report on issues and make recommendations by January 2000. The following key findings were included in the report:

- 25 to 40% of adult arrestees and 65 to 85% of incarcerated adult offenders need substance abuse treatment compared to only seven percent of the general adult population.
- 30 to 40% of juvenile arrestees and 65 to 80% of juvenile offenders in the youth rehabilitation and treatment centers at Geneva and Kearney need substance abuse treatment compared to only five percent of the general juvenile population.
- Treatment of addiction is as successful as the treatment of other chronic diseases such as diabetes, hypertension, and asthma as long as treatment “best practices” are implemented. In fact, it is estimated that for every \$1 spent on treatment, there is a \$4-\$7 reduction in drug-related crime and criminal justice costs. Furthermore, individuals who enter treatment under legal pressure have outcomes as favorable as those who enter voluntarily.
- Treatment does not need to be voluntary to be effective. Sanctions or enticements from the criminal justice system can increase treatment entry, retention rates, and the success of drug treatment interventions significantly (2001, 1).

Following the report to the Governor in January 2000 the Task Force met in subcommittees to work on additional specific recommendations. It was recognized early that the gaps between the justice system and providers needed to be bridged. It was also recognized that a simple, but standard manner of identifying the need for substance abuse treatment was needed. This became the work of the Standardization Subcommittee.

The Standardization Subcommittee was originally formed by the Substance Abuse task Force to develop and recommend standardized substance abuse evaluation instruments for adults and juveniles processed in the criminal and juvenile justice systems. The Standardized Model of Assessment was developed.

This manual is designed to provide guidance in the use of the Standardized Model of Assessment and the various “instruments” and procedures associated with the Model. The manual’s development emanates from the efforts of members of the Substance Abuse and Treatment Task Force to standardize the assessment of substance abuse treatment needs for both juveniles and adults in the justice system. It stems from more than three years of meetings designed to examine the needs of adult and juvenile offenders for better access to treatment while in the system.

EXECUTIVE SUMMARY

Nebraska law (LB 865) (1999) established the Nebraska Substance Abuse Treatment Task Force to examine adult and juvenile offenders' need to access substance abuse treatment. The Task Force consisted of key stakeholders from both the justice system and substance abuse treatment professionals. The Task Force found a great need for substance abuse treatment: 25-40% of adult arrestees and 65-85% of incarcerated adults; and 30-40% of juvenile arrestees and 65-80% of juvenile offenders in youth rehabilitation centers needed treatment. Part of the problem in providing treatment was found to be the major gap between the justice system and substance abuse treatment providers, including the lack of a standard method of identifying the need for treatment.

As a result of three years of work, the Task Force developed a Standardized Model for Assessing Drug Abuse Among Offenders (also referred to as the Standardized Model). Objectives of the model are to standardize: identification of the need for treatment, assessment of risk of re-offense; and, reporting/sharing of information within/between the justice and provider systems.

Components of the model include: Screening, Risk Assessment, and Evaluation. Screening and Risk Assessment are primarily the responsibility of the justice system whereas Evaluation is the responsibility of treatment providers. Attention to confidentiality and cultural competency issues are important throughout the entire process.

Screening clients for substance abuse is critical to early detection of a problem and the need for further evaluation. The Task Force chose the Simple Screening Instrument (SSI) for use by justice personnel statewide because of its ease of administration and scoring. Information gained from screening stays with the client throughout processing and is shared with providers if an evaluation is done.

Risk Assessment determines the chances of re-arrest of an offender who abuses alcohol and other drugs (AOD). The process takes into account three kinds of factors: risk factors which increase an individual's probability of engaging in crime or delinquent behavior, need factors which compound the effects of risk factors, and protective factors which help counter risk factors. Agencies are asked to convert information from their current risk assessment forms to the *Nebraska Standardized Risk Assessment Reporting Format for Substance Abuse Offenders*. The use of a standard reporting format is important in maintaining consistent information on all offenders. This form and other information (criminal history, SSI results, and disclosure forms) are sent to providers of evaluation services for referred clients.

Evaluation is the portion of the model that deals with evaluating what kind of treatment and level of care the AOD abuse client needs. The intent of the model is for treatment providers to receive standardized information for all clients referred through the justice system. This will enable providers to make well-informed decisions for placement.

The key assumption of the Standardized Model is that if the steps prescribed within the model are followed by all justice agencies and treatment providers in the state of Nebraska, offenders will be better served in addressing any substance abuse problems. Cooperation of all agencies involved with offenders with potential AOD abuse problems is essential to collecting and sharing appropriate and accurate information.

RATIONALE FOR TRAINING ON USE OF THE STANDARDIZED MODEL

In the past, persons screening offenders for substance abuse and treatment recognized that the system of screening, assessment, evaluation, and treatment was often fragmented and followed no standardized format. The result was inconsistent coordination and communication among justice professionals and substance abuse providers. It was extremely important that there be an appropriate matching of treatment settings, interventions and services to meet the individual needs of clients. The development of the *Standardized Model for Assessing Substance Abuse Among Offenders* closes this gap. It is important, therefore, that individuals involved in this process become familiar with the language, processes, and reporting formats necessary to provide the best treatment and level of care for offenders with problems. This manual serves as a means of meeting this need.

STANDARDIZED MODEL FOR ASSESSING SUBSTANCE ABUSE AMONG OFFENDERS

Training Objectives

At the end of this module participants should:

1. Be aware of the components of the *Standardized Model of Assessment*.
2. Be cognizant of the mission of the Model.
3. Understand the responsibilities of individuals/agencies in each component of the Model.

Description of the Model

The Standardized Model of Assessment, consists of three components – screening, risk assessment, and evaluation. The screening and risk assessment components are primarily the responsibility of the justice system. The evaluation component is the responsibility of substance abuse treatment providers.

The mission of the Standardized Model:

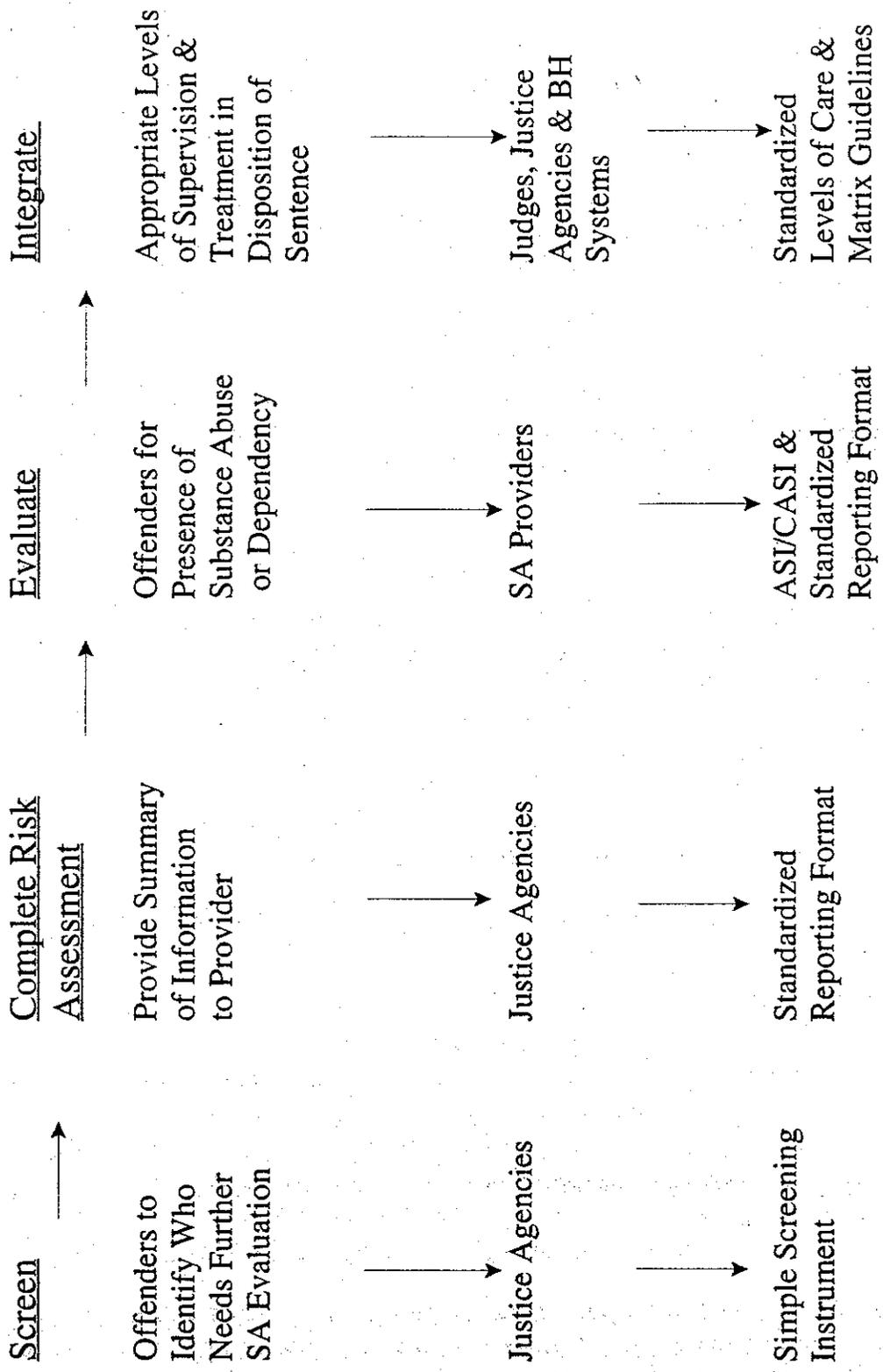
- To provide a mechanism to ensure that all offenders are consistently screened and evaluated (when necessary) for substance abuse and/or dependency and matched to appropriate treatment.
- To accurately identify substance abuse and/or dependency and access to appropriate treatment early in the criminal justice process in order to enhance public safety by reducing offender drug use and future criminal behavior.
- To coordinate and formalize information sharing between justice agencies and treatment providers in order to accurately and consistently assess substance abuse among offenders.
- To integrate appropriate levels of care with offender accountability.

The Standardized Model requires justice agencies:

- To screen all offenders for substance abuse as early in the process as possible
- To provide risk assessments to professionals conducting substance abuse evaluations for offenders observed as potential substance abusers
- To require that substance abuse professionals use a process of diagnostic impressions and recommendations that ensure the consistent and accurate diagnoses and recommendations for the appropriate level of care.
- To formalize information sharing between justice personnel and treatment providers.

The Standardized Model requires substance abuse professionals to evaluate offenders to ensure consistent and accurate diagnoses for treatment. The information and processes found in the following modules are necessary for the accomplishment of these factors.

Model Process & Requirements



CONFIDENTIALITY

Training Objectives

At the end of this module, participants should:

1. Understand the importance of keeping information confidential
2. Be aware of the Federal and State laws regarding confidentiality
3. Understand disclosure of information and client consent

Importance of Confidentiality

Confidentiality of information about alcohol and other drug abuse (AOD) abuse legally protects the right of privacy of the client and allows the client (rather than the program) to determine when and to whom information will be disclosed. Protecting confidentiality must occur at all points in the process, including gathering information from clients, referring clients for assessment, making diagnosis, providing treatment, and/or communicating with other agencies working with clients. Laws and regulations regarding confidentiality are primarily Federal and are intended to attract AOD abusers into treatment.

Note that while information about confidentiality laws is current as of the printing of this manual, laws change over time. Therefore, it is recommended that specific questions concerning confidentiality be discussed with an attorney or other expert in the area of confidentiality law.

Advantages of Confidentiality

Protects the client's right of privacy

Allows client the right to determine when and to whom disclosure of information is made

Avoids conflict with Federal and State confidentiality laws

Regulations

Federal statutes and regulations guarantee the strict confidentiality of information about all persons applying for or receiving AOD abuse prevention, screening, assessment, and treatment services and apply to any program that holds itself out as providing services for AOD abuse. Violating the regulations is punishable by a fine of up to \$500 for a first offense or up to \$5,000 for each subsequent offense. (See Appendix A, Part I) Although Federal regulations apply only to programs that receive Federal assistance, this includes indirect forms of Federal aid, such as tax-exempt status or State or local government funding received (in whole or in part) from the Federal Government. (See glossary for full definition.)

Federal law takes precedence over State law and no State law may either authorize or compel any disclosure prohibited by the Federal regulations. If a disclosure permitted under the Federal regulations is prohibited under State law, neither the Federal regulations nor the authorizing statutes may be construed to authorize any violation of that State law.

Nebraska has several statutes that relate to disclosure, and access and restriction to records (Appendix A, Parts III and IV).

Disclosure of Information and Client Consent

Because client information must be shared among professionals/agencies in order to provide good client services, Federal regulations (65 FR 53649) permit disclosure after the client has signed a proper consent form. This also allows disclosure without client consent in certain situations discussed later in this section.

A proper consent form must be in writing and must contain all of the following items:

- Name or general description of the program (s) making the disclosure
- Name or title of the individual or organization that will receive the disclosure
- Name of the client
- Purpose or need for the disclosure
- How much and what kind of information will be disclosed
- Signature of the client and, when required for a client who is a minor, the signature of a person authorized to give consent under §2.14; or, when required for a client who is incompetent or deceased, the signature of a person authorized to sign under §2.15 in lieu of the client.

Note: when the client is an adult with a guardian: whether a guardian can sign for his ward depends on the specific language used in the legal documents that created the guardianship. Most guardianship documents will contain language broad enough to allow the guardian to sign a waiver of the ward's confidentiality rights, but "never say never". Never get JUST the ward's signature. Even if the language in the legal documents that created the guardianship does not appear broad enough to grant the power to waive confidentiality, a court is likely to hesitate to find that a person who has a legally appointed guardian could ever be "bound" by the "ward's" signature alone on a waiver. So, get both if possible - if not possible, get the guardian's signature.

- Date on which the consent is signed.
- A statement that the consent is subject to revocation at any time except to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer.
- The date, event, or condition upon which the consent expires if not revoked before. This date, event, or condition must insure that the consent will last no longer than reasonably necessary to serve the purpose for which it is given.

The following sample consent form contains all required elements, but others may be added.

SAMPLE CONSENT FOR DISCLOSURE OF SUBSTANCE USE/ABUSE INFORMATION

1. I (name of client) _____ (")" Request "()" Authorize:
2. (name or general designation of program which is to make the disclosure)

3. To disclose: (kind and amount of information to be disclosed)

4. To: (name or title of the person or organization to which disclosure is to be made)

5. For (purpose of the disclosure)

6. Date (on which this consent is signed) _____
7. Signature of patient _____
8. Signature of parent or guardian (where required)

9. Signature of person authorized to sign in lieu of the patient (where required)

10. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: (specific date, event, or condition)
 - (c) Expired, deficient, or false consent. A disclosure may not be made on the basis of a consent which:
 - (1) Has expired;
 - (2) On its face substantially fails to conform to any of the requirements set forth in paragraph (a) of this section;
 - (3) Is known to have been revoked; or
 - (4) Is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

Important Points Regarding Disclosure

- Be specific about the need or purpose for information, (i.e. make an appointment for assessment).
- Expiration date, event, or condition must last no longer than reasonably necessary to serve the purpose for which it is given.
- The general consent form permits the client to revoke consent at any time, verbally or in writing. The consent form must include a statement to this effect. If the program has already disclosed information, it is said to have *acted in reliance on the consent* (relying on the permission given previously). The program is not required to try to retrieve the information it has already disclosed.
- Examples of *client-identifying disclosure*: when a worker makes an appointment for a client's assessment or treatment for AOD abuse, or when screening programs ask a collateral source (family member, employer, physician, mental health professionals) to verify client's information.
- Consent must be obtained before the AOD treatment program can receive screening results from the referring agency.
- Consent form that permits disclosure to several entities or persons as listed on the form allows communication about a client between two programs

Redisclosure

Disclosure to other entities is prohibited unless the client signs a consent form authorizing such redisclosure. Those who receive the redisclosure notice (shown below) are prohibited from re-releasing information except as permitted by the regulations.

The fact that a client has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure unless the program has also received a subpoena or court order. The program's only obligation is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or invalid. A program cannot be forced to disclose information, even by a subpoena, if a client has not given consent; however, a program can be forced to disclose by a subpoena if the client has given consent.

**Prohibition on Redisclosing Information Concerning
Clients Receiving Treatment for AOD Abuse**

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

Exceptions to Federal Confidentiality Laws

Some exceptions to Federal exists. The following general situations allow disclosure without consent.

- No client-identifying information is revealed (e.g. aggregated population data)
- Client's status as an AOD abuse patient is not revealed (e.g. health services information about illness but not AOD problems). Not applicable to programs that provide AOD services only, unless disclosure is anonymous.
- Members of the clinical team in the same program need to share AOD information about clients because their work requires it.

Court -Ordered Disclosures

One of the most widely used exceptions is the Court-Ordered Disclosure. Issued by State or Federal courts, this order permits a disclosure about a client that would otherwise be forbidden. The court must follow certain special procedures and makes particular determinations required by the regulations before disclosures can be ordered. Subpoenas, search warrants, or arrest warrants, even when signed by a judge, are not sufficient, standing alone, to require or even to permit a program to disclose information (§2.61).

A court must first notify the program and the client whose records are being sought of its application for the order. The program and the client then have an opportunity to make a oral or written statement to the court. Generally, the application and any court order must use fictitious names for any known client, and all court proceedings in connection with the application must remain confidential unless the client requests otherwise (§§2.64 (a), b, 2.65,2.66).

Before issuing an authorizing order, a court must find that there is "good cause" for the disclosure. A court can find good cause only if it determines that the public interest and the need for

disclosure outweigh any negative effect that the disclosure will have on the client, the relationship between the client and his or her physician or counselor, and the effectiveness of the program's treatment services. Before it may issue an order, the court must also find that other ways of obtaining the information are not available or would be ineffective (§2.64 (d)).

Other Exceptions

Other exceptions are found in Appendix A, Part II. These exceptions include the following:

- Qualified Service Organization Agreements
- Medical Emergencies
- Disclosures to Elements of the Criminal Justice System which have Referred Patients
- Crimes on Program Premises or Against Program Personnel
- Research, Audit, or Evaluation
- Client Notice and Access to Records
- Records (Nebraska statutes covering restriction of access to records) (See Appendix A, Part IV)

Barriers to Confidentiality

Non-compliance with confidentiality laws

Need to share information among agencies may inhibit compliance with confidentiality laws

Not understanding or incorporating the exceptions to confidentiality laws

Sources

Herz, D.C. (2001). Substance Abuse Treatment Task Force Final Report. September. Nebraska Commission on Law Enforcement and Criminal Justice. Lincoln, NE.

Winters, K.C. & Zenilman, J. M. (1994). Simple screening instruments for outreach for alcohol and other drug abuse and infectious diseases. U.S. Department of Health and Human Services, Substance abuse and Mental Health Services Administration, Treatment Improvement Protocol (TIP) Series # 11. Washington. *This publication is used heavily within the confidentiality section, with written permission.*

CULTURAL COMPETENCE

Training Objectives

At the end of this module participants should:

1. Have an understanding of the importance of cultural awareness when implementing the *Standardized Model of Assessment*
2. Be able to define cultural competence.
3. Understand the particular cultural factors associated with the use of the Model.
4. Know the specific skills associated with developing cultural competency.

Advantages of Cultural Competence

Increased understanding factors contributing to offender's potential for substance abuse

Ability to understand verbal and nonverbal communication from offenders

Increased ability to communicate with offenders

Effective Response to a Diverse Clientele

The increased number of substance abusers coupled with the demographic changes in America, leads to the question of whether existing policies, programs, and services are relevant to the cultural values, traditions, needs, and expectations of the population served. Compounding these factors is the fact that "Standardized assessments are highly problematic when used with individuals from other than mainstream United States culture" (Bonder, et al., 2001). Differences in perception on the part of professional and clients may lead to inaccurate assessments.

The information compiled in this module makes no assumptions regarding the abilities of justice professionals or the providers of substance abuse treatment to operate in a multicultural setting. This unit provides information on how to more effectively respond to the challenges associated with obtaining information from, and providing services to a culturally diverse clientele.

Diversity

Diversity is defined as "a mix of people in one social system who have distinctly different, socially relevant group affiliations. There are many kinds of group affiliations such as gender, nationality, racioethnic identity, age cohort, levels or types of physiological abilities or disabilities, religion" (Cox and Beale, 1997). This list is by no means exhaustive. A socially relevant group

affiliation is one to which some strong meaning is attached when people interact together. When these group affiliations are socially relevant and have cultural significance, the term *cultural diversity* is used (Cox and Beale, 1997). This information contained in this module assumes all aspects of diversity to be relevant.

Cultural Competence

Cultural competency results from a sequence of actions that “leads to an ability to effectively respond to the challenges and opportunities posed by the presence of social-cultural diversity in a defined social system”(Cox and Beale, 1997). The learning process entails (1) recognizing that diversity has genuine effects on the behavior within an organization and the work outcomes; (2) understanding why cultural competency is relevant to the good performance; and (3) taking steps to change non-productive actions (Cox and Beale, 1997).

Individuals and organizations have cultures. The interface of these two cultures present important dynamics. This is especially true when the culture of the individual and the culture of the organization negatively affects those to whom they deliver services (substance abusers, and those suspected of substance abuse). Organizational culture affects, as well as effects, the relationships that occur within the organization’s environment. According to the Child Welfare League of America, “Every organization has an unwritten set of rules, or organizational culture. How the organization functions and what the organization values is part of the culture of the organization” (1999).

Factors Affecting the Use of the Standardized Model of Assessment

Factors of assessment that appear most objective are subject to misinterpretation. The cultural issues present in all standardized assessments are conceptual differences and the use of language.

Conceptual Differences. Differences in perception can often lead to inaccurate results when standardized measures are used. Even when language does not appear to be a barrier, “cultural values and beliefs can affect the accuracy with which the client’s and the clinician’s messages are conveyed” (Bonder 2001). Often what is assumed by professionals may not be the same assumptions made by clients. It is vitally important to check frequently for the level of understanding and to be sure that both parties are working from the same premise. Non-verbal signals such as facial expression, body language, and voice tone can provide an abundance of information. It is up to service providers to learn to read them accurately (Wright 1996).

Language. Interacting with an individual for whom English is not the first language may find communication difficult because of vocabulary limitations. Often the mere use of terminology may lead to misunderstanding. Within the context of the justice system, additional barriers may exist in attempting to communicate for the purposes of evaluation. In a multicultural society where diversity goes beyond race and ethnicity, awareness and use of the proper terms is important. While there is little agreement on language, it is important to use phrases that promote inclusiveness without restriction.

Cross-Cultural Skills

Developing skills that promote proficiency in communicating and interacting with a diverse clientele can be helpful when using the Standardized Model of Assessment. The following areas of competency have been recommended by Green (1999) and Bonder, et al. (2001).

- Develop cultural awareness
- Build a knowledge base
- Determine cultural salience of presenting problems
- Individualize clients within the context of community variations
- Recognize power differentials between clients and professionals
- Think comparatively

Cultural awareness is the deliberate, cognitive process in which service providers become appreciative and sensitive to the values, beliefs, practices and problem solving strategies of clients' cultures. "This awareness process involves examination of one's own biases toward other cultures and in-depth exploration of one's own cultural background. This is imperative because there is a tendency to be ethnocentric regarding one's own values, beliefs, and cultural practices. Without being aware of the influence of one's own cultural values, there is a risk that service providers may engage in cultural imposition" (Campinha-Bacote 1999).

Knowledge Base. A *knowledge base* often begins with seeking and obtaining a sound educational foundation concerning the various world views of different cultures. It also involves understanding specific physical, biological, and physiological variations among groups. These variations include the "biological differences that affect the way drugs are metabolized by the body (Purnell 1998).

"The word **salience** suggests something that is noticeable, prominent, or distinctive" (Green, 166). What may be salient for those being treated within the justice/substance abuse treatment system, such as their ways of understanding, or working through problems may not always be obvious to justice and treatment professionals. The range of possible decisions and behavior is extremely wide. It is the responsibility of the professionals to be observant and nonjudgmental.

The remainder of the cross-cultural list of skills require a literal interpretation on the part of service providers. They suggest that service professionals fully understand the values, preferences, and cultural norms intended to be representative of specific groups. Justice and treatment professionals must always keep in mind that individuals moving through treatment defined in the Standardized Model of Assessment are not there voluntarily. Issues regarding the thin line between control as therapeutic guidance and control as dominance may be problematic. Cross cultural effectiveness is built on small "wins" and continuous learning.

Model for Developing Cultural Competence

Cultural competence can be achieved on both individual and organizational levels. One of the more effective models of cultural competence for social service and justice providers is defined by Green (1999).

An awareness of one's limitations. Individual service providers need to see their own actions and values in a comparative way so that their personal choices do not keep them from perceiving why others may have different choices.

Openness to cultural differences. This requires a genuine and open appreciation of ethnic differences without condescension and without patronizing gestures. It means some acknowledgment that the substance abuser's and justice and/or service provider's gender, ethnic and cultural identities may be different, and that the differences may be important to counseling and giving assistance. It is important to recognize that the client has more to contribute than the presentation of a problem.

A client-oriented systemic learning style. Cultural competence assumes that individuals, however plagued by personal problems and uncertainties, know a great deal about what is happening to them. The justice professional and the social service provider needs to know the same information so they can integrate it into whatever therapeutic model is to be followed (Gubrium 1991)

Cultural competence as appropriate utilization of cultural resources. The culturally competent worker should encourage substance abusers to draw on the natural strengths found in their own traditions and communities once they have left the justice system. "The capacity for individualizing the client within a specific cultural matrix is the ... challenge of effective cross-cultural" service delivery. This means that justice and substance abuse providers must know the resources available, and how they can be used in planning and guiding intervention. The term "resources" should be understood to mean more than community agencies and referral services. It includes institutions, individuals, and customs for resolving problems that are indigenous to the individual's own community (Green 1999).

Nash suggests that organizations may have barriers to cultural competence based on the culture within the organization. Because the administration of the Standardized Model bridges a number of organizations justice and substance abuse treatment providers must be especially aware that the barriers for each agency or organization may be different.

Barriers to Achieving Cultural Competence

Cultural competence is hard work.

There is no blueprint for achieving cultural competence.

Cultural competence requires the commitment of a number of resources.

Cultural competence is like trying to reach infinity, we may come close, but there is always room for work.

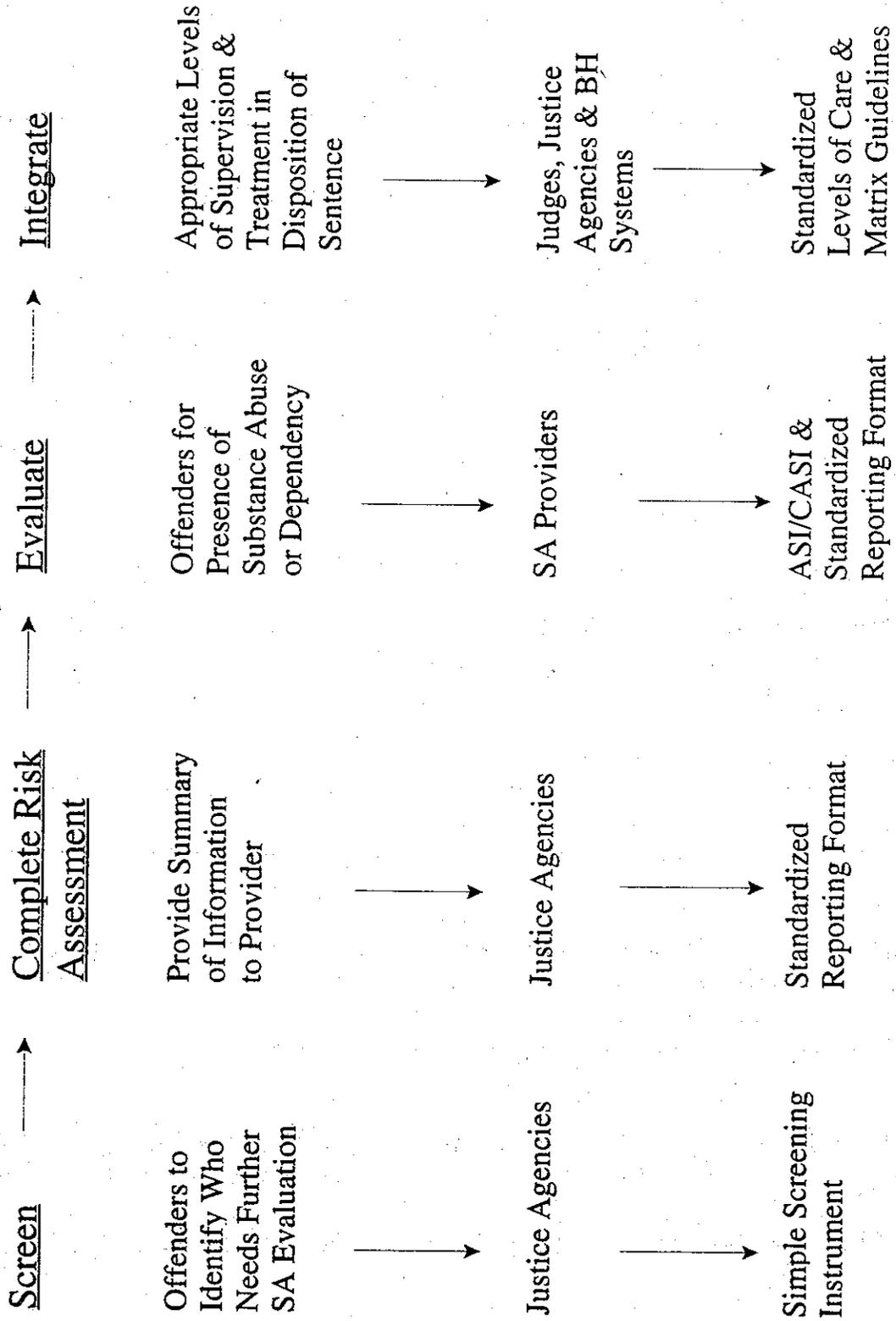
Cultural competence may require several revisions to policies, procedures and organizational culture.

Organizational size and structure may complicate cultural competence.

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Model Process & Requirements



SCREENING

SCREENING	
Goal	To determine the presence of a current drug abuse problem and identify the need for further evaluation.
Tool	<i>Simple Screening Instrument</i>
Responsibility	Completed by all justice agencies
Individuals Served	Adult and youth offenders

Training Objectives

At the end of this module participants should:

1. Know the rationale for screening clients for substance abuse
2. Understand the details of the process of screening
3. Know the responsibilities of individuals/agencies involved in the screening process

Advantages of Screening

Can be completed in short time frame
Enables early detection of AOD abuse
Expedites evaluation for treatment

Overview of the Screening Process

Detection of alcohol and other drug (AOD) abuse is critical because abuse can lead to negative physical, social, and/or emotional consequences. AOD abuse disorders are defined as biopsychological disorders, causing impairment and dysfunction in physical, emotional, and social domains by the World Health Organization and the American Psychiatric Association. Certain cognitive and behavioral signs and symptoms are also associated with AOD abuse. Although many of these signs and symptoms can be the result of various medical, psychiatric, and social problems, individuals with an AOD abuse disorder generally exhibit several of them (Winters and Zenilman, 1994).

Early identification of AOD abuse, or screening, is essential to identify the presence of a current alcohol or other drug (AOD) abuse problem and the need for further evaluation. Ideally, screening involves a standardized short interview (10-15 minutes) with the offender to identify immediate safety issues, and the need for further substance abuse evaluation.

Some important points related to screening include the following:

- the same screening instrument will be used statewide;
- criminal/juvenile justice personnel will administer the screening instrument;
- screening will be completed as early in processing as possible;
- screening information will stay with the offender throughout processing; and
- screening information will be shared with providers in an evaluation is completed.

(Substance Abuse Treatment Task Force Final Report, 2001).

It is important that anyone involved in screening understand the process, with its limitations, so that it can be used appropriately and effectively. The AOD screening process is:

- never diagnostic by itself, although it is often used to identify individuals at high risk for a diagnosis;
- a preliminary assessment or evaluation that attempts to measure whether key or critical features of the target problem area are present in an individual;
- usually a single event; and
- based on a screening instrument that is intentionally designed to achieve high sensitivity to identify large numbers of persons with the condition. This means that individuals with a positive screening test may subsequently be found not to have the disorder. Conversely, a negative screening test may not necessarily rule out the possibility that the disorder is present.

Barriers to Successful Screening

Client gives untruthful answers

Non-adjudicated clients may refuse screening

Client tests negatively but has disorder (false negative)

Client tests positively but does not have disorder (false positive)

The *Standardized Model for Assessing Substance Abuse Among Offenders* demonstrates three possible outcomes of screening: (1) that AOD abuse is highly suspected, (2) the individual is referred for a comprehensive assessment, or (3) no problem is currently detected and no referral is made. Screening may also be repeated at a later time (Winters and Zenilman, 1994). The following Table shows where and when screening takes place, and whether it is mandatory or voluntary.

DETAILS OF THE SCREENING PROCESS

WHERE	WHEN COMPLETED	COMPLIANCE
Criminal Justice		
Jail	Pre-Adjudication	Voluntary
Jail	Post-Adjudication	Mandatory
Diversion Programs	Part of Intake Process	Mandatory
Drug Courts	Part of Eligibility Determination	
Probation	Part of Pre-Sentence Investigation	Mandatory
Department of Corrections	Part of Intake Process	Mandatory
Juvenile Justice		
Detention	Pre-Adjudication	Voluntary
Detention	Post-Adjudication	Mandatory
Diversion Programs	Part of Intake Process	Mandatory
Drug Courts	Part of Eligibility Determination	
Probation	Part of Pre-Disposition Investigation	Mandatory
Office of Juvenile Services	Part of Intake Process	Mandatory

Herz, D. C. (2001). Substance Abuse Treatment Task Force Final Report. September. Nebraska Commission on Law Enforcement and Criminal Justice. Lincoln, NE

Simple Screening Instrument

The focus of AOD screening is the Simple Screening Instrument (SSI). This instrument is based upon valid and reliable methodology upon which to make referral decisions. It meets the criteria set by the Center for Substance Abuse and Treatment (CSAT) which establishes that an effective screening instrument must be:

- for adults *and* juveniles;
- highly sensitive;
- able to detect all substances of abuse;
- rapidly administered (no more than 10-15 minutes),
- relatively simple to read, administer, score, and interpret
- user friendly to a diverse group of outreach workers, paraprofessionals, and professionals in the field of AOD;

- able to be easily administered by personnel without specific background or training in the field;
- flexible and broadly applicable to diverse populations that vary in ethnic and cultural background, age, gender, and socioeconomic status, literacy level, and sexual orientation; and
- limited to screening for potential problems, not establishing a diagnosis.

Training Objectives for the SSI

At the completion of the training, individuals using the screening instrument should be able to do the following:

- explain to clients the reasons for screening
- be familiar with the categories/domains of the questions contained in the SSI
- be comfortable in administering the SSI
- interpret the results
- be familiar with the appropriate referral actions that should be taken after identifying a person in need of further assessment
- know the difference between screening and assessment
- know that a negative screening does not necessarily either indicate or rule out the presence of AOD problems
- know the legal issues concerning clients' confidentiality, and
- know what kind of client information should be kept and how it should be transferred.

Administering the SSI

Completion of the SSI is best done through client interviews to help ensure consistent collection of information. Although less desirable, the instrument may also be self-administered. For the purposes of best practice, the following pertains to interviewing techniques.

Interviews should be carried out in a comfortable setting, with noise and distractions kept to a minimum. Remember that the screening is voluntary for offenders who have not been adjudicated so they have the right of refusal. The interviewer should talk with the client about the purposes of screening and how results will be used and then ask for permission to administer the SSI. All necessary consent forms must be signed. All information must be kept confidential in accordance with Federal and State laws (see Confidentiality section)

Because of where interviews will take place, safety of the interviewer may be an issue. Remember that you cannot and should not force someone to respond if he or she refuses to answer questions. Interviewers should leave situations that do not feel safe and workers should provide backup for each other.

It is important to obtain the best possible results from using the SSI. Therefore, the following suggestions may help the interviewer gain necessary and reliable information:

- Interviewers should ask questions straightforwardly, without either verbal or nonverbal signs that may discourage the client from giving an honest answer.
- Interviewers must employ the basic counseling skills of listening and empathy.
- Under ideal circumstances, the interviewer should not rush from one question to the next, but should pause between questions, allowing time for discussion when it seems appropriate.
- In general, it is desirable to adhere to the wording of the questions in the instruments. It is expected, however, that some flexibility in the wording of the questions will be needed.
- Sometimes the interviewer may want to repeat the person's responses, particularly if the client appears to be denying that he or she has any problems. For example, consider question 7 in the SSI: "has your drinking or other drug use caused problems at school or at work?" If a subject answers "no" to this question, the interviewer may want to follow with "So you would say that your drinking or other drug use has never led to problems at school or at work. Is that correct?"

The next part of this section is devoted to furthering screening personnel's understanding of the SSI. Rationale for the questions in the instrument and explanation of terms are discussed.

Understanding the SSI

To do a good job of screening, a thorough understanding of the SSI is important. When developing the instrument, five primary content categories (domains) of AOD abuse were identified and included in the instrument. Questions addressing the categories were adapted from existing tools found in the published literature and were assigned to the appropriate category. The five domains measured by the SSI are:

- alcohol and other drug (AOD) consumption,
- preoccupation and loss of control,
- adverse consequences,
- problem recognition, and
- tolerance and withdrawal.

AOD Consumption

AOD consumption is based on a pattern of frequency, length, and amount of use of AODs. It is an important marker for evaluating whether an individual has an AOD abuse problem. Patterns of AOD consumption can vary widely among individuals or even for the same individual. Although

substance use disorders often consist of frequent, long-term use of AOD, addiction problems may also be characterized by periodic binges over shorter periods. Questions 1, 10, and 11 were formulated to help delineate an individual's consumption pattern.

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin, or other opiates, uppers, downers, hallucinogens, or inhalants.) (Yes/no).
10. Are you needing to drink or use drugs more and more to get the effect you want? (Yes/no)
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (Yes/no)

Preoccupation

Symptoms of preoccupation are common in persons with substance use disorders. Preoccupation refers to an individual spending inordinate amounts of time concerned with matters pertaining to AOD use. The symptom of preoccupation is marked by an individual's tendency to spend a considerable amount of time thinking about, consuming, and recovering from the effects of the substance(s) of abuse. In some cases, the individual's behavior may be noticeably altered by his or her preoccupation with these matters or with obtaining more of the substance of abuse. The SSI question concerned with preoccupation is #11.

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (Yes/no)

Loss of Control

Loss of control over AOD use is typified by the consumption of more of the substance(s) of abuse than originally intended. Many persons with an AOD abuse problem feel that they have no direct, conscious control over how much and how often they use AOD. Such an individual may, for example, initially intend to have only one drink but then be unable to keep from drinking more. He or she may find it difficult or impossible to stop drinking once started. The same is true with drugs. Questions 2 and 3 of the SSI pertain to the loss of control

2. Have you felt that you use too much alcohol or other drugs? (Yes/No)
3. Have you tried to cut down or quite drinking or using drugs? (Yes/No)

Loss of Behavioral Control

Loss of behavioral control is typified by loss of inhibitions and by behaviors that are often destructive to oneself or others. In many cases, these behaviors do not occur when the individual is not using AODs. A person with an AOD problem may begin taking unnecessary risks and may act

in an impulsive, dangerous manner. Individuals who are intoxicated from AOD abuse may, for example, have sex with someone in whom they ordinarily would not have a sexual interest, or they may start an argument or fight. SSI questions 9 and 12 deal with the issue of loss of behavior control.

9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (Yes/No).
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (Yes/No)

Adverse Consequences

Adverse consequences include several areas of an individual's life, including physical, psychological, and social domains. These areas of places where adverse consequences can occur are delineated separately in the following narrative. It is important to mention that as an individual's use continues over time and addiction takes hold, adverse consequences tend to worsen. Thus, people in the very early stages of addiction may have fewer adverse consequences than those in the later stages. Individuals in the early stages of addiction may therefore not make the connection between their AOD abuse and the onset of negative consequences. For this reason, some of the items directed at identifying AOD-related adverse consequences in the screening instrument attempt to obtain this information without making an overt association with AOD abuse.

Physical Consequences

Examples of adverse physical consequences resulting from AOD abuse include experiencing blackouts, injury and trauma, or withdrawal symptoms. Question 5 of the SSI addresses the issue of physical consequences.

5. Have you had any of the following?
 - Blackouts or other periods of memory loss
 - Injury to your head after drinking or using drugs
 - Convulsions or delirium tremens ("DT"s)
 - Hepatitis or other liver problems
 - Feeling sick, shaky, or depressed when you stopped drinking or using drugs
 - Feeling "coke bugs" or a crawling feeling under the skin, after you stopped using drugs
 - Injury after drinking or using drugs
 - Using needles to shoot drugs.

Psychological Consequences

Adverse psychological consequences arising from AOD abuse include depression, anxiety, mood changes, delusions, paranoia, and psychosis. Question 13 of the SSI addresses the psychological consequences.

13. Do you feel bad or guilty about your drinking or drug use? (Yes/No)

Social Consequences

Negative social consequences include involvement in arguments or fights; loss of employment, intimate relationships, and friends; and legal problems such as civil lawsuits or arrests for abuse, possession, or selling illicit drugs. SSI questions 6, 7, 8, 9, and 12 are related to negative social consequences.

6. Has drinking or other drug use caused problems between you and your family or friends? (Yes/No)
7. Has your drinking or other drug use caused problems at school or at work? (Yes/No)
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (Yes/No)
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (Yes/No)
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (Yes/No)

Problem Recognition

Making a mental link between one's use of AOD and the problems that result from it - such as difficulties in personal relationships or at work is an important step in recognizing one's own AOD abuse problem. Questions 2, 3, 4, 13, 14, 15, and 16 are problem recognition items. Some of these items ask about past contacts with intervention and treatment services, because both research and clinical experience indicate that a history of such contacts can be a valid indicator of AOD abuse problems.

Some individuals who have experienced negative consequences resulting from their AOD abuse will report these problems during a screening assessment. Clients who show insight about the relationship between these negative consequences and their use of AODs should be encouraged to seek help.

Many, if not most, people who abuse AODs, however, do not consciously recognize that they have a problem. Other reasons why a person may not disclose an AOD abuse problem include denial, lack of insight, and mistrust of the interviewer. These individuals cannot be expected to respond affirmatively to "transparent" problem recognition items- those in the form of direct questions, such as "Do you have an AOD problem? - during a screening interview. For these individuals, questions

must be worded indirectly in order to ascertain whether negative experiences have ensued from the use of AODs.

2. Have you felt that you use too much alcohol or other drugs? (Yes/No)
3. Have you tried to cut down or quit drinking or using drugs? (Yes/No)
4. Have you gone to anyone for help because of your drinking or drug use (such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)? (Yes/No)
13. Do you feel bad or guilty about your drinking or drug use? (Yes/No)
14. Have you ever had a drinking or other drug problem? (Yes/No)
15. Have any of your family members ever had a drinking or drug problem? (Yes/No)
16. Do you feel that you have a drinking or drug problem now? (Yes/No)

Tolerance and Withdrawal

AOD abuse, particularly prolonged abuse, can cause a variety of physiological problems that are related to the development of tolerance and withdrawal. Tolerance is defined as the need to use increasing amounts of a substance in order to create the same effect. If tolerance has developed and the individual stops using the substance of abuse, it is common for withdrawal effects to emerge. Withdrawal from stimulants and related drugs often includes symptoms of depression, agitation and lethargy; withdrawal from depressants (including alcohol) often includes symptoms of anxiety, agitation, insomnia, and panic attacks; and withdrawal from opiates produces agitation, anxiety, and physical symptoms such as abdominal pain, increased heart rate, and sweating. Question 10 is aimed at determining whether an individual has experienced any of the signs of tolerance. Question 5 is concerned with withdrawal.

10. Are you needing to drink or use drugs more and more to get the effect you want? (Yes/No)
5. Have you had any of the following?
 - Blackouts or other periods of memory loss
 - Injury to your head after drinking or using drugs
 - Convulsions or delirium tremens ("DT"s)
 - Hepatitis or other liver problems
 - Feeling sick, shaking, or depressed when you stopped drinking or using drugs
 - Feeling "coke bugs" or a crawling feeling under the skin, after you stopped using drugs
 - Injury after drinking or using drugs
 - Using needles to shoot drugs

Scoring and Interpretation

Questions 1 and 15 are not scored. While affirmative responses to these questions may provide important background information about the respondent, they are too general for use in scoring. Questions 17 and 18, related to gambling, are also not scored. Observational items are not intended to be scored, although the presence of most of these signs and symptoms may indicate an AOD problem.

It is expected that people with an AOD problem will probably score 4 or more on the SSI. A score of less than 4, however, does not necessarily indicate the absence of an AOD problem. A low score may reflect a high degree of denial or lack of truthfulness in the subject's responses. Persons who score 4 or higher will be referred.

Referral Issues

The SSI, as a first step in the process of assessment for AOD abuse problems, can help service providers determine whether an individual should be referred for a more thorough assessment. When an individual with a potential AOD problem is identified through the instrument, the interviewer has the further responsibility of linking the individual to resources for further assessment and treatment. Agencies and providers should be prepared to make an appropriate referral when the screening identifies a person with a possible AOD problem.

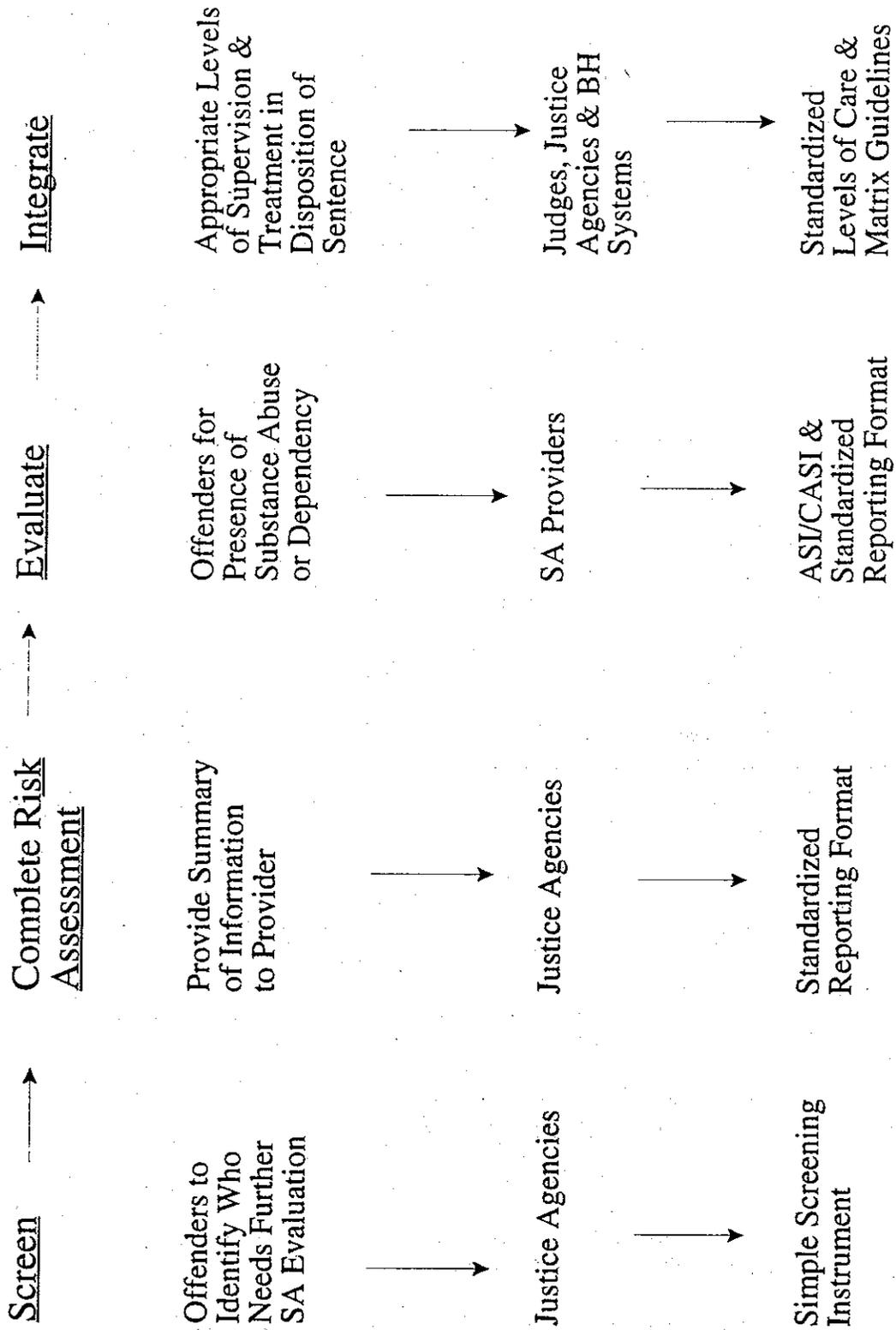
Some of the items in the screening instrument may trigger emotional distress or a crisis. Reactions may sometimes include anxiety or depression, which may be accompanied by suicidal thoughts and behaviors. Agencies should therefore develop specific protocols to manage such crises. These protocols should include in-house management and appropriate referrals and followup.

Sources

Herz, D.C. (2001). Substance Abuse Treatment Task Force Final Report. September. Nebraska Commission on Law Enforcement and Criminal Justice. Lincoln, NE.

Winters, K.C. & Zenilman, J. M. (1994). Simple screening instruments for outreach for alcohol and other drug abuse and infectious diseases. U.S. Department of Health and Human Services, Substance abuse and Mental Health Services Administration, Treatment Improvement Protocol (TIP) Series # 11. Washington.

Model Process & Requirements



RISK ASSESSMENT

RISK ASSESSMENT	
Goal	To ensure that justice agencies consistently provide relevant information on offenders' risk factors to evaluators.
Tools	<i>Nebraska Standardized Risk Assessment Reporting Format for Substance Abuse Offenders</i>
Responsibility	Completed by all justice agencies
Individuals Served	Adult and youth offenders

Training Objectives

At the end of this module participants should:

1. Understand the difference between risk assessment and evaluation
2. Understand risk and need assessments
3. Know the factors that increase the probability that an individual will engage in crime or delinquent behavior.
4. Understand the characteristics that compound the effects of risk factors.
5. Understand the characteristics that counter the effects of risk factors.
6. Be cognizant of the protocol for using the *Nebraska Standardized Risk Assessment Reporting Format for Substance Abuse Offenders*.

Advantages of Risk Assessment

Helps plan interventions
 Provides a means of monitoring progress
 Assists in updating risk status judgments
 Serves as a foundation for management and termination decisions
 Increases the justice system's ability to effectively address public safety and rehabilitation

Difference Between Risk Assessment and Evaluation

It is important to understand that risk assessment and evaluation should not be used interchangeably. Assessments are management tools that help justice and behavior health professionals determine the appropriate types and levels of care. *Risk assessment* is a process to determine the chances of re-arrest of an AOD offender. *Evaluation* is concerned with determining the types and levels of client substance abuse and referral to the appropriate treatment. However, the two areas of the Standardized Model are interrelated. The goal is that ultimately this information will be formally incorporated into recommendations for levels of treatment across a system of care.

Risk Factors Defined

Risk factors are characteristics that increase the probability that an individual will engage in crime or delinquent behavior. There are five domains of risk factors, the first two will be combined in the explanation below.

Individual and Peer Factors

These factors include early antisocial behavior, low self-control, withdrawal from conventional social norms, rebelliousness against conventional social norms, association with peers involved in delinquency or other problem behaviors, attitudes favorable toward problem behaviors, early onset of negative behaviors, and an offense history.

Family Factors

This category is characterized by multigenerational involvement in crime, substance abuse, and dropping out of school; poor parenting practices, inconsistent or overly punitive disciplinary practices; high levels of family conflict, and parental attitudes that condone substance use and/or delinquent behavior.

School Factors

Early antisocial and/or aggressive behavior, continued disruptive behavior, truancy in the early adolescent years, academic failure, lack of commitment to learning, and lack of attachment to the school setting may contribute to the probability of engaging in crime or delinquent behavior.

Community Factors

This domain includes extreme economic deprivation, high rates of mobility, disorganized neighborhoods, high levels of violence, lack of positive role models availability of firearms, availability of alcohol and other drugs, media portrayals, norms favorable to drug use and/or crime, low attachment and commitment to traditional neighborhood institutions.

Need Factors Defined

Need factors are characteristics that compound the effects of risk factors. These factors include:

- Substance use
- Mental health problems
- Financial need
- Learning disabilities

Protective Factors Defined

Protective factors are conditions that counter risk factors or increase resistance to them; thus inhibiting the development of problems. Protective factors fall into three areas:

- Individual characteristics such as temperament and intelligence
- Attachment/commitment to pro-social persons institutions and values
- Healthy beliefs and clear standards for behavior.

Response of the Justice System to Risk

Justice professionals must realize that risk, need and protective factors vary in importance across the stages of life. To be effective the justice system response should integrate interventions that address risk, need, and protective factors simultaneously. These factors can play a critical role in planning interventions, monitoring progress, updating risk status judgments and making case management and termination decisions. Recognizing that risk factors are both dynamic (substance abuse, peer relationships, school performance, etc.) and static (age, number of prior arrests and referrals, age at first referral, etc.) enhances the probability of effectively and efficiently assessing the risk of clients. It also contributes to the justice system more proficiently rehabilitating clients while increasing public safety.

The major purposes of the risk assessment process include the ability to:

- Identify risk, need and protective factors present in an individual's life
- Identify the appropriate level of supervision needed to ensure public safety
- Identify the appropriate levels of interventions and treatment to address dynamic risk factors and need factors
- Produce a case plan that integrates appropriate levels of supervision, intervention, and treatment in order to decrease risk and need factors and increase protective factors; thereby increasing an offender's resiliency and reducing his/her probability for future crime or delinquency.

The process and instrument that will be used for assessing risk of recidivism of AOD offenders is the *Nebraska Standardized Risk Assessment Reporting Format for Substance Abusing Offenders*. The instrument is intended to summarize the information currently collected by justice agencies, thus giving providers consistent, relevant information on offender risk factors. This instrument assesses risk based on the following facts or observations about the offender:

- age
- prior record
- types of offenses
- attitude
- personal relationships
- school/employment
- maltreatment
- and overall impression by the assessor.

Protocol for Use of the *Nebraska Standardized Risk Assessment Reporting Format for Substance Abuse Offenders*

1. Administer the risk assessment form that is currently in use by individual agencies.
2. Convert the information from the agency form to the *Nebraska Standardized Risk Assessment Reporting Format for Substance Abuse Offenders*.
3. Send the following information to providers of evaluation services for referred clients:
 - *Nebraska Standardized Risk Assessment Reporting Format for Substance Abuse Offenders*
 - Criminal history and other information
 - Simple Screening Instrument results
 - Disclosure forms (release of information)

Barriers to Risk Assessment

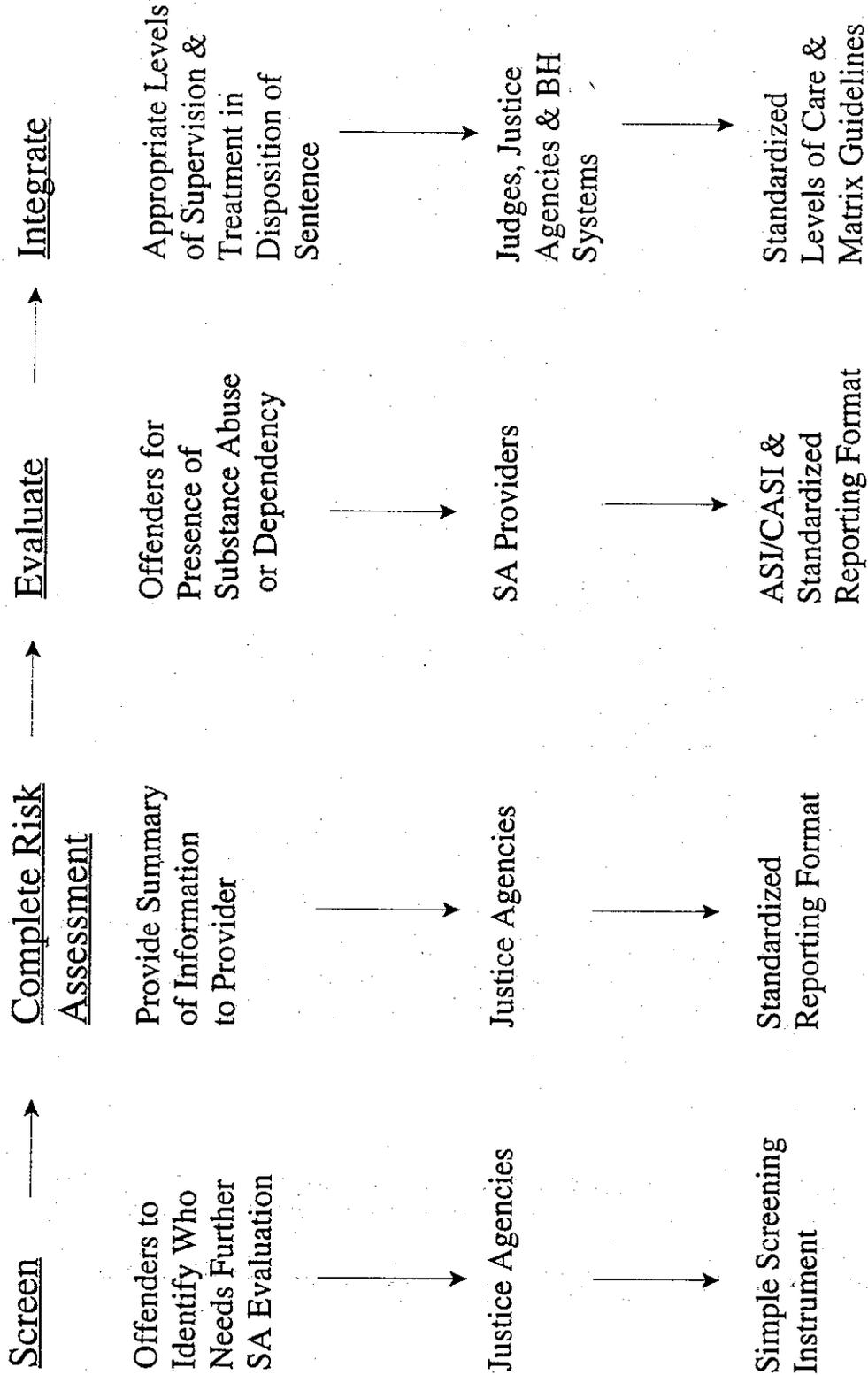
Failure to gather sufficient information
Erroneous identification of risk, need, or protective factors
Not using the Standardized Risk Assessment Reporting Format

Sources

Herz, D.C. (2001). Substance Abuse Treatment Task Force Final Report. September. Nebraska Commission on Law Enforcement and Criminal Justice. Lincoln, NE.

Herz, D.C. (2002). Overview of Risk Assessment in the Justice System.

Model Process & Requirements



EVALUATION

EVALUATION	
Goal	To ensure consistent and accurate diagnoses and recommendations
Tool	<ol style="list-style-type: none"> 1. <i>Adult Severity Index (ASI)</i>¹ in conjunction with a second tool of the providers' choice. 2. <i>Comprehensive Adolescent Severity Inventory (CASI)</i>¹ in conjunction with a second tool of the providers' choice. 3. <i>Required Reporting Format for Nebraska Standardized Substance Abuse Evaluation for Adult Justice Referrals</i> 4. <i>Required Reporting Format for Nebraska Standardized Substance Abuse Evaluation for Youth Justice Referrals</i>
Responsibility	Completed by Certified Alcohol/Drug Abuse Counselors (CADACs) and Certified Provisional Drug Abuse Counselors (CPDACs)
Individuals Served	Adult offenders (ASI) Youth offenders (CASI)

Training Objectives

At the end of this module participants should:

1. Understand the type and extent of a client's AOD problems
2. Be familiar with instruments used for evaluating adults and juveniles
3. Understand the *Substance Abuse Services* for adults and children/youth in Nebraska by levels of care.
4. Understand the *Required Reporting Format for Nebraska Standardized Substance Abuse Evaluation for Adult Justice Referrals* and the *Required Reporting Format for Nebraska Standardized Substance Abuse Evaluation for Youth Justice Referrals*.
5. Be aware of the *Substance Abuse Services for Adult Criminal Justice Clients* and the *Substance Abuse Services for Children/Youth Criminal Justice Clients* in Nebraska.

¹ Training on the use of the ASI and CASI is available for approved providers.

Advantages of Evaluation

Evaluation is performed by qualified providers of alcohol and other drug abuse counseling
Accurate evaluations ensure the recommendation of appropriate levels of care

Purpose of Evaluation

Evaluation is the process of determining the type and extent of a client's AOD problems and making referrals to appropriate treatment. The purpose of evaluation is to consistently pursue the information elicited in the offender screening, and risk assessment interviews. It is also used to consistently deliver the kind of information on offenders appropriate for their treatment needs.

Criteria for Approval of Evaluators

A critical part of the success of the Standardized Model is having qualified providers of AOD abuse evaluation and treatment. To be recognized as an approved provider, a substance abuse treatment provider must meet all of the following criteria:

- Evaluation for justice clients must be completed by a certified alcohol and drug abuse counselor (CADAC) or a provisional CADAC (CPADAC) who is supervised by a CADAC, supervised by a licensed psychologist, or supervised by a licensed physician with an addictions specialty.
- Attend training and achieve competency on the ASI and/or CASI
- Attend training and achieve competency on the Standardized Model
- Formal agreement with justice agencies with regard to collateral contacts and the exchange of information within the rules of confidentiality
- Compliance with the Standardized Model evaluation and reporting process
- Successful completion of twelve (12) hours of continuing education credits in criminal behaviors and the criminal and juvenile justice systems

Explanation of Instruments Used for Evaluation

The Substance Abuse and Standardization Task Forces chose the use of two instruments for the purpose of evaluation: the Addiction Severity Index (ASI) for adults and the Comprehensive Adolescent Severity Inventory (CASI) for juveniles. These instruments were chosen by the

Substance Abuse Task Force to ensure consistent and accurate diagnoses and recommendations for treatment and to formalize information sharing. The ASI and CASI will be administered only by persons who have been adequately trained in their use. These tools are to be used by providers across the state.

The proper use of the recommended tools for evaluation by certified treatment providers assures the appropriate levels of supervision and treatment in the disposition of sentencing. This also leads to the care at the appropriate treatment level (see diagram following this page).

Barriers to Successful Evaluation

Lack of training on use of the ASI and CASI
Failure to use the *Standardized Reporting Format*

Source

Herz, D.C. (2001). Substance Abuse Treatment Task Force Final Report. September. Nebraska Commission on Law Enforcement and Criminal Justice. Lincoln, NE.

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GLOSSARY OF TERMS

Admitted: a person can be *admitted* to any service whether that admission is voluntary, or involuntary through a commitment. Persons admitted to a service are determined to meet admission criteria to ensure the service is appropriate to meet their specific needs.

Agitation: a restless inability to keep still. Agitation is most often psychomotor agitation, that is, having emotional and physical components. Agitation can be caused by anxiety, overstimulation, or withdrawal from depressants and stimulants.

Alcohol abuse: the use of an alcoholic beverage which impairs the physical, mental, emotional, or social well-being of the user.*

Blackouts: a type of memory impairment that occurs when a person is conscious but cannot remember the blackout period. In general, blackouts consist of periods of amnesia or memory loss, typically caused by chronic, high-dose AOD abuse. Blackouts are most often caused by sedative-hypnotics, such as alcohol and the benzodiazepines.

Chemically Dependent (CD): a maladaptive pattern of repeated substance use that usually results in tolerance, withdrawal, and compulsive substance-taking behavior. The essential feature of dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating continued use despite significant substance-related problems. Term used interchangeably with substance dependence.

Coke bugs: tactile hallucinations (also called formications) that feel like bugs crawling on or under the skin. Chronic and high-dose stimulant abuse can cause various types of hallucinations.

Committed or Court Ordered: when the Mental Health Board (adults) or a Judge (adolescents) upon recommendation from an appropriately licensed or certified professional finds that the individual has a mental illness and is dangerous, OR has a chemical dependency and is dangerous, they will commit or court order to involuntary treatment. A person under *committed or court ordered* (involuntary) status must comply with the commitment or court order, no matter where they are committed or ordered to inpatient or a community based provider).

Constricted pupils (pinpoint pupils): pupils that are temporarily narrowed or closed. This is usually a sign of opiate abuse.

Convulsions: a seizure is a sudden episode of uncontrolled electrical activity in the brain. If the abnormal electrical activity spreads throughout the brain, the result may be a loss of consciousness and a grand mal seizure. One symptom of a seizure is convulsions or twitching and jerking of the limbs. Seizures may occur as the result of head injury, infection, cerebrovascular accidents, withdrawal from sedative-hypnotic drugs, or high doses of stimulants.

* Denotes Federal definition

CPC: Civil Protective Custody. An involuntary hold that law enforcement can use to hold an intoxicated adult (age 19 and over) for 24 hours in a social detoxification facility with the capability of locking the doors.

Crack: cocaine (cocain hydrochloride) that has been chemically modified so that it will become a gas vapor when heated at relatively low temperatures; also called "rock" cocaine.

Crisis Center: once an involuntary hold is placed on an adult, the holding facility has 72 hours to have a licensed professional forward an evaluation to the county attorney to determine if the person is mentally ill or chemically dependent. Crisis centers are medical facilities that are funded through the Regions to serve adults with a mental illness and/or substance abuse crisis in the counties of that region.

Developmental Disability (DD): a person with a developmental disability has an Intelligence Quotient (IQ) of 69 or lower, is considered mentally retarded (MR). The intelligence level does not change during the person's lifetime. The service system serving persons with a developmental disability is often referred to as the "DD" system. Adults or children with development disabilities are NOT considered mentally ill.

Diagnosis: any reference to an individual's alcohol or drug abuse or to a condition which is identified as having been caused by that abuse which is made for the purpose of treatment or referral for treatment. *

Dilated pupils: pupils that have become temporarily enlarged.

Disclose or disclosure: a communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or the communication of any information from the record of a patient who has been identified. *

Division of Behavioral Health: a division within the Department of Health and Human Services that oversees the administration of services for mental health, substance abuse, and special populations such as aged and developmental disabilities to people in Nebraska. This includes (1) community based services under the management of the Office of Mental Health, Substance Abuse and Addiction Services and (2) state operated services provided at the State Regional Centers.

Downers: slang term for drugs that exert a depressant effect on the central nervous system. In general, downers are sedative-hypnotic drugs, such as benzodiazepines, and barbiturates.

Drug abuse: the use of a psychoactive substance for other than medicinal purposes which impairs the physical, mental, emotional, or social well-being of the user. *

DTS: delirium tremens; a state of confusion accompanied by trembling and vivid hallucinations. Symptoms may include restlessness, agitation, trembling, sleeplessness, rapid heartbeat, and possibly convulsions. Delirium tremens often occurs in chronic alcoholics after withdrawal or abstinence from alcohol.

Dual Disorder: an *adult* with a primary severe and persistent mental illness AND a primary chemical dependency disorder. An *adolescent* with a primary serious emotional disturbance AND a primary chemical dependency (or diagnosed entrenched dependency pattern).

Dual Disorder Treatment: dual disorder services provide primary integrated treatment simultaneously to persons with an Axis I chemical dependency AND an Axis I major mental illness. Clients served exhibit more unstable or disabling co-occurring substance dependence and serious and persistent mental illness disorders. The typical client is unstable or disabled to such a degree that specific psychiatric and mental health support, monitoring and accommodation are necessary in order to participate in addictions treatment. Providers of Dual Disorder Treatment programs demonstrate a philosophy of integrate treatment in treatment plans, program plans, staffing, and services provided. Both disorders are treated as equally primary. Appropriate licensed and certified staff including staff with addiction certification is required to provide treatment.

Dual Enhanced Treatment: a service for persons whose mental illness or substance disorder is less active than the primary diagnosis. Providers of these treatment services may elect to enhance their primary service to address the client's other relatively stable diagnostic or sub--diagnostic co-occurring disorder. The primary focus of such programs is mental health or addictions treatment rather than dual diagnosis concerns and is not a primary, integrated dual disorder treatment.

Ecstasy: slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family (for example, speed). At lower doses, MDMA causes distortions of emotional perceptions. At higher doses, it causes potent stimulation typical of the amphetamines.

EPC: Emergency Protective Custody. An involuntary hold that law enforcement can use to hold an adult (age 19 and over) they determine to be mentally ill and dangerous, or chemically dependent and dangerous.

Federally Assisted Program: includes any alcohol abuse or drug abuse program that "is supported by funds provided by any department or agency of the United States "by being either a recipient of Federal financial assistance in any form, including financial assistance which does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities", or by being a State or local government unit which, through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program." (Code of Federal Regulations, Title 42, Chapter I, Subchapter A, Part 2)

Hallucinogens: a broad group of drugs that cause distortions of sensory perception. The prototype hallucinogen is lysergic acid diethylamide(LSD). LSD can cause potent sensory perceptions, such as visual, auditory, and tactile hallucinations. Related hallucinogens include peyote and mescaline.

Hepatitis: an inflammation of the liver, with accompanying liver cell damage and risk of death. Hepatitis may be of limited duration or a chronic condition. It may be caused by viral infection, as well as chronic exposure to poisons, chemicals, or drugs of abuse, such as alcohol.

Ice: slang term for smokeable methamphetamine. Much as cocaine can be modified into a smokeable state (crack cocaine), methamphetamine can be prepared so that it will produce a gas vapor when heated at relatively low temperatures. When smoked, ice methamphetamine produces an

extremely potent and long-lasting euphoria, an extended period of high energy and possible agitation, followed by an extended period of deep depression.

Involuntary: a person is placed in a service and loses certain rights until the involuntary order is lifted.

Legal problems: AOD abusers are at a higher risk of engaging in behaviors that are high risk and illegal. These behaviors may result in arrest and other problems with the criminal justice system. Examples of legal problems include driving while intoxicated, writing bad checks to obtain money for drugs, failure to pay bills and credit card debts, being arrested for possession or sale of drugs, evictions, and arrest for drug-related violence.

Marijuana: the dried leaves and flowering tops of the Indian hemp plant *cannabis sativa*, also called "pot" or "weed". It can be smoked or prepared in a tea or food. Marijuana has two significant effects. In the non tolerant user, marijuana can produce distortions of sensory perception, sometimes including hallucinations. Marijuana also has depressant effects and is partially cross-tolerant with sedative-hypnotic drugs such as alcohol. Hashish (or hash) is a combination of the dried resins and compressed flowers from the female plant.

Medicaid: Federal and State funding available to persons who meet Medicaid eligibility criteria: children, adults with children who meet poverty guidelines, certain adults with a disability, and the elderly. Medicaid is a financing system, not a service system.

Medical emergency: a situation that poses an immediate threat to health and requires immediate medical intervention.

Mental Health Board: if the evaluation at a Crisis Center finds that there is a mental illness and/or chemical dependency and the County Attorney agrees, a Mental Health Board hearing is set for adults within seven days of the EPC hold to have a neutral board of three individuals determine if there is mental illness, or chemical dependency and if there is dangerousness

Mental Illness (MI): persons with mental illness have a normal range of intelligence, but also have a brain disease. The most common brain diseases fall within the category of major mental illness and are sometimes referred to as severe and persistent mental illness (SPMI). The diagnoses for SPMI include schizophrenia or schizoaffective, bi-polar, and major depression. These diseases are controllable within limitations, but not curable.

NBHS: Nebraska Behavioral Health System is the publicly funded community based mental health and substance abuse service system in Nebraska administered by the Office of Mental Health, Substance Abuse and Addiction Services with funding going through the Mental Health and Substance Abuse Regions to provider networks.

Needle tracks: bruising, collapsed veins, or a series of small holes on the surface of the skin caused by chronic injection of drugs into the veins (intravenous injection) or muscle (intramuscular injection) or under the skin (subcutaneous injection).

Nodding out: slang term for the early stages of depressant-induced sleep. Opioids and sedative-hypnotics induce depression of the central nervous system activity. Prescription opiates include

morphine, meperidine (Demerol), methadone, codeine, and various opioid drugs for coughing and pain. Illicit opioids include heroin, also called "smack", "horse", and "boy".

Paranoia: a type of delusion, or a false idea, that is unchanged by reasoned arguments or proof to the contrary. Clinical paranoia involves the delusion that people or events are in some way specially related to oneself. People who are paranoid may believe that others are talking about them, plotting devious plans about them, or planning to hurt them. Paranoia often occurs during episodes of high-dose chronic stimulant use and may occur during withdrawal from sedative-hypnotics such as alcohol.

Paraphernalia: a broad term that describes objects used during the chemical preparation or use of drugs. These include syringes, syringe needles, roach clips, and marijuana or crack pipes.

Patient: any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine that individual's eligibility to participate in a program. *

Patient identifying information: name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. The term does not include a number assigned to a patient by a program, if that number does not consist of, or contain numbers (such as a social security, or driver's license number) which could be used to identify a patient with reasonable accuracy and speed from sources external to the program. *

Person: an individual, partnership, corporation, Federal, State or local government agency, or any other legal entity. *

Program: (a) An individual or entity (other than a general medical care facility) who holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or (b) An identified unit within a general medical facility which holds itself out as providing, and provides, alcohol or drug abuse diagnosis, treatment or referral for treatment; or (c) Medical personnel or other staff in a general medical care facility whose primary function is the provision of alcohol or drug abuse diagnosis, treatment or referral for treatment and who are identified as such providers. (See S 2.12(e)(1) for examples.)*

Program director: (a) In the case of a program which is an individual, that individual: (b) In the case of a program which is an organization, the individual designated as director, managing director, or otherwise vested with authority to act as chief executive of the organization.*

Qualified service organization: a person which: (a) provides services to a program, such as data processing, bill collecting, dosage preparation, laboratory analyses, or legal, medical, accounting, or other professional services, or services to prevent or treat child abuse or neglect, including training on nutrition and child care and individual and group therapy, and (b) has entered into a written agreement with a program under which that person: (1) acknowledges that in receiving, storing, processing or otherwise dealing with any patient records from the programs, it is fully bound by these regulations; and (2) if necessary, will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations.*

Records: any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program.*

Regional Center: a state operated 24-hour psychiatric facility for persons with mental illness. The state currently operates three Regional Centers: Hastings Regional Center, Lincoln Regional Center, and Norfolk Regional Center. Within the NBHS, the Regional Centers provide inpatient and secure residential services for adults of the state (EXCEPTION: HRC has an adolescent alcohol/drug treatment program for boys referred from the Youth Treatment Center in Kearney). HRC primarily serves residents from Regions 1, 2, and 3. LRC primarily serves residents from Region 5. NRC primarily serves residents from Regions 4 and 6.

Regional Governing Boards: the public mental health and substance abuse community service system is divided into six geographic regions. A county commissioner from each county in the region serves on a governing board to plan, develop, and implement services, and hires staff to fulfill the administrative duties. Region 1 includes 11 counties with the Regional Office in Scottsbluff. Region 2 includes 17 counties with the Regional Office in North Platte. Region 3 includes 22 counties with the Regional Office in Kearney. Region 4 includes 22 counties with the Regional Office in Norfolk. Region 5 includes 16 counties with the Regional Office in Lincoln. Region 6 includes 6 counties with the Regional Office in Omaha.

Self-help groups: self-help groups differ from therapy groups in that self-help groups are not led by professional therapists.

Severe Emotional Disturbance (SED): Severe Emotional Disturbance is an Axis I diagnosable mental disorder in children and adolescents that is persistent and results in functional impairment in two or more life domains.

Skin abscesses: a collection of pus formed as a result of bacterial infection. Abscesses close to the skin usually cause inflammation, with redness, increased skin temperature, and tenderness. Abscesses may be caused by injecting drugs and impurities into the body.

Slurred speech: a sign of depressant intoxication. When people consume significant amounts of sedative-hypnotics and opioids, their speech may become garbled, mumbled, and slow.

Substance Use: the taking of any substance whether alcohol, drugs and/or tobacco; includes both legal and illegal substances.

Substance Abuse: a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. The criterion does not include tolerance, withdrawal, or a pattern of compulsive use.

Third party payer: a person who pays, or agrees to pay, for diagnosis or treatment furnished to a patient on the basis of a contractual relationship with the patient or a member of his family or on the basis of the patient's eligibility for Federal, State, or local governmental benefits.

Treatment: the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient.*

Tremors: an involuntary and rhythmic movement in the muscles of parts of the body, most often the hands, feet, jaw, tongue, or head. Tremors may be caused by stimulants such as amphetamines and caffeine, as well as withdrawal from depressants.

Unsteady gait: unsteady, crooked, meandering, and uncoordinated walk, typical of alcohol-impaired individuals.

Uppers: slang term to describe drugs that have a stimulating effect on the central nervous system. Examples include cocaine, caffeine, and amphetamines.

Voluntary: the ability of any person to choose a service they would like to participate in.

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APPENDICES

APPENDIX A

Confidentiality Laws and Regulations Pertinent to AOD Abuse

I. Federal Confidentiality Laws and Regulations

Federal Regulation 42 U.S.C. §§290dd-2

“Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall...be confidential and be disclosed only for the purposes and under the circumstances expressly authorized...’ by the statute or by regulations promulgated under that statute’s authority.

Title 42 Code of Federal Regulations Chapter 1, Subchapter A, Part 2

The regulations are authorized to contain such definitions and may provide for such safeguards and procedures, including procedures and criteria for the issuance and scope of court orders, as in the judgment of the Secretary are necessary or proper to effectuate the purposes of the statute, to prevent circumvention or evasion thereof, or to facilitate compliance therewith.

II. Exceptions to Federal Confidentiality Laws and Regulations

Qualified Service Organization Agreements

Qualified service organization agreements (QSOA) are permitted when programs need to share information about clients with outside agencies that provide services to the program (e.g., clinical laboratory performing AOD analyses). These written agreements are between a program and a person providing services to the program, in which that person: (1) acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the program, he or she is fully bound by the Federal confidentiality regulations; and (2) promises that, if necessary, he or she will resist in judicial proceedings any efforts to obtain access to patient records except as permitted by these regulations (2.11, 2.12 (c) (4)). Not to be substituted for individual consent in other situations, QSOA may not be between two AOD abuse service programs.

Medical Emergencies

A program may make disclosures to public or private medical personnel “who have a need for information about a client for the purpose of treating a condition which poses an immediate threat to the health of the client or any other individual” (not as a basis for a disclosure to family or the police or other nonmedical personnel).

The following must be documented in client's records: (a) name and affiliation of the recipient of the information, (b) name of the individual making the disclosure, (c) date and time of the disclosure, (d) nature of the emergency.

Disclosures to Elements of the Criminal Justice System which have Referred Patients

A program may disclose information about a patient to those persons within the criminal justice system who have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody under special circumstances. (See Appendix A, Part II).

Crimes on Program Premises or Against Program Personnel

If a client has committed or threatened to commit a crime on program premises or against program personnel, the program can report the crime or threat to a law enforcement agency or to seek its assistance. Without special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a client at the program (§2.12(c)5).

Research, Audit, or Evaluation

Client-identifying information can be provided to researchers, auditors, and evaluators without client consent, provided that certain safeguards are met (§§2.52, 2.53).

Client Notice and Access to Records

Clients must be notified of their right to confidentiality and given a written summary of the regulations' requirements early in participation in the program. (§2.22 (a)). The regulations also contain a sample notice. Clients can see their own records without obtaining written consent.

Records

Several Nebraska statutes and regulations cover the restriction of access to records (see Appendix A, Part IV).

III. Nebraska Disclosure Laws and Regulations

Patient's privilege to refuse disclosure

Nebraska evidentiary Rule 504(2)(a) states that a *patient* has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purposes of diagnosis or treatment of his or her physical, mental, or emotional condition among himself or herself, his or her physician, or persons who are participating in the diagnosis or treatment under the

direction of the physician, including members of the patient's family. It also states that a *client* has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made during counseling between himself or herself, his or her professional counselor, or persons who are participating in the counseling under the direction of the professional counselor, including members of the client's family. However, there is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for physical, mental, or emotional illness if the physician, in the course of diagnosis or treatment, has determined that the patient is in need of hospitalization or if a professional counselor deems it necessary to refer a client to determine if there is need for hospitalization.

Nebraska statute 71-1,206.29 puts psychologists and their clients and patients on an equal footing with physicians under Rule 504.

Prohibition of disclosure by professional counselors

71-1,335, R. R. S. Ne, states "No person licensed or certified pursuant to sections 71-1,295 to 71-1,338 shall disclose any information he or she may have acquired from any person consulting him or her in his or her professional capacity...."

Disclosures to elements of the criminal justice system who have referred patients

42CFR, Chap. I, Subchap A, Part 2, 2.35 states that (a) a program may disclose information about a patient to those persons within the criminal justice system which have made participation in the program a condition of the disposition of any criminal proceedings against the patient or of the patient's parole or other release from custody if:

(1) The disclosure is made only to those individuals within the criminal justice system who have a need for the information in connection with their duty to monitor the patient's progress (e.g. a prosecuting attorney who is withholding charges against the patient, a court granting pretrial or posttrial release, probation or parole officers responsible for supervision of the patient); and (2) The patient has signed a written consent meeting the requirements of S 2.31 (except paragraph (a)(8) which is inconsistent with the revocation provisions of paragraph (c) of this section) and the requirements of paragraphs (b) and (c) of this section.

(b) Duration of consent. The written consent must state the period during which it remains in effect. This period must be reasonable, taking into account:

- (1) the anticipated length of the treatment;
- (2) the type of criminal proceeding involved, the need for the information in connection with the final disposition of that proceeding, and when the final disposition will occur; and
- (3) such other factors as the program, the patient, and the person(s) who will receive the disclosure consider pertinent.

(c) Revocation of consent. The written consent must state that it is revocable upon the passage of a specified amount of time or the occurrence of a specified, ascertainable event. The time or occurrence upon which consent becomes revocable may be no later than the final disposition of the conditional release or other action in connection with which consent was given.

(d) Restrictions on redisclosure and use. A person who receives patient information under this section may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent is given.

IV. Nebraska Statutes Regarding AOD Records

Restriction of AOD abuse records in mental health system

83-1068 R. R. S. Ne, states "(1) All records kept on any subject of a petition shall remain confidential except as may be provided otherwise by law. Such records shall be accessible to (a) the subject except as provided in subsection (2) of this section, (b) the subject's counsel, (c) the subject's guardian if the subject is legally incompetent, (d) the mental health board having jurisdiction over the subject, (e) persons authorized by an order of a judge or court, (f) persons authorized by written permission of the subject, or (g) the Nebraska State Patrol or the Department of Health and Human Services pursuant to section 69-2409.01."

Access to Records by Office of Juvenile Services

Neb.Rev. St. § 43-409. Infants; Article 4 Office of Juvenile Services

The Office of Juvenile Services shall have access to and may obtain copies of all records pertaining to a juvenile committed to it or placed with it, including, but not limited to, school records, medical records, juvenile court records, probation records, test results, treatment records, evaluations, and examination reports. Any person who, in good faith, furnishes any records or information to the Office of Juvenile Services shall be immune from any liability, civil or criminal, that might otherwise be incurred or imposed. The owners, officers, directors, employees, or agents of such medical office, school, court, office, corporation, partnership, or other such entity shall not be liable for furnishing such records or information.

Restriction of juvenile records

Neb. Rev. St §43 -3001 Chapter 43. Infants; Article 30 Access to Information and Records

(1) Notwithstanding any other provision of law regarding the confidentiality of records and when not prohibited by the federal Privacy Act of 1974, as amended, juvenile court records and any other pertinent information that may be in the possession of school districts, county attorneys, law enforcement agencies, state probation personnel, state parole personnel, youth detention facilities, medical personnel, treatment or placement programs, the Department of Health and Human Services,

the Department of Correctional Services, the State Foster Care Review Board, child abuse and neglect investigation teams, child abuse and neglect treatment teams or other multidisciplinary teams for abuse, neglect, or delinquency concerning a child who is in the custody of the state may be shared with individuals and agencies who have been identified in a court order authorized by this section

(2) In any judicial proceeding concerning a child who is currently, or who may become at the conclusion of the proceeding, a ward of the court or state or under the supervision of the court, an order may be issued which identifies individuals and agencies who shall be allowed to receive otherwise confidential information concerning the juvenile for legitimate and official purposes. The individuals and agencies who may be identified in the court order are the child's attorney or guardian ad litem, the parents' attorney, foster parents, appropriate school personnel, county attorneys, authorized court personnel, law enforcement agencies, state probation personnel, state parole personnel, youth detention facilities, medical personnel, treatment or placement programs, the Department of Health and Human Services, the Office of Juvenile Services, the Department of Correctional Services, the State Foster Care Review Board, child abuse and neglect investigation teams, child abuse and neglect treatment teams, and other multidisciplinary teams for abuse, neglect, or delinquency. Unless the order otherwise states, the order shall be effective until the child leaves the custody of the state or until a new order is issued.

(3) All information acquired by an individual or agency pursuant to this section shall be confidential and shall not be disclosed except to other persons who have a legitimate and official interest in the information and are identified in the court order issued pursuant to this section with respect to the child in question. A person who receives such information or who cooperates in good faith with other individuals and agencies identified in the appropriate court order by providing information or records about a child shall be immune from any civil or criminal liability. The provisions of this section granting immunity from liability shall not be extend to any person alleged to have committed an act of child abuse or neglect.

(4) Any person who publicly discloses information received pursuant to this section shall be guilty of a Class III misdemeanor.

APPENDIX B

Nebraska Standardized Model: Simple Screening Instrument

Nebraska Standardized Model: Simple Screening Instrument

The questions that follow are about your use of alcohol and other drugs. Mark the response that best fits for you. Answer the question in terms of your experiences in the past 6 months. *In the past 6 months.*

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin, or other opiates, uppers, downers, hallucinogens or inhalants.)	Yes No
1a. When did you first use alcohol or other drugs (excluding tobacco)?	__/__/__
1b. When did you last use alcohol or other drugs (excluding tobacco)?	__/__/__
2. Have you felt that you use too much alcohol or other drugs?	Yes No
3. Have you tried to cut down or quit using alcohol or other drugs?	Yes No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program)	Yes No
5. Have you had any of the following?	Yes No
a. Blackouts or other periods of memory loss?	Yes No
b. Injured your head after drinking or using drugs?	Yes No
c. Had convulsions delirium tremens ("DT's")?	Yes No
d. Hepatitis or other liver problems	Yes No
e. Felt sick, shaky or depressed when you stopped?	Yes No
f. Felt a crawling feeling under the skin when you stopped using drugs?	Yes No
g. Been injured after drinking or using ?	Yes No
h. Used needles to shoot drugs?	Yes No
6. Has drinking or using drugs caused problems between you and your family or friends?	Yes No
7. Has drinking or drug use caused problems at school or at work? (Including attendance.)	Yes No
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)	Yes No
9. Have you lost your temper or gotten into arguments or fights while using alcohol or drugs?	Yes No
10. Have you needed to drink or use drugs more and more to get the effect you want?	Yes No
11. Have you spent a lot of time thinking about or trying to get alcohol or drugs?	Yes No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?	Yes No
13. Have you felt bad or guilty about your alcohol or drug use?	Yes No
The next questions are about your lifetime experiences.	Yes No
14. Have you <u>ever</u> had a drinking or drug problem?	Yes No
15. Have any of your family members <u>ever</u> had a drinking or drug problem?	Yes No
16. Do you feel that you have a drinking or drug problem <u>now</u> ?	Yes No
The next questions are about your experience with gambling.	Yes No
17. Have you ever had to lie to people important to you about how much you gambled?	Yes No
18. Have you ever felt the need to bet more and more money?	Yes No

Individual ID: _____

Interviewer ID: _____

Nebraska Standardized Model: Simple Screening Instrument (cont'd)

Scoring for SSI (For official use only)		
Individual ID: _____	Date: _____	
Location: _____		
Items 1 and 15; 17 and 18 are <u>not</u> scored. The following items are scored as a 1 (yes and 0 (no):		
___ 2	___ 7	___ 12
___ 3	___ 8	___ 13
___ 4	___ 9	___ 14
___ 5 (any items listed)	___ 10	___ 16
___ 6	___ 11	
	Total Score ___	Score Range: 0 -14
Preliminary interpretation of responses:		
Score	Degree of Risk for AOD Abuse	
0-1	None to low	

Observation Checklist for Interviewer: Did you observe any of the following while screening this individual?

	Yes	No
a. Needle track marks		
b. Skin abscesses, cigarette burns, or nicotine stains		
c. Tremors (shaking and twitching of hands and eyelids)		
d. Unclear speech: slurred, incoherent, or too rapid		
e. Unsteady gait: staggering, offbalance		
f. Dilated (enlarged or constricted (pinpoint) pupils		
g. Scratching		
h. Swollen hands or feet		
i. Smell of alcohol or marijuana on breath		
j. Drug paraphernalia such as pipes, paper, needles, or roach clips		
k. "Nodding out" (dozing or falling asleep)		
l. Agitation		
m. Inability to focus		
n. Burns on the inside of the lips		

Interviewer Comments:

APPENDIX C

Nebraska Standardized Risk Assessment Reporting Format For Substance Abusing Offenders

Client's Name _____
Rater's Name _____

Today's Date _____
Date of Birth _____

NEBRASKA STANDARDIZED RISK ASSESSMENT REPORTING FORMAT FOR SUBSTANCE ABUSING OFFENDERS

Purpose: This instrument is used to give treatment providers an indication of the offender's risk of rearrest. Please indicate whether, in your professional judgement, the offender's circumstances in each of the following areas indicate an increased likelihood of rearrest.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Age
Examples: The offender was relatively young at the time of first arrest/conviction.
The offender is currently 12 or younger. | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Prior Record
Examples: The offender's arrest record causes concern.
The offender has had prior terms of probation/parole.
The offender has absconded or been revoked. | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Offense Types
Examples: The offender has prior arrests for theft/auto theft/burglary/robbery.
The offender has an arrest for assault, sexual assault or weapons. | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Attitude
Examples: The offender does not accept responsibility/rationalizes behavior.
The offender is unwilling to change. | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Personal Relations
Examples: The offender's personal relationships are unstable or disorganized.
The offender has gang associations. | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Substance Use
Examples: The offender is involved in occasional or frequent use of alcohol/drugs.
The use of alcohol/drugs causes any disruption of functioning. | <input type="checkbox"/> | <input type="checkbox"/> |

For Juveniles Only:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 7. School/Employment
(Check "Yes" if offender has dropped out and is not employed.)
Examples: The offender has behavior or attendance problems at school or work.
The offender is placed below expected grade. | <input type="checkbox"/> | <input type="checkbox"/> |

For Adults Only:

- | | Yes | No |
|---|--------------------------|--------------------------|
| 7. Employment
(Check "No" if full-time student)
Examples: The offender has unsatisfactory employment or is unemployed.
The offender has not been regularly employed or in school for the last year. | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | |
|---|--------------------------|--------------------------|
| 8. Maltreatment | <input type="checkbox"/> | <input type="checkbox"/> |
| Examples: The offender has been reported to be the victim of either neglect or abuse (emotional, physical or sexual). | | |

Overall Impression:

In your professional judgement, indicate the relative level of risk of rearrest posed by this offender.

Low

Medium

High

Comments/Concerns/Complicating Factors (e.g., trauma, victim, mental health, other identified needs):

APPENDIX D

Required Reporting Format For Nebraska Standardized Substance Abuse Evaluation (Adult and Juvenile)

**REQUIRED REPORTING FORMAT FOR NEBRASKA
STANDARDIZED SUBSTANCE ABUSE EVALUATION
FOR ADULT 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. SCHOOL / WORK / MILITARY HISTORY

E. ALCOHOL / DRUG HISTORY SUMMARY

1. Frequency and amount
2. Drug and alcohol of choice
3. History of all substance use / misuse / abuse
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 SA evaluations and findings
13. Prior SA treatment

F. LEGAL HISTORY (Information from Criminal Justice System)

1. Criminal History & Other Information :
2. Drug Testing Results:
3. Simple Screening Instrument Results
4. Nebraska Standardized Risk Assessment Reporting Format for Substance Abusing Offenders

G. FAMILY / SOCIAL / PEER HISTORY

H. PSYCHIATRIC / BEHAVIORAL HISTORY

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

I. COLLATERAL INFORMATION (Family / Friends / Criminal Justice)

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

J. OTHER DIAGNOSTIC / SCREENING TOOLS - SCORE & RESULTS

K. CLINICAL IMPRESSION:

1. Summary of Evaluation:
 - a. Behavior during evaluation (agitated, mood, cooperative)
 - b. Motivation to change
 - c. Level of denial or defensiveness
 - d. Personal agenda
 - e. Discrepancies of information provided
2. Diagnostic Impression (including justification): (May include Axis I-V)
3. Strengths Identified (client and family)
4. Problems Identified

L. RECOMMENDATIONS

1. Primary / Ideal Level of Care Recommendation:
2. Available level of Care / Barriers to Ideal Recommendation
3. Client / Family Response to Recommendation:

ATTACHMENT A: PERTINENT BIOPSYCHOSOCIAL INFORMATION

Notes

1. MEDICAL / HEALTH STATUS

YES	NO

- 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
- d. Abuse / trauma issues present
(domestic,sexual,physical, neglect, etc.)

4. DEVELOPMENTAL

YES	NO

- a. Abandonment issues
- b. Significant childhood experiences

5. SOCIAL COMPETENCY / PEER RELATIONSHIPS

YES	NO

- 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. PSYCHIATRIC / BEHAVIORAL

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

**REQUIRED REPORTING FORMAT FOR NEBRASKA
STANDARDIZED SUBSTANCE ABUSE EVALUATION
FOR JUVENILE 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. SCHOOL / WORK / MILITARY HISTORY

E. ALCOHOL / DRUG HISTORY SUMMARY

1. Frequency and amount
2. Drug and alcohol of choice
3. History of all substance use / misuse / abuse
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 SA evaluations and findings
13. Prior SA treatment

F. LEGAL HISTORY (Information from Criminal Justice System)

1. Criminal History & Other Information :
2. Drug Testing Results:
3. Simple Screening Instrument Results
4. Nebraska Standardized Risk Assessment Reporting Format for Substance Abusing Offenders

G. FAMILY / SOCIAL / PEER HISTORY

H. PSYCHIATRIC / BEHAVIORAL HISTORY

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

I. COLLATERAL INFORMATION (Family / Friends / Criminal Justice)

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

J. CLINICAL IMPRESSION:

1. Summary of Evaluation:
 - a. Behavior during evaluation (agitated, mood, cooperative)
 - b. Motivation to change
 - c. Level of denial or defensiveness
 - d. Personal agenda
 - e. Discrepancies of information provided
2. Diagnostic Impression (including justification): (May include Axis I-V)
3. Strengths Identified (client and family)
4. Problems Identified

K. RECOMMENDATIONS

1. Primary / Ideal Level of Care Recommendation:
2. Available level of Care / Barriers to Ideal Recommendation
3. Client / Family Response to Recommendation:

ATTACHMENT A: PERTINENT BIOPSYCHOSOCIAL INFORMATION

Notes

1. MEDICAL / HEALTH STATUS

YES	NO

- 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
- d. Abuse / trauma issues present
(domestic,sexual,physical, neglect, etc.)

4. DEVELOPMENTAL

YES	NO

- a. Abandonment issues
- b. Significant childhood experiences

5. SOCIAL COMPETENCY / PEER RELATIONSHIPS

YES	NO

- 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. PSYCHIATRIC / BEHAVIORAL

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

APPENDIX E

Comprehensive Adolescent Severity Inventory (CASI)

Client ID # _____

Comprehensive Adolescent Severity Inventory

CASI

<input type="checkbox"/> Health Information	<input type="checkbox"/> Peer Relationships
<input type="checkbox"/> Stressful Life Events	<input type="checkbox"/> Sexual Behavior
<input type="checkbox"/> Education	<input type="checkbox"/> Family / Household Member
<input type="checkbox"/> Drug / alcohol Use	<input type="checkbox"/> Legal Issues
<input type="checkbox"/> Use of Free Time	<input type="checkbox"/> Mental Health

Select The Modules You Wish To Administer

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FACE SHEET

1. Site ID #: _____

2. SS #: _____

3. Date of Adm: _____ MM/ _____ DD/ _____ YY

4. Date of Int: _____ MM/ _____ DD/ _____ YY

5. Time Int. Began: _____ HR: _____ MN

6. Time Int. Ended: _____ HR: _____ MN

7. Category

1) Intake

2) Follow-up

If follow-up, specify month (e.g., record February '02')

8. Special

1) Subj. misrepresentation

3) Subj. terminated

2) Subj. not able to respond

9. Standardized Test Scores

Test Name:	Test Result:
a)	
b)	
c)	
d)	

Urine Drug Screening Results			
Drug Category	Result		Drug Category
10. Opiates		Coding Key 0) Negative for drug metabolites 1) Positive for drug metabolites 2) Quantity was insufficient for test 3) Was not tested 4) Pt. refused to submit sample	14. Barbs/Seds/Hypnotics <small>Pheno/Pentobarbital, Chloral Hydrate</small>
11. Hallucinogens			15. Benzodiazepines <small>Oxazepam, Diazepam</small>
12. Amphetamines <small>Buphetamine/ Methamphetamine</small>			16. Inhalants
13. Cocaine <small>Any form.</small>			17. Marijuana <small>THC in any form.</small>

18. Alcohol Breathalyzer Reading

Enter blood level from breathalyzer report (e.g., .00, .09, .10).

--	--

REASON FOR INTAKE: _____

GENERAL INFORMATION

1. Name: _____

2. Nickname: _____

3. Address: _____

4. Phone #: () _____

5. Geographic type of primary residence:

Urban Suburban Rural

6. Age: _____ 7. Birth Date: ____/____/____

8. Gender: Male Female

9. Race

- | | | |
|---------------------|---------------------|------------------|
| 1) Caucasian | 5) Native American | 9) Filipino |
| 2) African-American | 6) Pacific Islander | 10) Asian Indian |
| 3) Latino/a | 7) Other: specify | |
| 4) Asian | 8) Southeast Asian | |

10. Spoken Languages

Spoken Languages	Primary <small>X most spoken</small>	Other <small>X all others</small>
English		
Spanish		
Chinese		
French		
Vietnamese		
Portuguese		
Other: please specify		

11. Marital Status

- | | |
|---------------------------|-------------|
| 1) Single (never married) | 4) Divorced |
| 2) Married | 5) Widowed |
| 3) Separated | |

12. Referral Source:

- | | |
|-----------------|------------------------------|
| 1) Self | 5) Child Protective Services |
| 2) Family | 6) Court |
| 3) School | 7) Other: specify |
| 4) Professional | |

13. Have you been in a controlled environment in the past month?

- | | |
|-------------------------|-------------------|
| 1) No | 5) Med. Tx |
| 2) Jail/Youth Detention | 6) Psych. Tx |
| 3) Youth Shelter | 7) Other: specify |
| 4) D&A Tx | |

14. Number of days during past month in a controlled environment:

--	--

Have there ever been significant periods during which you _____?

Ever	PAST YEAR	
	Past Month	Other 11 Months
0) No	0) No	0) No
1) Yes	1) Yes	1) Yes

15. Had a belief in a "God" or a "Higher Power"?

16. Prayed or meditated in line with your spirituality/beliefs?

17. Do you want to learn more about a particular religion?
Which one? _____

- 0) No
1) Yes

18. Religion Currently Practicing

- | | | |
|---------------|-------------------|-------------|
| 1) Protestant | 4) Islam | 7) Mormon |
| 2) Catholic | 5) None | 8) Buddhist |
| 3) Jewish | 6) Other: specify | 9) Hindu |

COMMENTS: _____

LEGAL GUARDIAN(S)

Name: _____

Relationship: _____

Address: _____

Phone #: _____

Highest grade completed: _____

Occupation: _____

Does this adult receive ____?	Yes	No
General public assistance?		
Medicaid?		
Food stamps?		
WIC?		
SSI/SSDI?		

Name: _____

Relationship: _____

Address: _____

Phone #: _____

Highest grade completed: _____

Occupation: _____

Does this adult receive ____?	Yes	No
General public assistance?		
Medicaid?		
Food stamps?		
WIC?		
SSI/SSDI?		

OTHER INVOLVED ADULTS

Name: _____

Relationship: _____

Address: _____

Phone #: _____

Name: _____

Relationship: _____

Address: _____

Phone #: _____

Name: _____

Relationship: _____

Address: _____

Phone #: _____

Name: _____

Relationship: _____

Address: _____

Phone #: _____

HEALTH INFORMATION

Do you have _____?	Yes	No	Don't know	Other Illnesses <i>please specify</i>	Surgical Procedures <i>please specify</i>	Date
Asthma?						
Diabetes?						
Epilepsy?						
A heart murmur?						

Prescribed Medications

OTC Medications

Medication Allergies

Food Allergies

Time since last _____?	Time (in months)	Doctor's Name or Medical Care Provider	Phone #
Comprehensive physical exam (not a sports physical)?			
<i>For females only - Gynecological exam?</i>			
Dental exam?			
Eye exam?			
Hearing exam?			

COMMENTS: _____

DRUG/ALCOHOL USE

Have you ever used ____? <small>* Please circle each substance ever tried, even if substance was used only one time.</small>	How old were you when you 1st tried ____?	How old were you when you 1st started using ____ on a regular basis?	In the past year, what was your typical and peak pattern of use? 0) No past year use 1) One to ten times 2) Episodic use 3) Binge use only 4) Once per month 5) Two or more times per month 6) Once per week 7) Two or more times per week 8) Once per day 9) More than once per day TYPICAL PATTERN PEAK PATTERN		When you use ____ with whom do you typically use? 1) Alone 2) Friend(s) 3) Sibling(s) 4) Parent(s) 5) Acquaintance(s) 6) Stranger(s) 7) Other: specify	When you use ____ what is your usual or most recent route of administration? 1) Oral 2) Nasal 3) Smoking 4) Non-IV injection 5) IV injection	In the past month, how many days did you use ____?	How long you used ____? <small>*Record total and months substance was used.</small> YEARS MO	
1. Tobacco									
2. OTC drugs: <small>specify in comments</small>									
3. Alcohol									
4. Cannabis									
5. Cocaine									
6. Amphetamines									
7. Barbituates/ Sedatives									
8. Inhalants									
9. Hallucinogens									
10. Opiates									
11. Other: <small>specify in comments</small>									

COMMENTS:

1) Parent(s)/Guardian(s)	3) Illegal means	5) Boyfriend/Girlfriend
2) Employment	4) Public Assistance	6) Other: specify
12. Major source of support: (e.g., housing, clothes, etc.): <input type="checkbox"/>		
13. Major source of spending money: <input type="checkbox"/>		

COMMENTS:
 Include question # with each comment.

Section II

Complete only if youth is currently not enrolled in school or not attending school.

WHEN YOU STOPPED GOING TO SCHOOL:

14. Were you working? 0) No
1) Yes

15. Were you self-supportive, that is, did you make enough money to eat and to live in a safe place? 0) No
1) Yes

Complete items #16 and #17 only if unemployed and not in school.

16. Reason for not working:

1) Don't want to work	5) Medical reasons
2) Unable to find a job	6) Psychiatric reasons
3) Not actively seeking	7) Drug/alcohol reasons
4) Not old enough	8) Other: specify

17. Are you actively seeking employment (e.g., completing applications, answering advertisements, etc.)? 0) No
1) Yes

Section III - LEISURE ACTIVITIES

All youth should complete this section.

In the past year, how often have you _____?	0) Never	4) Once per week
	1) 1 to 10 times	5) >2 times per week
	2) Once per month	6) Daily
	3) >2 times per month	

18. Worked (i.e., a job, paid employment)?

19. Played team sports or participated in athletic activities?

20. Participated in academic, leadership or career clubs (e.g., school newspaper, debate club)?

21. Been involved in music (bands, chorus), theater, dance, or art clubs/activities?

22. Volunteered or done community service or civic work?

23. Done homework or studied?

GRID CONTINUES ON NEXT PAGE.....

SEXUAL BEHAVIOR

Have you ever _____?	Ever	Age 1st	PAST YEAR			
			Past Month	Other 11 Months	Condom Use	Other Contraceptives
	0) No 1) Yes		0) No 1) Yes	0) No 1) Yes	0) Never 1) Sometimes	2) Almost always 3) Always
1. Had oral sex?						
2. Had vaginal sex?						
3. Had anal sex?						
4. How many different male sexual partners have you had? <i>Please record total number in each box.</i>						
5. How many different female sexual partners have you had? <i>Please record total number in each box.</i>						
6. Been forced to be sexual with someone outside of your family when you did not want to, engaged in sexual activity against your will?						
7. Forced someone to engage in sexual activity when they did not want to?						
8. Had sex when you were high or drunk?						
9. Had sex in exchange for food or a place to stay (i.e., survival sex)?						
10. Had sex with someone who has or might have AIDS (e.g., prostitute, IV drug user, men who have sex with men)? 0) No 1) Yes 2) Don't know						

Have you ever been tested for _____?	Ever	Age 1st	Total # Positive Results	PAST YEAR	
				Past Month	Other 11 Months
0) No 2) Yes, positive result 1) Yes, negative result 3) Yes, don't know result					
11. A sexually transmitted disease (STD)?					
12. AIDS?					

COMMENTS:

Include question # with each comment.

LEGAL ISSUES

Have you ever _____?	Ever	Age 1st	PAST YEAR	
			Past Month	Other 11 Months
1. Committed a crime?	0) No 1) Yes		0) No 1) Yes	0) No 1) Yes
2. Been picked up by the police?				
3. Been charged with a crime?				
4. Been convicted of a crime?				
5. Spent time in a juvenile detention facility or jail?				
6. Been on probation?				
7. Filed or obtained a restraining order against someone else?				
8. Had a restraining order filed or obtained against you?				
9. Have you ever committed, been charged with or been convicted of _____?	Committed	Charged	Convicted	
	0) No 1) Yes	0) No 1) Yes	0) No 1) Yes	0) No 1) Yes
Running away				
Incorrigibility				
Truancy				
Driving violations (including DWI/DUI)				
Loitering, Vagrancy				
Disorderly Conduct, Public Drunkenness				
Vandalism, Criminal Mischief				
Terroristic Threats/Harassment				
Drug charges (not drug dealing)				

GRID CONTINUES ON NEXT PAGE.....

COMMENTS:

Include question # with each comment

INTERVIEWER PERCEPTIONS

The following items are to be completed based upon the interviewer's observations:

At the time of the interview, was the youth _____ ?	0) No 1) Yes
1. Obviously depressed/withdrawn?	
2. Obviously hostile/angry?	
3. Obviously uncooperative?	
4. Obviously disinterested?	
5. Having trouble comprehending or understanding?	
6. Having trouble concentrating or remembering?	
7. Having trouble with reality testing, distorted thinking or paranoid thinking?	
8. Having suicidal thoughts?	
9. Making eye contact with the interviewer?	
10. Displaying appropriate affect?	
11. Well-groomed?	
12. Wearing clean clothes?	

COMMENTS:

Include question # with each comment.

PARENTING STYLES

A. My parents try to control everything I do; I sometimes feel as though I am on a leash. They tell me where I can go, what I can do, and who I can have as friends. They expect me to do everything they say without an explanation. They think they are always right.

B. My parents seem to have a difficult time saying "NO" to me. If I get upset, sad, or angry with them, my parents usually let me do what I want. They rarely set limits on what I can do, where I can go, or who I can hang around with. They seem to avoid arguments or trouble at all costs. My parents just want life to go on smoothly and quietly without conflict. Although they seem to try, they just do not know how to handle me nor how to understand me. They do not seem to feel competent as parents.

C. My parents think that order and routine at home is boring. To them, life is only bearable when something out of the ordinary is happening. They do not care if they disrupt the routine at home, even if it results in arguments or fighting. My parents sometimes forget birthdays, and holidays are not always celebrated. I never know what to expect when I am at home.

D. Although there are rules at home, I have some say in what those rules are and the reasons for them are usually explained to me. Discipline for breaking rules is almost always fair and appropriate. As I grow older, my parents give me more responsibility and personal freedom. They seem to know and trust that I try to make good decisions. They encourage discussions and usually ask for my opinion. Although I don't always like it, my parents try to be somewhat involved in my life. They truly seem to be interested in what I do, what I think, and how I feel.

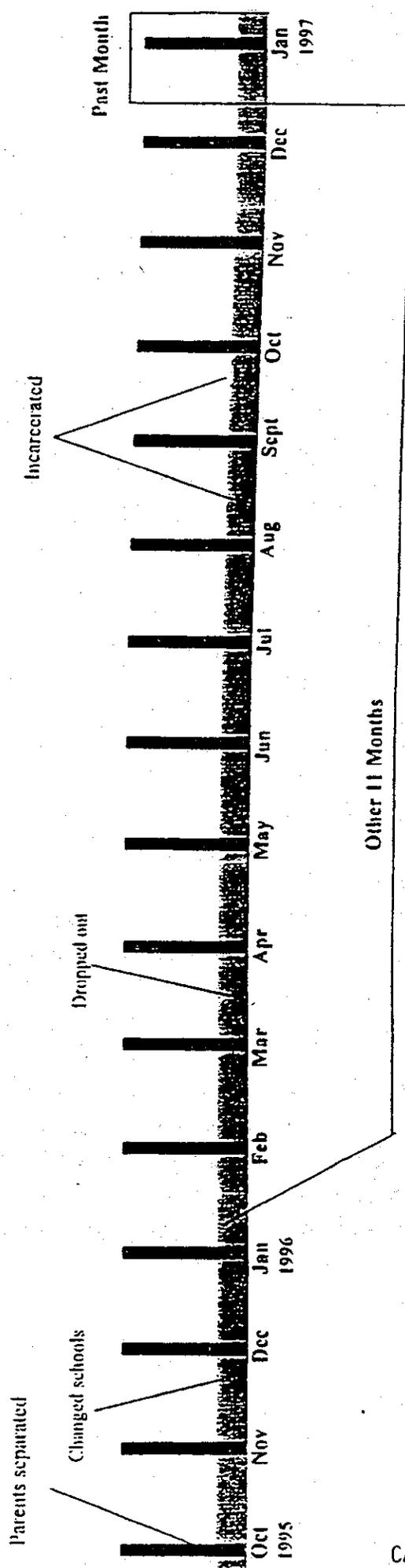
E. My parents give little support to me, even when I am hurting. They are usually unavailable to me. They are sometimes cold and harsh. They usually do not know, and do not care to know, what I do, where I go, or who I hang around with. I often feel that they do not care about me, that they try to avoid me, and that they wished that I was not around. We have never been close.

TIMELINE Sample grid

Age at beginning of Kindergarten

Grades Repeated

Critical Event	Age
Mom in drug rehab	<input type="text" value="7"/>
Dad incarcerated	<input type="text" value="9"/>
Foster care	<input type="text" value="9"/>
Pregnant/miscarried	<input type="text" value="13"/>
Arrested for drug dealing	<input type="text" value="15"/>



TIMELINE

Age at beginning of Kindergarten	<input type="checkbox"/>			
Grades Repeated	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Critical Event	Age
<input type="checkbox"/>	<input type="checkbox"/>



GRADE - AGE CONVERSION TABLES

Began K at Age 4

Grade	Age
K	4
1	5
2	6
3	7
4	8
5	9
6	10
7	11
8	12
9	13
10	14
11	15
12	16

Began K at Age 5

Grade	Age	Rep K	RepG1	RepG2	RepG3	RepG4
K	5	5 & 6	5	5	5	5
1	6	7	6 & 7	6	6	6
2	7	8	8	7 & 8	7	7
3	8	9	9	9	8 & 9	8
4	9	10	10	10	10	9 & 10
5	10	11	11	11	11	11
6	11	12	12	12	12	12
7	12	13	13	13	13	13
8	13	14	14	14	14	14
9	14	15	15	15	15	15
10	15	16	16	16	16	16
11	16	17	17	17	17	17
12	17	18	18	18	18	18

Began K at Age 6

Grade	Age	RepK	RepG1	RepG2	RepG3	RepG4
K	6	6 & 7	6	6	6	6
1	7	8	7 & 8	7	7	7
2	8	9	9	8 & 9	8	8
3	9	10	10	10	9 & 10	9
4	10	11	11	11	11	10 & 11
5	11	12	12	12	12	12
6	12	13	13	13	13	13
7	13	14	14	14	14	14
8	14	15	15	15	15	15
9	15	16	16	16	16	16
10	16	17	17	17	17	17
11	17	18	18	18	18	18
12	18	19	19	19	19	19

ADDENDUM: Supplemental Questions to CASI Version 1-1

Module:	Ever 0) No 1) Yes	Age First	Past Month 0) No 1) Yes	Other 11 Months 0) No 1) Yes
Stressful Life Events				
Been homeless?				
Peer				
Could say no to your friends, would only do what you wanted to do, did not do something that you did not want to do?				
Could work out issues/problems with your friends in a non-hostile/non-violent manner?				
Did not always need or seek out the approval of your friends?				
Claimed a gang (e.g., wore certain clothes, had certain tattoos)?				
Family/Household Relationships				
Felt close to someone in your family/ household (i.e., bonded with someone, were attached to someone)?				
Were reinforced, given credit or praised for doing the right thing, for good behavior?				
Your family/household members could work out issues/problems with you in a non-hostile/non-violent manner?				
Your parent(s)/guardian(s) really knew where you went at night/after school, who you hung out with and how you got or spent your money?				
Have you ever hit someone who lived with you so hard that they had bruises, broken bones, or had to be taken to the hospital?				
Mental Health				
Had recurrent distressing thoughts, dreams or perceptions of a traumatic event?				
Had persistent or recurrent experiences of feeling detached from or outside of your body or thoughts?				
Had the urge or thoughts to beat, kill or seriously injure someone?				
Tried to beat, kill or seriously injure someone?				
Felt like you had control over daily events, over what happens in your life?				
Alcohol/Drug				
Date of last use?				

APPENDIX F

Addiction Severity Index (ASI)

Addiction Severity Index, 5th Edition

Clinical/Training Version

A. Thomas McLellan, Ph.D.

Deni Carise, Ph.D

INTRODUCING THE ASI: Seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychological. All clients receive the same standard interview. All information gathered is *confidential*.

We will discuss two time periods:

1. The past 30 days
2. Lifetime data

Patient Rating Scale: Patient input is important. For each area,

I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you in the area being discussed.

The scale is: 0—Not at all

- 1—Slightly
- 2—Moderately
- 3—Considerably
- 4—Extremely

If you are uncomfortable giving an answer, then don't answer.

Please do not give inaccurate information!
Remember: This is an interview, not a test.

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of comments and include the question number before each comment. If another person reads this ASI, that person should have a relatively complete picture of the client's perceptions of his or her problems.
3. X = Question not answered.
N = Question not applicable.
4. Stop the interview if the client misrepresents two or more sections.
5. Tutorial and coding notes are preceded by *.

INTERVIEWER SCALE: 0-1 = No problem
2-3 = Slight problem
4-5 = Moderate problem
6-7 = Severe problem
8-9 = Extreme problem

HALF TIME RULE: If a question asks for the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS:

- Last two items in each section.
- Do not overinterpret.
- Denial does not warrant misrepresentation.
- Misrepresentation is overt contradiction in information.

PROBE AND MAKE PLENTY OF COMMENTS!

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Painkillers = Morphine; Dilaudid; Demerol; Percocet; Darvon; Talwin; Codeine; Tylenol 2, 3, 4
Barbiturates:	Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol
Sedatives/ Hypnotics/ Tranquilizers	Benzodiazepines, Valium, Librium, Ativan, Serax Tranxene, Dalmane, Halcion, Xanax, Miltown Chloral Hydrate (Noctex), Quaaludes
Cocaine:	Cocaine Crystal, Freebase Cocaine or "Crack," and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstasy
Inhalants:	Nitrous Oxide, Amyl Nitrate (Whippets, Poppers), Glue, Solvents, Gasoline, Toluene, etc.

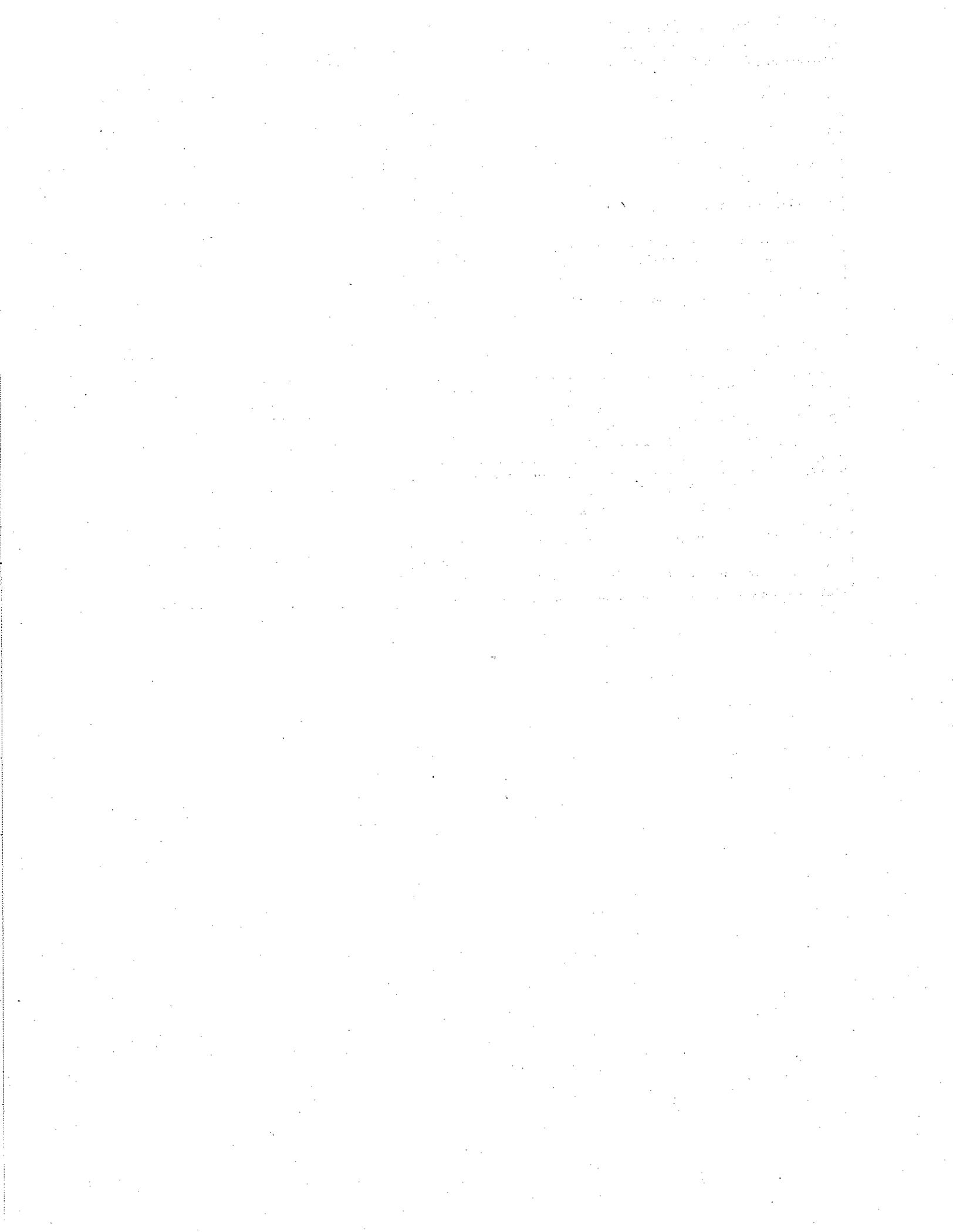
Just note if these are used:

- Antidepressants
- Ulcer Medications—Zantac, Tagamet
- Asthma Medications—Ventoline Inhaler, Theo-Dur
- Other Medications—Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:

This section looks at two time periods: the past 30 days and years of regular use, or lifetime use. Lifetime use refers to the time prior to the past 30 days.

- 30-day questions require only the *number* of days used.
- Lifetime use is asked to determine extended periods of *regular* use. It refers to the time prior to the past 30 days.
- Regular use = 3+ times per week, 2+ day binges, or problematic, irregular use in which normal activities are compromised.
- Alcohol to intoxication does not necessarily mean "drunk"; use the words "felt the effects," "got a buzz," "high," etc. instead of "intoxication." As a rule of thumb, 5+ drinks in one day, or 3+ drinks in a sitting defines intoxication.
- How to ask these questions:
 - ✓ How many days in the past 30 days have you used...?
 - ✓ How many years in your life have you *regularly* used...?



APPENDIX G

Crosswalk of Substance Abuse Services (Adults and Juveniles)

HHS/SUBSTANCE ABUSE SYSTEM AND JUSTICE SYSTEM

Crosswalk of Substance Abuse Services -- ADULTS

LEVELS OF CARE	a	b	c	d	e	f
	HHS/DIV OF MH, SA & ADDICTIONS	ASAM CRITERIA	CJS/INSTITUTIONS	CJS/FEDERAL PROBATION	CJS/STATE PROBATION	
Emergency Services	24-hr Clinician On-Call/Phone	Early Intervention/Screening/Referral	24-hr Clinician On-Call			
	Emergency Shelter - Social Detox	Clinically Managed Residential Detox	Medical Detox (available at NSP & DEC hospitals)			Social Detox (3-5 days in community)
	Emergency Community Support	Ambulatory Detox w/OnSite Monitoring	Medical Detox (available at NSP & DEC hospitals)			Medical Detox (5-10 days in hospital)
Assessment	Emergency Protective Custody - MH & SA	Ambulatory Detox w/Extended OnSite Monitoring	Medically Monitored or Managed Inpt. Detox			
	Civil Protective Custody - SA	Clinically Managed Detox/Legal Hold (35 hr/22 hr)	Clinically Managed Detox/Legal Hold (24 hr)			
		Medically Managed-Intensive Res (Inpatient)				
Residential Services	Emergency Assessment/Evaluation (within 36 hrs by CADAC or scope of practice)					
	Screening required for all admissions in all services (including mental health)	Early Intervention/Screening/Referral	Assessment/Evaluation (PRN; no cost; CADAC signatures; DEC provides screening and LOC recommendation when appropriate)			Problem Identification; screening; referral
	Assessment/Evaluation - SA (CADAC or scope of practice)	Outpatient Services				A/D Evaluation (CADAC or CPADAC only)
Level 1	Intermediate Residential					
	Extended Residential - SA	Clinically Managed-Medium Intensity Res.				Intensive Res Tx (no more than 270 days; monitored & reviewed by Probation Officer every 60 days)
	Transitional Residential	Clinically Managed-Medium-High Intensity Res.				Residential Tx (no more than 90 days; monitored & reviewed by Probation Officer every 30 days)
Level 2	Dual Residential (SPMI/CD)	Clinically Managed-High Intensity Res. and Medically Monitored-Intensive Residential				Residential Treatment (30 day in residential facility or hospital)
	Short Term Res - SA					
	Therapeutic Community - SA	Clinically Managed Medium-High Intensity Res.				Halfway House (minimum stay of 90 days)
Level 3	Halfway House - SA	Clinically Managed-Low Intensity Residential				Partial Care (4 hrs/day; 5 days/wk)
	Partial Care - SA					Intensive Outpatient (10-25 hrs/wk; 4-8 wks)
	Intensive Outpatient - SA	Partial Hospitalization (20+ hrs/wk.)				
Level 4	Community Support - SA	Intensive Outpatient (9+ hrs/wk)				Outpatient Treatment (Grp 2x/wk; Ind 1x/wk) Aftercare Program/Group Support (1x/wk)
	Outpatient Therapy - SA					A/D Education (1 six hr class)
	Methadone Maintenance - SA	Outpatient Services				Substance Abusers Progrm (8 wk @ 1-2x/wk)
Level 5	Case Monitoring - SA	Oploid Maintenance Therapy				Support/Self Help Groups (not funded)
		Early Intervention				Support/Self Help Groups (not funded)

ASAM = American Society of Addiction Medicine CJS = Criminal Justice System; includes all adult correctional facilities and adult parole.

HHS/SUBSTANCE ABUSE SYSTEM AND JUSTICE SYSTEM

Crosswalk of Substance Abuse Services -- JUVENILES

A	B	C	D	E	F
LEVELS OF CARE	HHS/DIV OF MH, SA & ADDICTIONS	ASAM CRITERIA	OJSMEDICAID	OJ/INSTITUTIONS	CJ/STATE PROBATION
Emergency Services		Clinically Managed Detox			
		Ambulatory Detox w/OnSite Monitoring			
		Ambulatory Detox w/Extended OnSite Monitoring Medically Monitored or Managed Inpt. Detox	Treatment Crisis Intervention		
Assessment		Medically Managed-Intensive Res (Inpatient)			
		Emergency Assessment/Evaluation (within 36 hrs by CADAC or scope of practice)			
		Assessment/Evaluation - SA (CADAC or scope of practice) <i>Intermediate Residential</i>	Pre-Tx Assessment Evaluation/Assessment	A/D Evaluation	Problem Identification; screening; referral CD Evaluation (CADAC or CPADAC only)
Residential Services		<i>Transitional Residential</i> Therapeutic Community - SA			
		Clinically Managed Medium-High Intensity Res.	Residential Treatment Center Treatment Home	Residential Drug/Alcohol Treatment (6-10 months; srvc)	Residential Treatment (30 day in residential facility or hospital) Halfway House (minimum stay of 90 days)
		Clinically Managed Low Intensity Residential		Adolescent Residential Treatment (LOS = # days or # months ?; srvc at HRC for YRTC-Kearney only)	Halfway House (minimum stay of 90 days)
Non-Res	Level 1	Partial Care - SA	Day Treatment		Partial Care (4 hrs/day; 5 days/wk)
	Level 2	Intensive Outpatient - SA	Intensive Outpatient		Intensive Outpatient (10-25 hrs/wk; 4-6 wks)
	Level 3	Community Support - SA	Outpatient Services		Outpatient Treatment (Grp 2x/wk; Ind 1x/wk)
	Level 4	Outpatient Therapy - SA	Outpatient Counseling		Aftercare Program/Group Support (1x/wk)
	Level 5	Case Monitoring - SA	Community Treatment Aides	Stabilization and Education Tx Groups (Srvc at YRTC-Kearney) A/D Education (groups) (Srvc at YRTC-Kearney)	A/D Education (1 six hr class) Substance Abusers Prgrm (8 wk @ 1-2x/wk) Support/Self Help Groups (not funded)

OJ/S = HHS/Office of Juvenile Justice includes (1) Youth Residential Treatment Center at Geneva for girls, (2) Youth Residential Treatment Center at Kearney for boys, and (3) Juvenile Parole.

OJ/S/Parole = Use all services available through Medicaid and through the Division.

OJ/S/Medicaid = all service terms apply to both MH & SA; no specific definition in the Medicaid regulations indicate what exact SA service is provided under the umbrella of each service name. The expectation is that ASAM (American Society of Addiction Medicine) criteria is applied as it relates to the Nebr. Medicaid State Plan.

March 1, 2002

SUBSTANCE ABUSE SERVICES FOR ADULT CRIMINAL JUSTICE CLIENTS

The terms listed are for use by all substance abuse providers and criminal justice entities in referring criminal justice system clients to substance abuse services provided in Nebraska.

LEVEL OF CARE (LOC): General category that includes several similar types of services.
Substance Abuse Services: The specific service name that more specifically identifies the type of actual substance abuse service a client will receive.

Adult: Age 19 and above.

NOTE: Not all of these services are available in Nebraska; some services may be available in some regions but not in others. This service array is intended to be a balanced array of substance abuse services that could meet various needs at different levels of severity.

LOC: EMERGENCY SERVICES (very short term, unscheduled service availability in time of crisis in a variety of settings)

Crisis Phone Line	Clinician on-call for early intervention/screening/referral; available 24/7
Mobile Crisis / Crisis Response Teams	Teams of professional and/or paraprofessionals that offer on-site screening usually in the home; brief interventions to stabilize the crisis and refer for SA Crisis/Crisis Respite or other appropriate service, and a thorough SA evaluation; available 24/7; includes access to a CADAC by phone.
SA Emergency Shelter or SA Respite	Residential or home based service for a short term placement of an individual in a substance abuse crisis; most clients are not intoxicated but program has capability to supervise alcohol/drug social setting detoxification (non-medical); length of stay varies by legal status, but emphasis is very short term (less than 7 days); 24/7 availability of on-site clinically managed and monitored services as needed; client is medically stable; very limited nursing support service for persons once a MH or SA crisis has been stabilized; 1:1 staff to client work to ensure client focuses on relapse and recovery mgmt, and skill teaching, assistance with housing, ensure attendance at medical appointments or SA non-residential treatment services; coordination of a care plan; coordinating services, transportation; 24/7 on call; service is very short term; often provided concurrently with another SA service to ensure client stays connected with services; LoS varies but not longer than 30-90 days.
Emergency Community Support	Service to stabilize acute withdrawal and/or intoxication symptoms and return person to independent living in the community or engage & refer the person to a recovery program; supportive services therapy, brief SA assessment, primary clinical treatment for substance abuse disorder implemented, and coordination of services to help the client alleviate a substance abuse crisis; LoS varies but not longer than 14 days; on site clinically managed and monitored, medically stable, limited nursing coverage.
Emergency Stabilization & Treatment	Residential service for the short term placement for an adult needing alcohol/drug detoxification (non-medical); length of stay varies but usually not more than 5-7 days depending on the drugs involved; 24/7 on-site availability of clinically managed and monitored; medically stable; limited nursing coverage.
Social Detox	24-hr medically supervised alcohol/drug detoxification where severe medical issues are involved; 24/7 medical staff coverage.
Medical Detox	Crisis Center services provided in a medical facility to stabilize a person in psychiatric and/or substance abuse crisis; clinically managed detox with legal hold; 24/7; admission on involuntary basis by EPC legal hold because of alleged dangerousness to self or others; generally 7 day or less stay to stabilize, begin emergency treatment & referral to most appropriate service to meet client's need; LoS not longer than 7 days, or if the client is on an EPC hold may continue to a commitment hearing.
Emergency Protective Custody (EPC)	Residential services; 24 hr legal hold to keep someone involuntarily in a social detox service.
Civil Protective Custody (CPC)	

LOC: ASSESSMENT SERVICES (screening and evaluation tools used to determine the level of a SA problem & make appropriate service referral; generally provided in a non-residential setting)

Screening
General screening by provider to identify a substance abuse problem and refer for a complete SA assessment, early intervention or treatment; includes screen for mental health and gambling issues. Criminal justice referrals will have had an SSL screen done by criminal justice system staff.

Emergency SA Evaluation
SA evaluation needed on an unscheduled basis and available within 24 hours of request; all evaluations completed for justice clients must be completed by a certified alcohol and drug abuse counselor (CADAC), or a provisional CADAC (CPDAC) who is supervised by a CADAC, a licensed psychologist or a licensed physician with an addictions specialty; available in the EPC/Crisis Center service or at any state certified SA service provider; Evaluation/Assessment Tool Required: Addiction Severity Index (ASI); Approved State Reporting Format: SA

SA Evaluation
All SA evaluations completed for justice clients must be completed by a certified alcohol and drug abuse counselor (CADAC), or a provisional CADAC (CPDAC) who is supervised by a CADAC, a licensed psychologist or a licensed physician with an addictions specialty; available at any state approved SA service provider; Evaluation/Assessment Tool Required: Addiction Severity Index (ASI); Approved State Reporting Format: SA
Evaluation/Assessment results are required to be provided in the state approved reporting format only.

LOC: NON-RESIDENTIAL SERVICES (least intensive services based on clinical need offered in a variety of community settings; client lives independently) NOTE: Persons MUST be psychiatrically and medically stable to be admitted to the non-residential services.

NON-RESIDENTIAL SERVICES: A range of services for persons at risk of developing, or who have substance abuse problems, specific functional deficits, problems with intoxication or withdrawal, but few biomedical complications. Clients may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment, and thus is in need of interventions directed by CADACs or other non-physician addiction specialists rather than medical or psychiatric personnel in a variety of non residential settings. Level 1 is the most intensive and Level 5 is the least intensive service in this level of care.

Lv 5 Prevention
Education and other activities designed to prevent using substances.

Lv 5 Intervention
Intervention counseling and education for persons experimenting or currently using substances but who are NOT dependent; staff supervised EDUCATION programs are very structured with a specific outcome for the client; LoS varies (i.e., minimally one staff supervised 6 or 8 hr class; other options might include eight one-hour sessions, 3-4 four-hour sessions, or other); includes support group or self help referrals.

Lv 5 Methadone Maintenance
Administration of methadone medication to enable an opiate addicted person to be free of heroin; methadone replacement for heroin is a lifetime maintenance program; counseling, therapy interventions are included in the service.

Lv 5 Case Monitoring SA/MH
Monitoring service designed for persons eligible under the definition for Community Support Mental Health or Substance Abuse, who have made significant progress in recovery and stable community living, or for those clients unwilling to accept the more intensive and rehabilitative community support service; this service monitors a client's progress in community living, provides crisis/relapse intervention/prevention as needed, provides oversight and follow-up functions as identified in the client's monitoring plan (i.e., services, appointments, reminders), and intervenes to protect current gains and prevent losses or decompensation/relapse; contact with client as needed.

Lv 4 Outpatient Counseling
Individual and/or group counseling/therapy by a CADAC or CPADAC under supervision for a variety of substance use disorders which disrupt a client's life; treatment focus is on changing behaviors, modifying thought patterns, coping with problems, improving functioning, and other services to achieve successful outcomes and prevent relapse. LoS varies depending on individual illness and response to treatment (i.e., may average 10-12 sessions at 1-4 hrs per week but treatment frequencies and duration will vary); includes brief therapy model (3-5 sessions); group therapy sessions include approx 3-8 persons; family counseling is included.

Lv 3 Community Support
Support for a persons with chemical dependency and functional deficits; 1:1 staff to client support (face to face) in residence or other non-office location to ensure client focus on rehabilitating his/her social and relationship skills; aiding client in use of appropriate coping skills; active relapse and recovery mgmt and skill teaching; provides client advocacy; assistance with housing, accessing transportation, and a variety of other case management activities; ensure attendance at medical appointments or SA non-residential treatment; coordination of a care plan and services; 24/7 on call availability of community support worker; often provided concurrently with another non-residential SA non-residential service.

Lv 2 Intensive Outpatient
Counseling

Intensive group and individual counseling for persons with substance abuse disorders or chemical dependence; counseling provided by a CADAC or CPADAC under supervision; offered in day or evening, before or after work; more intensive than Outpatient Therapy and less intensive than Partial Care; service includes a combination of group sessions 3-5 times/week plus individual sessions 1-3 hrs/week; total services to the client averages 10-15 hours per week; hours per week are tapered to a prescribed schedule or client need as the client transitions to the less intensive Outpatient Therapy or other service; LoS varies with individual response to treatment but the intensity of the service averages 5-6 weeks in duration.

Lv 1 Partial Care

Very intensive day treatment program by CADAC or CPADAC under supervision for clients with substance abuse or dependence problems; medical backup; includes individual and group counseling and medication monitoring services; services are provided 5 days per week at 6-8 hours of daily including a minimum of 4 hrs daily of primary SA treatment; LoS varies but average is 5-6 weeks; highest intensity, non-residential service.

LOC: RESIDENTIAL SERVICES (treatment services provided in a 24 hr community based residential setting)

NOTE: Persons MUST be psychiatrically and medically stable to be admitted to the residential services.

CLINICALLY MANAGED RESIDENTIAL SERVICES: An array of residential services for persons who need a structured, safe living environment to develop recovery skills; have specific functional deficits; minimal problems with intoxication or withdrawal and few biomedical complications; client may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment, and thus is in need of interventions directed by CADACs or other non physician specialists rather than medical or psychiatric personnel. Level 1 is the most intensive and Level 3 is the least intensive service in this level of care.

Lv 3 Halfway House

CLINICALLY MANAGED, LOW INTENSITY: Non-medical transitional residential program for persons who as with chemical dependency or substance abuse disorder who are successfully moving from more intensive treatment to independent living and seeking to re-integrate into the community; structured living environment and semi-structured activities designed to develop recovery living and relapse prevention skills; assistance in maintaining or accessing employment and developing the skills necessary for an independent life free from substance abuse outside of residential treatment; service has capacity to address mental health issues; counseling is provided by a CADAC or CPADAC under supervision; LoS varies but is usually not longer than 3-6 months.

Lv 2 Therapeutic Community

CLINICALLY MANAGED, MEDIUM INTENSITY: Non-medical transitional residential treatment for persons with chemical dependency; treatment includes psychosocial skill building through a longer term, highly structured set of peer oriented activities incorporating defined phases of progress; services include individual and group counseling/therapy, relapse prevention, education, vocational and skill building; service has the capacity to address mental health issues; counseling is provided by a CADAC or CPADAC under supervision; program is staff secure; LoS varies but is usually not longer than 10-18 months.

Lv 2 Dual Residential (MH/SA)

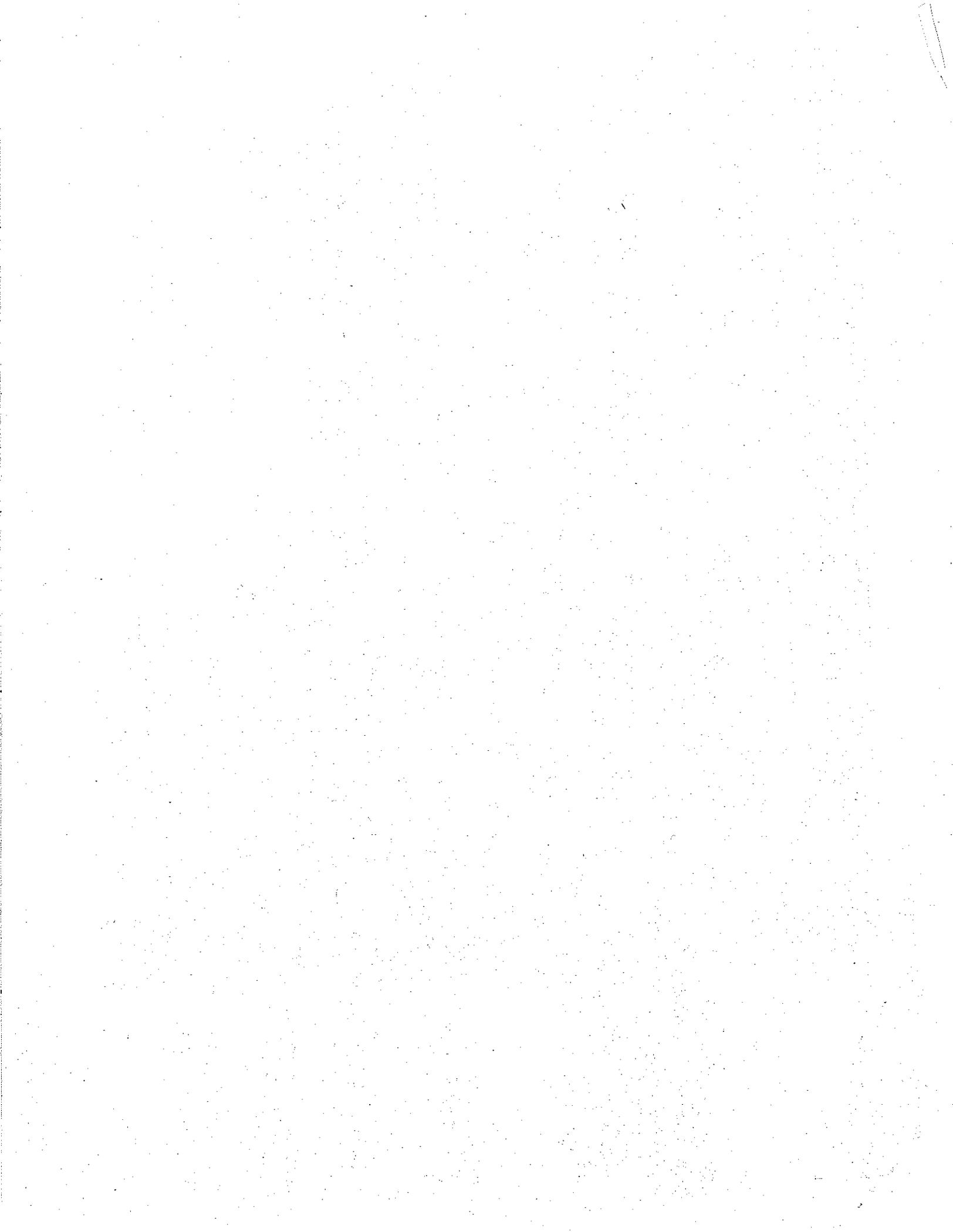
CLINICALLY MANAGED, MEDIUM-HIGH INTENSITY: Non-medical, simultaneous, integrated substance abuse and mental health residential treatment for persons with co-occurring primary chemical dependence AND primary major mental illness (schizophrenia, bi-polar, major depression, major psychosis); structured, supervised service includes addiction recovery counseling & activities, medication management and education, and psychosocial rehabilitation services; focus on mental functioning, not psychiatric care; staff include dually credentialed clinicians (CADAC/LMHP) and/or both LMHPs and CADACs; LoS varies but is usually not longer than 4-8 months.

Lv 2 Extended Residential

CLINICALLY MANAGED, MEDIUM-HIGH INTENSITY: Non-medical longer term, medium intensity residential service for chronic chemically dependent persons who are at a high risk for relapse and/or potential harm to self or others; clients have significant deficits in ability to perform activities of daily living and/or cognitive deficits; counseling is provided by CADACs or CPADACs under supervision; program is staff secure; LoS ranges from 8-24 months; service has capability to address mental health issues.

Lv 1 Short Term Residential

CLINICALLY MANAGED, HIGH INTENSITY: Non-medical residential community treatment for persons with a primary chemical dependency, an entrenched dependency pattern of usage and an inability to remain drug-free outside of a 24 hr care; highly structured, intensive, shorter term comprehensive addiction recovery service including individual, group counseling/therapy and relapse prevention; medication monitoring; service has the capacity to address mental health issues; counseling is provided by a CADAC or CPADAC under supervision; program is staff secure; LoS varies but is usually not longer than 14-30 days.



March 1, 2002

SUBSTANCE ABUSE SERVICES FOR JUVENILE JUSTICE CLIENTS

The terms listed are for use by all substance abuse providers and justice entities in referring justice system clients to substance abuse services provided in Nebraska.

LEVEL OF CARE (LOC): General category that includes several similar types of services.

Substance Abuse Services: The specific service name that more specifically identifies the type of actual substance abuse service a consumer will receive.
Children/Youth: Age 18 and below (note that Medicaid SA services apply for ages 21 and below).

NOTE: Not all of these services are available in Nebraska; some services may be available in some regions but not in others. This service array is intended to be a balanced array of substance abuse services that could meet various needs at different levels of severity.

LOC: EMERGENCY SERVICES (very short term, unscheduled service availability in time of crisis in a variety of settings)

Crisis Phone Line	Clinician on-call for early intervention/screening/referral; available 24/7.
Emergency SA Evaluation	SA evaluation needed on an urgent and unscheduled basis; a provider is available within 24 hours to do a complete evaluation; <i>all evaluations completed for justice clients must be completed by a certified alcohol and drug abuse counselor (CADAC), or a provisional CADAC (CPDAC) who is supervised by a CADAC, a licensed psychologist or a licensed physician with an addictions specialty; available in the EPC/Crisis Center service or at any state certified SA service provider. Evaluation Tool Required: Drug/Alcohol Section of the Comprehensive Adolescent Severity Inventory (CASI); Approved State Reporting Format: SA Evaluation results are required to be provided in a state approved format only.</i>
Mobile Crisis	A two member team that offers on-site screening usually in the home, brief interventions to stabilize the crisis, and referrals for SA Crisis Respite and through SA evaluation; available 24/7; includes access to a CADAC.
Emergency Crisis Stabilization	Supportive services therapy, brief SA assessment, and coordination of svcs to help a child and/or family to alleviate a crisis and facilitate involvement in ongoing services; services may be provided in a variety of settings (i.e. residential or non-residential, dependent on severity of crisis).
SA Emergency Shelter or SA Respite	Residential or home based service for a short term placement of a youth or child in a substance abuse crisis; program has capability to supervise alcohol/drug social setting detoxification (non-medical); length of stay varies by legal status, but emphasis is short term (less than 14 days); 24/7 availability of on-site clinically managed and monitored services; medically stable; limited nursing coverage.
Medical Detox	24-hr medically supervised alcohol/drug detoxification where severe medical issues are involved; 24/7; medical staff coverage.

LOC: ASSESSMENT SERVICES (screening or evaluation tools used to determine the level of a SA problem & make appropriate service referral; generally provided in a non-residential setting)

Screening	General preliminary screening by provider to identify a substance abuse problem and refer for a complete SA evaluation and early intervention or treatment; includes a screening for mental health and gambling issues. For justice referrals, the Simple Screening Instrument (SSI) that indicates the need for a further evaluation is completed by the criminal justice system and will be sent to the SA provider.
Pre-Treatment SA Evaluation	SA evaluation completed for justice clients PRIOR to admission in any treatment program; the evaluation must be completed by a certified alcohol and drug abuse counselor (CADAC), or a provisional CADAC (CPDAC) who is supervised by a CADAC, a licensed psychologist or a licensed physician with an addictions specialty; Evaluation Tool Required: Comprehensive Adolescent Severity Inventory (CASI); Approved State Reporting Format: SA Evaluation results are required to be provided in a state approved reporting format only.
SA Evaluation	SA evaluation for justice clients must be completed by a certified alcohol and drug abuse counselor (CADAC), or a provisional CADAC (CPDAC) who is supervised by a CADAC, a licensed psychologist or a licensed physician with an addictions specialty; available at any state approved SA service provider; Evaluation Tool Required: Comprehensive Adolescent Severity Inventory (CASI); Approved State Reporting Format: SA Evaluation results are required to be provided in a state approved reporting format only.

LOC: NON-RESIDENTIAL SERVICES (least intensive services based on clinical need offered in a variety of community settings; youth/child lives independently with family, guardian, relatives, or other).

NON-RESIDENTIAL SERVICES: A range of services for youth at risk of developing or who have substance abuse problems, specific functional deficits, problems with intoxication or withdrawal, but few biomedical complications. Youth may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment and thus is in need of interventions directed by CADACs or other non physician addiction specialists rather than medical or psychiatric personnel in a variety of non residential settings. Level 1 is the most intensive and Level 5 is the least intensive service level of care.

Lv 5	Prevention	Education and other activities designed to prevent using substances.
Lv 5	Intervention	Intervention counseling and education for persons experimenting or currently using substances but who are NOT dependent; staff supervised EDUCATION programs are very structured with a specific outcome for the client; LoS varies (i.e., minimally one staff supervised 6 or 8 hr class; other options might include eight one-hour sessions, 3-4 four-hour sessions, or other); includes support group or self help referrals.
Lv 5	Case Monitoring SA/MSH	Monitoring service designed for youth eligible under the definition for Community Support Substance Abuse, who have made significant progress in recovery and stable community living, or for those youth unwilling to accept the more intensive and rehabilitative functions as identified in the youth's monitoring plan (i.e., services, appointments, reminders), crisis/relapse intervention/prevention as needed, provides oversight and follow-up functions as needed; contact with youth as needed.
Lv 4	Outpatient Counseling	Individual and/or group counseling/therapy by a CADAC or CPADAC under supervision for a variety of substance use disorders which disrupt a client's life; treatment focus is on permanent change of behaviors and modifying thought patterns, coping with problems, improving functioning, and other services to achieve successful outcomes and prevent relapse. LoS varies depending on individual illness and response to treatment (i.e., may average 10-12 sessions at 1-4 hrs per week but treatment frequencies and duration will vary); includes brief therapy model (3-5 sessions); group therapy sessions include approx 3-8 persons; family counseling is included.
Lv 3	Community Support	Support for a children and youth with chemical dependency, habitual use/abuse, and functional deficits; 1:1 staff to client support in school, residence or other non-office location to ensure child's focus on rehabilitating his/her social and relationship skills; aiding the child in using appropriate coping skills; child, guardian, and family relationship building; relapse and recovery mgmt and skill teaching; provides client advocacy; assistance with schooling, housing, accessing transportation, and a variety of other case management activities; ensure attendance at medical appointments or SA non-residential treatment services; coordination of a care/case plan and services; 24/7 on call availability of community support worker; often provided concurrently with another SA non-residential service.
Lv 2	Intensive Outpatient Counseling	Intensive group and individual therapy and counseling for persons with substance abuse disorders or chemical dependence; provide essential education and treatment counseling components while allowing clients to apply new skills within real world environments; counseling provided by a CADAC or CPADAC under supervision; offered in day or evening, before or after work or school; more intensive than Outpatient Therapy and less intensive than partial care; service includes a combination of group sessions 3-5 times/week plus individual sessions 1-3 hrs/week; total services to the client average 10-15 hours per week; hours per week are tapered to a prescribed schedule or client need as the client transitions to the less intensive Outpatient Therapy or other service; LoS varies with individual response to treatment but the intensity of the service averages 5-6 weeks in duration.
Lv 1	Partial Care	Very intensive day treatment program by CADAC or CPADAC under supervision for clients with substance abuse disorders or chemical dependence problems; medical backup; includes individual and group counseling, medication monitoring services; services may occur during school hours, but education must be available through other resources; client needs are of higher intensity need than Intensive Outpatient; services are provided 5 days per week at 6-10 hours daily including minimum of 4 hrs daily of primary SA treatment; LoS varies but averages 5-6 weeks; highest intensity, non-residential service.

LOC: RESIDENTIAL SERVICES (treatment services provided in a 24 hr community based residential setting)

CLINICALLY MANAGED RESIDENTIAL SERVICES: An array of residential services for youth who need a safe living environment to develop recovery skills; have specific functional deficits; minimal problems with intoxication or withdrawal and few biomedical complications; youth may have significant deficits in the areas of readiness to change, relapse, continued use or continued problem potential or recovery environment and thus is in need of interventions directed by CADACs or other non physician addiction specialists rather than medical or psychiatric personnel. Level 1 is the most intensive and Level 3 is the least intensive service level of care.

Lv 3	Halfway House or SA Group Home	CLINICALLY MANAGED, LOW INTENSITY: Non-medical transitional residential program of substance abuse treatment for youth who are transitioning from more intensive treatment to family/independent living; structured living environment and semi-structured activities designed to develop/support recovery living and relapse prevention skills; maintaining the skills necessary for a life free from substance abuse outside of residential treatment; service has ability to arrange for services or support/coordinate access to school, work, concurrent emotional/behavioral/other treatment activities; staffing plan must include relapse prevention planning (crisis); LoS varies but averages 3 - 6 months.
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March 1, 2002

Lv Therapeutic Community
2 for SA Therapeutic
Group Home

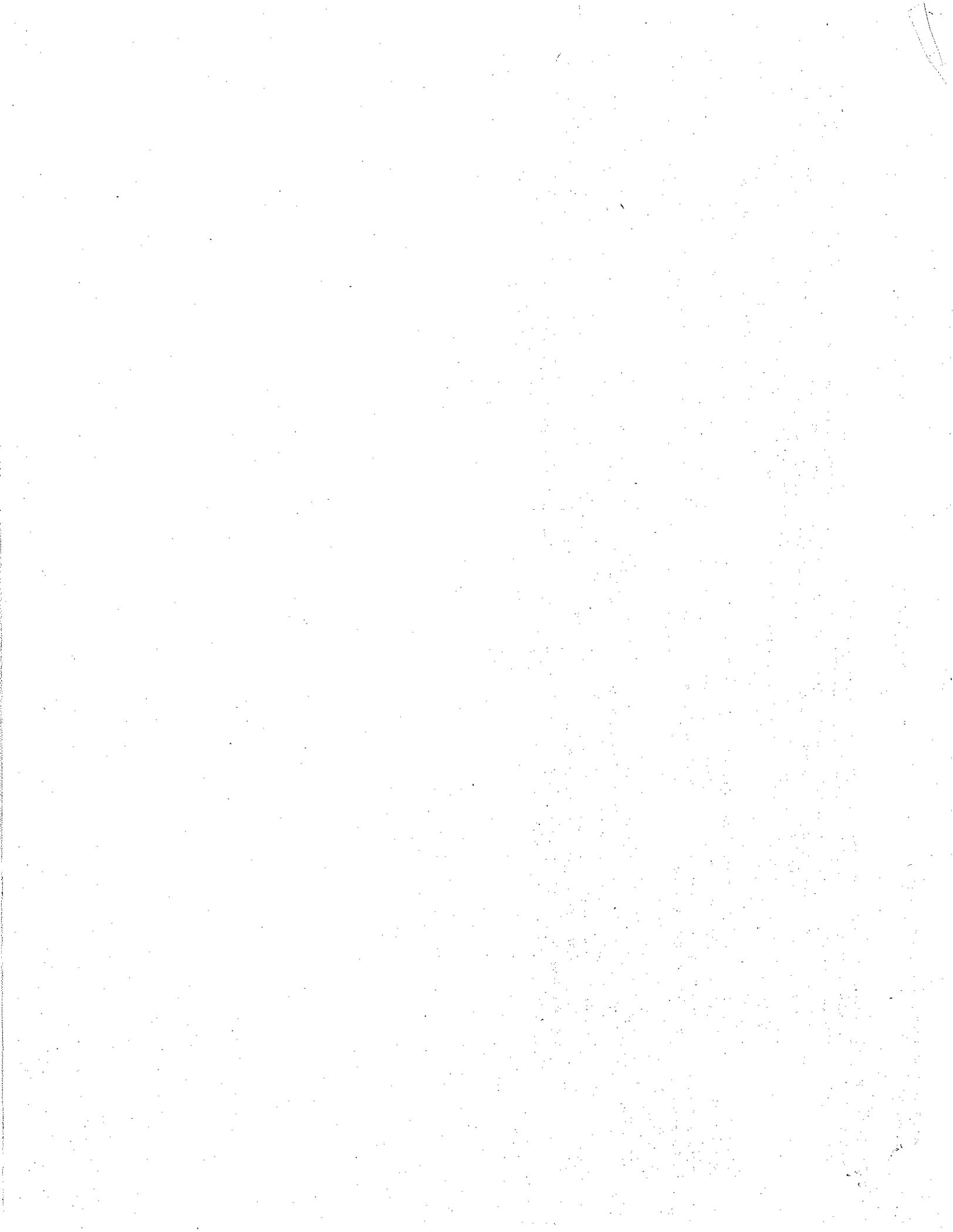
CLINICALLY MANAGED, MEDIUM INTENSITY: Non-medical residential program of substance abuse treatment for youth with chronic substance use, repeated relapse &/or resistance to treatment whose substance use recovery efforts are effected by emotional, behavioral or cognitive problems; 24 hour structured therapy to promote sustained focus on recovery tasks; program relies on a treatment community or milieu as the agent of change for acquiring recovery and basic life skills; skills are built through a longer term, highly structured set of peer oriented activities; services include individual & group counseling/therapy, relapse prevention (crisis), education, vocational & skill building; treatment goals include motivation to change, anger management, conflict resolution, values clarification & limit setting; program facilitates integration into the community; treatment services are directed by CADACs/addiction specialists and access to medical/other consultation; program is staff secure & has ability to arrange for services or support/coordinate access to school, work; LoS varies from 6 - 18 months. TC or SA-TGH programs specialize in serving youth in the justice system, many with conduct or personality disorders.

Lv SA Extended
2 Residential or
SA Residential
Treatment Center

CLINICALLY MANAGED, MEDIUM-HIGH INTENSITY: Non-medical longer term, medium intensity residential service for adolescents who are chemically dependent and who are at high risk for relapse &/or potential harm to self or others; clients have significant deficits in ability to perform activities of daily living &/or cognitive deficits; skills training emphasizes impulsive behavior change & other behavior deficits; service may be combined for chemically dependent youth transitioning from Short Term Res who need longer term structured treatment; LoS ranges from 4 - 24 months; service has capability to address mental health issues; staffing includes CADACs; program is staff secure.

Lv Short Term Residential
1

CLINICALLY MANAGED, HIGH INTENSITY: Enhanced non-medical residential program of primary substance abuse treatment for youth with an entrenched dependency pattern of usage and an inability to remain drug free outside of a 24 hour care; highly structured, intensive, shorter term comprehensive addiction recovery service including group counseling/therapy and relapse prevention; that is of shorter duration but at a higher intensity level; access to medical evaluation and consultation available 24/7; significant emphasis is on readiness to change and treatment engagement; experience induces the adolescent into a peer group; promote coordination of the multiple systems surrounding the youth and implement strategies for ongoing engagement in treatment; physician monitoring and nursing care observation available as needed; addiction treatment by CADACs; interdisciplinary staff including LMHP, psychologists as needed; administer/monitor medications; program is staff secure. LoS varies but averages 30 - 45 days.



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