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Group Versus Individual Therapy in Adolescent Substance Abuse Treatment: Finding Interventions that Work

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Abstract

This study explored the effectiveness of individual therapy versus group therapy in the treatment of adolescents in an outpatient substance abuse treatment clinic. Chart review was used to collect information from adolescent male and female clients. Independent samples t-tests, chi-square analyses, and ANOVA tests were used to determine the relationship between interventions and success in treatment. Clients receiving individual therapy only in both The Seven Challenges program and the eclectic counseling category had greater decreases in substance use and had more successful discharges in fewer overall treatment sessions. There is need for further research with a larger sample size to confirm the findings.

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Past addiction treatment research has focused mainly on interventions and outcomes with the adult population. Research has been limited regarding the important differences between adolescent and adult addiction treatment interventions and outcomes. Adolescents have unique social and developmental needs that need to be considered yet counselors often use treatment modalities and interventions with their adolescent clients that have been proven helpful and economical for the adult population. It has been shown that successful interventions for the adult population may not provide successful client outcomes with adolescents (Burleson, Kaminer, & Dennis, 2006).

Adolescent substance abuse is a widespread issue that not only impacts the individual but can also have devastating effects on family, friends, and the community. Genetic, environmental, and social influences all are factors that can lead to the development of substance abuse or dependence. Due to the breadth of contributing factors, a holistic intervention is necessary for successful treatment outcomes with teens (Winters et al., 2011). The chapter one literature review will cover a brief history of addiction treatment, the trends and barriers that are currently occurring in the field, and will focus on the effectiveness of group treatment, family treatment, and individual treatment with the adolescent population. The research is mixed but suggests that group treatment is effective and widely used (Tanner-smith, Wilson, & Lipsey, 2012). Family therapy was identified by the literature as very effective, but barriers to implementation seem to be under reported (Bertrand et al., 2013). The study will address eclectic

counseling interventions versus evidence based practices (EBP's) that have been shown to be effective with adolescents.

This research study compared individual counseling with teens versus individual counseling combined with group therapy. Adolescent addiction treatment has low success rates (Becker & Curry, 2008; Najavitis, 2002). This may be related to the rush to abstinence that seems to be forced by insurance agencies and family members (National Institute on Drug Abuse [NIDA], 2012; Schwebel, 2002). If this study is able to prove that better treatment outcomes occur with more individualized treatment, it may result in an incentive to work on individualizing services for adolescents. The Seven Challenges program will also be evaluated. Success in treatment will be measured by change in use over time and by a successful discharge from the outpatient treatment program.

In chapter two the program and participants studied will be described to gain a better understanding of the population. The chart review and data collection will be discussed. In chapter three the results will be presented using independent samples t-tests, chi-square analysis, and ANOVA tests. In chapter four, discussion will be on individual therapy as more effective than group therapy as the primary treatment modality in adolescent addiction treatment. The study will evaluate the hypotheses:

1. Individual therapy only interventions with adolescents will result in greater treatment satisfaction, decreased recidivism, greater decreases in substance use, and increased success rates in treatment, compared to when group treatment is used in addition to individual therapy.
2. Utilizing The Seven Challenges program in both individual and group combined with individual therapy will result in greater treatment satisfaction, decreased

recidivism, greater decreases in substance use, and increased success rates in treatment, compared to when group treatment is used in addition to an eclectic counseling intervention.

Literature Review

The purpose of this section is to further examine the literature regarding treatment interventions for adolescents. To gain a better understanding of current treatment models for adolescents the literature review will begin by focusing on the history of addiction treatment. Trends and barriers in current evidence based practices for outpatient adolescent treatment will then be reviewed. The effectiveness of individual, family and group treatment interventions will be discussed. Treatment interventions will be separated by evidence based practices. Finally, additional factors that have been found in the literature to impact treatment outcome will be explored.

Trends and Barriers in Addiction Treatment

Addiction treatment as it is provided today was basically non-existent in the past. Addiction was viewed as a moral flaw in a person, which led to "treating" the individual through imprisonment, sentencing to asylums, and through church-guided prayer. The current stance on addiction as a brain disease has been proven by significant long-term changes in the brain as a result of drug use and is the foundation for the evidence-based treatments of today (Genetic Science Learning Center, 2012).

The community self-help group Alcoholics Anonymous (A.A.) was one group that helped to inadvertently spread and popularize the view of addiction as a disease. Founded by Bill W. and Dr. Bob S., A.A. began in 1935. By the 1950's there was a ten percent success rate (measured by abstinence). This was better than any other organized

approach at the time. A.A. is not identified as a treatment program, but rather as a group of individuals working toward a similar goal who are not funded by any outside organization or institution. Since the 1970's, treatment programs have used the philosophy of A.A., relying on peer support and the use of primarily group therapy in treatment (General Service Organization, 2013; White, 1998). The voluntary nature of A.A. shows the individual's motivation to make a change, which is often not the case in addiction treatment with adults and even more so with adolescents'.

Alcohol and drug addiction is a growing public health concern and treatment tends to be funded by the local, state and federal governments. Due to high demand and limited resources available, managed care has decreased the total treatment sessions available and is looking for the most cost effective treatments available (National Institute on Drug Abuse [NIDA], 2012). Short-term outpatient group therapy has become popular because it provides quality care while costing less than individual treatment. Although this may be cost effective, it may not be so effective or successful for the adolescent population.

Adolescents in treatment for substance abuse have unique concerns that need to be addressed. In one study, it was found that approximately forty-seven percent of adolescents in substance abuse treatment have a diagnosis of conduct disorder (Brown, & Gleghorn, 1996). Adolescents have more rapid progression from first use to abuse or dependence, and more co-occurring psychiatric problems than their adult counterparts (Becker & Curry, 2008). They are also at higher risk for accidents, suicide, and violent crimes. They have more difficulty with controlling impulses, seeking instant gratification, and planning to prevent future consequences due to incomplete

development of the orbitofrontal cortex. Incomplete brain development combined with fewer health complications due to their age frequently results in feelings of invincibility (Galvan et al., 2007). The abovementioned factors are involved with less willingness to engage in substance abuse treatment (Stein, Deberard, & Homan, 2012; Radcliffe & Stevens, 2008).

Adolescents have higher treatment dropout rates yet there has been limited study in effective treatment methods specifically for adolescents (Becker & Curry, 2008). Until the 1980's, despite being developmentally inappropriate, adolescents were treated in adult programming (Winters et al., 2011). It may be difficult to provide effective treatment in groups that consist primarily of clients diagnosed with co-occurring conduct disorder. Adolescent boys with conduct disorder also may have difficulty identifying and responding to social cues and will frequently respond with aggression to solve social problems (Burleson et al., 2006). The high prevalence of conduct disorder in addition to the aforementioned unique traits of adolescents in substance abuse treatment present a need for research in this area.

Treatment Interventions

Group therapy has been the most common substance use treatment intervention for both adults and adolescents (Burleson et al., 2006). However, the developmental needs of adolescents can present challenges in the group environment.

Group therapy. The majority of research that has been done with adolescent addiction treatment has been focused on CBT group therapy (Winters et al., 2011). Group has been shown in some research to be effective in adolescent addiction treatment. With adolescence being a time of psychosocial vulnerability the research suggests that

group treatment could potentially be a place for youth to learn cooperation and deal with issues such as envy and anger with their peers. Teens are more easily influenced than adults in the group setting. The research has been conflicted regarding if the peer influence will have a more positive or negative impact on adolescents. Some research suggests that group provides an area for healthy social learning to occur, including the development of socializing techniques, role modeling, rehearsing as well as giving and receiving feedback. Group has the benefit of creating an environment that may be similar to daily social situations, which has been shown to be helpful with relapse prevention (Waldron & Kaminer, 2004). Group however also has the potential to be a place where "deviancy training" can occur (Wood, 2009; Burleson et al., 2006). There is higher potential for iatrogenic effects in group treatment with adolescents' compared to adults since adolescent peers may have greater ability to potentially reinforce drug use (NIDA, 2012). Group selection therefore is a key part in a successful group (Wood, 2009).

The stigma of addiction, vulnerability, fear and suspicion often keep adolescents resistant to attendance of group at first. While group treatment is one of the most common interventions with adolescents, it has been found that poorly run groups can be harmful to clients. Some research suggests that increased structure in groups may be needed with teens to prevent aggressive responses as an attempt to problem solve (Burleson et al., 2006). Other research models suggest that if a trusting and safe environment is established, defenses of the clients will lower and work to occur (Smith et al., 2006).

Studies on two evidence based practices that use group as the primary intervention will be explored to look at what has been demonstrated to work with the

adolescent population, and the positive aspects of group seen in the research. The Seven Challenges and Cognitive behavioral therapy (CBT) are two evidence based practices that will be discussed.

Group CBT. CBT works to help adolescents' self-regulate emotions and behaviors by changing thought patterns even when external situations do not change. This treatment modality works to identify stimulus cues that lead to drug use in an effort to prevent future triggers to use (Winters et al., 2011). The main assumption of group CBT is that behavior is learned and engaged in as part of a context (Waldron & Kaminer, 2004; Winters et al., 2011). To be able to change self-destructive behaviors and thoughts distorted core beliefs need to be confronted by the group and reconstructed. The research is mixed in regards to the effectiveness of group CBT with adolescents. Studies are split as to whether there are statistically significant changes with group CBT. However, all studies do show some improvement while participating in group CBT (Burleson et al., 2006; Tanner-smith et al., 2012; Waldron & Kaminer, 2004). CBT has been tested in very structured environments and often involves very structured interventions that try to fit the client to a manual program. Participants in CBT programs have been shown to make greater improvements than individuals with no treatment. Individuals who received mixed counseling services including eclectic interventions had the most significant treatment results in one study (Tanner-smith et al., 2012).

Motivation in treatment may be one factor influencing success rates. Adolescents in addiction treatment are typically motivated by the courts, or their parents rather than by an internal desire to change. By teaching CBT skills counselors assume that clients are in the action or maintenance stages of change. Often adolescents who come to

substance abuse treatment are in the pre-contemplation stage, where they do not believe their use is problematic (Schwebel, 2002). Other youth may be in the contemplation stage where they are beginning to weigh the pros and cons but have not yet decided what they will do (DiClemente, Debra Schlundt, & Gemmell, 2003). This means that finding motivation to make changes is a vital piece of making changes while in treatment (Diamond et al., 2002). After problem areas are identified, CBT can help clients to gain coping skills to assist in changing behavior (Waldron & Kaminer, 2004). Until the client has decided to change and is motivated internally the skills learned with CBT may not be utilized by the youth. Focusing only on solutions to be abstinent can result in increased defiance or "faking it" rather than having clients utilize the CBT skills learned in their daily life (Schwebel, 2002).

Family therapy. Family therapy interventions have been shown to be effective with the adolescent population. In one meta-analysis, family therapy interventions were more effective than group and individual interventions alone (Tanner-smith et al., 2012). A strong parent-child relationship is a protective factor that can help in a youth's recovery. Increased parent involvement in family sessions has indicated greater treatment impact (Bertrand et al., 2013).

Brief Strategic family therapy (BSFT) works with individual families and is based on family systems theory which assumes that behaviors of family members' are interdependent and need to be looked at and changed as a system (NIDA, 2012). Teens who have family therapy as a part of their treatment were three and a half times more likely to make changes in their use, compared to individuals receiving only group therapy. They also had greater reductions in use than clients who have only individual

CBT (NIDA, 2003; Liddle et al., 2008). BSFT treatment works to change interaction patterns within a family and as a result, with the identified client (NIDA, 2003). This model is adaptable to many different families, treatment settings, and treatment modalities. Including family system approaches to therapy helps the entire family, which may mean more long-term outcomes for the youth. The more long-term success is a result of better family communication, coping skills, emotion regulation, problem solving skills, and social support. For the parents this intervention helps in limit setting, communication, parental involvement, and improving emotional regulation skills. Family systems therapy can help in relapse prevention for teens by decreasing overall family conflict, improving emotional attachments, communication, and problem solving skills (Liddle et al., 2008). The structure that is put in place during treatment has a more long lasting impact than individual or group therapy alone (Sherman, 2010).

The Seven Challenges. The Seven Challenges program recognizes that there needs to be a different approach to work on meeting the client where they are at. The Seven Challenges is developmentally appropriate and works to help adolescent clients continue in the task of forming their own identity. Developmentally appropriate interventions would help the adolescent to figure out how they feel about their use through dialogue and interaction rather than rushing to get the adolescent clean by only teaching them skills and discussing only the harm of use. Many youth enter treatment identifying themselves with their use, telling them what to do in regards to the thing that defines them it may actually reinforce continued use (Schwebel, 2002). Strength based approaches including The Seven Challenges help clients to reframe the problem behaviors and find positive characteristics about themselves. Strength based approaches

have been shown to decrease internalized and externalized problem behaviors by focusing on what they are able to do versus what they are not able to do (Harris et al., 2012; Smith et al., 2006). Focusing on strengths rather than problems may help youth to learn more aspects of who they are and work toward continued formation of their identity.

The program challenges clients to make thoughtful decisions through working on The Seven Challenges, which are as follows:

1. We decided to open up and talk honestly about our-selves and about alcohol and other drugs.
2. We looked at what we liked about alcohol and other drugs and why we were using them.
3. We looked at our use of alcohol and other drugs to see if it has caused harm or could cause harm.
4. We looked at our responsibility as well as the responsibility of others for our problems.
5. We thought about where we seemed to be headed, where we wanted to go, and what we wanted to accomplish.
6. We made thoughtful decisions about our lives and about our use of alcohol and other drugs.
7. We followed through on our decisions about our lives and our drug use. If we saw problems we went back to earlier challenges and mastered them.

The Seven Challenges allow clients to work through a decision making process and helps to empower clients, helps them to become more aware of the harm they are engaging in without increasing their defensiveness, it is validating, and person centered. While this is a flexible model, there are certain areas and quality indicators, which need to be followed in order to maintain fidelity to the model. Coping skills training, life skills training, reading time in sessions, journaling time in sessions, relapse prevention, integrating trauma recovery, family sessions (when possible), and sexual issues must be covered in The Seven Challenges program while using motivational interviewing concepts, decision making exercises, skills training and interactive journaling (Schwebel, 1995). Family work is integrated into The Seven Challenges and helps the client and family to work on challenge four, which states: "we looked at our responsibility as well as the responsibility of others for our problems". The program works to build relationships not only with the therapist or group members, but also with family members for more lasting treatment success (Schwebel, 2002). Individuals and families have unique needs and may need flexible interventions. Family therapy has been shown to positively impacts outcomes for youth but there are situations where family is not able to attend sessions due to transportation, scheduling, or their own resistance to treatment.

Group is recommended for clients whom are appropriate. Group rules are implemented to ensure safety in groups and to allow clients to feel comfortable doing work in group (Schwebel, 1995). One study implemented two-hour weekly Seven Challenges group sessions and one-hour bi-weekly Seven Challenges individual sessions and found significant changes in substance use (Smith et al., 2006).

Individual therapy. Individual therapy is not the primary intervention in many agencies due to low staff resources and high treatment need (Engle & MacGowan, 2009). Group interventions are more cost efficient than using individual therapy as the primary intervention. Cognitive behavioral therapy (CBT), and The Seven Challenges, have both been shown to be effective in individual therapy as well as in group (Waldron & Kaminer, 2004; Smith et al., 2006; Diamond et al., 2002). More agencies choose to use group rather than individual as their primary treatment intervention. In order to meet the need of each individual, it may be more beneficial to have a client in individual therapy only if family members cannot attend sessions, and if they do not fit a group due to high risk for iatrogenic effects (Burleson et al., 2006).

Barriers to Implementation of Evidence Based Practices (EBP)

The majority of interventions in the research are done in controlled settings, while the majority of treatment is done in community settings with fewer controls including individual counselor differences and less fidelity to the model. In real world settings, efficacy is greatly reduced (Chassin et al., 2009; Donovan et al., 2002). In one study, only two percent of community counselors studied could be classified as “purists” to the model they were trying to replicate (Taxman & Bouffard, 2003). The Seven Challenges program became and EBP after implementation was proven to be effective in community settings, unlike most studies that are done primarily in research settings. It is designed to be flexible for the agency implementing the program. This Seven Challenges program could be a possible solution to the decreased success found with applying theory in community settings.

Additional factors in treatment effectiveness. No two counselors will have the exact same interactions and interventions with clients. Individual differences in counselor approaches of EBP's have been shown to have an impact on treatment effectiveness. Counselors who have person centered approaches and who build positive relationships with the adolescent have been shown to be more effective (Taxman & Bouffard, 2003). Additionally, a mix of interpersonal connectedness (feeling safe in treatment), perceived relevance of treatment (if it is found to be helpful), feeling comfortable or ready for treatment, and practical obstacles such as having transportation and financial resources were found to be additional factors in client outcomes (Mensinger et al., 2006).

The final external variable in treatment outcome that will be discussed is community involvement in Alcoholics anonymous (AA), narcotics anonymous (NA), or family involvement in Al-anon. AA has been shown to be a highly effective relapse prevention tool in combination with treatment in the adult population and adolescent population when there is motivation to make changes. It is a community resource that can be utilized by all ages however with only two percent of AA members are under the age of 21. Teens are much less likely to access traditional self-help in their community. Young people who went to meetings with at least some other young people were more likely to attend, became more involved, and had better post-treatment outcomes than clients with no AA or NA involvement (A.A. World Service Inc., 2012; Kelly, Dow, Yeterian, & Kahler, 2010; Passetti & Godley, 2008). One predictor of increased involvement of AA or NA was having parents with favorable views of 12-step programs (Kelly et al., 2010). Al-anon is a program that helps family members to accept

powerlessness over the addiction and assists family members not enable by detaching with love. Parental involvement in al-anon can help a client to engage in treatment and help change the family system by not enabling behaviors of the substance abuser. Change within the family system may increase the adolescents motivation to make a change (Roozen, Waart, & van der Kroft, 2010). With so many barriers to change and such high risk factors for this population there is a high need for interventions that are able to engage and maintain adolescents in treatment.

Gaps in the research. More research needs to be done on treatment factors and interventions that influence positive outcomes, such as clients staying in treatment and maintaining the gains made in treatment. There is a very high treatment drop out rate with adolescents and juvenile offenders. Due to the majority of information about adolescent addiction treatment being done in research settings, little is known about the effects of real world treatment with juvenile offenders (Chassin et al., 2009). Treatment drop out while in drug court has been suggested to be associated with a failure to form a strong therapeutic alliance, unsupportive parental attitudes, family distress and the belief that therapy is not needed. These factors may be related to the high recidivism rate of 30%-65% (Stein, Deberard, & Homan, 2012).

Looking into specific treatment interventions could help in understanding more effective treatment modalities. Rigidity to one specific intervention such as using CBT interventions only does not seem to be working in community settings. It is also not effective to use anything and everything in practice without paying attention to evidence based programs. Guidelines are needed to assist in treatment while not having excessive constraints in implementation of a model.

Summary of Literature

In the past, treatment agencies and drug courts have tried to implement the same treatments for adults and adolescents. They have tried to make adolescents quit using drugs and have found the adult treatment interventions were not developmentally appropriate (Schwabel, 2002). The trend over the past sixty years has been to work on individualizing the treatment of clients to meet their unique needs. The push for cost effectiveness by insurance companies and funders may be negatively impacting the treatment outcomes with adolescents. The research suggests that group treatment is an effective treatment for the adolescent population and can meet developmental needs, however also presents with developmental challenges. The majority of research focuses on lab based studies rather than community based studies. Family therapy consistently seems to benefit client outcomes in the research, however the research does not discuss the potential logistical barriers to implementation such as getting parents to sessions, parent resistance to treatment, and cost barriers for treatment agencies. Finally, individual therapy has been shown to have positive outcomes, but the research is limited. This is an area that needs further study in outcomes.

Regardless of intervention, person centered approaches to treatment overall had positive outcomes in the research. The idea of having a flexible person centered approach that works to meet the needs of each individual client and family is different from many treatment programs that seem to focus on meeting the needs of the agency rather than the client. Further research is needed on how flexibility impacts treatment results, such as modifying the mode of treatment (individual, family, group) to match the needs of the individual. These findings may help address engagement and retention

issues in treatment. With a 30-65 % recidivism and drop out rate, this is an area to explore further (Stein et al., 2012).

The research suggests a systems approach that focuses on the person's needs through a combination of family, group, individual therapy, and community support has been found to address the diverse needs of adolescents who abuse substances and assists in maintaining progress during and after treatment

Method

The method section will discuss the participants, research design, instrumentation and materials used in the study, the procedure of the study, and data analysis.

Participants

The clinic studied provides therapy to primarily adolescents in a non-secure residential setting. There was a larger sample of males (n = 32) than females (n = 16). A total of 93.75 percent (n = 45) of the clients studied (N = 48) were in residential placement during treatment. In terms of race, 43.75 percent (n = 21) were White, 27.08 percent (n = 13) were Black, 14.58 percent (n = 7) were Black and White mixed race, 8.33 percent (n = 4) were Hispanic, and 6.25 percent (n = 3) were Black and Hispanic mixed race.

A total of 66.67 percent (n = 32) of the clients in the study were currently involved with PINS (People In Need of Services) and/ or probation. Due to the high percentage of clients in residential placement, 95.83 percent (n = 46) of clients were also receiving other services for behavioral and mental health needs. Most clients in the study had external pressures to stop using drugs, such as court, probation, or residential placement. Clients in residential care are in a more restrictive setting, yet still have

access to use in the community while on home visitation or if they leave the non-secure facility, with or without consent.

Research Design

The independent variable in this study was treatment intervention and the dependent variables were success in treatment measured by change in use over time and treatment outcome, drop out from treatment, satisfaction score and time in treatment. The four treatment interventions included: eclectic individual only, eclectic group and individual, individual Seven Challenges, and individual and group Seven Challenges. The study included both nominal and scale variables. Nominal variables included: gender, race, successful or unsuccessful discharge from treatment, treatment intervention utilized, dropout from treatment, and legal involvement. Scale variables included: age, use at intake, use at 6 weeks, use at discharge, change in use over time, satisfaction score, number of days in treatment, and number of sessions.

This was a quantitative study utilizing independent samples t-tests, chi-square analysis, and ANOVA. The study was conducted solely through chart review. The sample was not randomized due to the data coming from a review of available client charts. At the time of admission to the clinic clients were administered a pre-admission assessment and gave a self-report of drug use. Following admission, client use was recorded at six weeks and at discharge. At discharge the client was asked to complete a satisfaction survey.

Instrumentation and Materials

The instruments used to measure client outcomes were all previously documented in the client charts. Client outcomes were evaluated through drug use self-report, urine

screen and the OASAS (Office of Alcohol and Substance Abuse Services) admission and discharge forms. Client satisfaction was measured using the clinics client satisfaction survey (see appendix A for client satisfaction survey).

Self-report and urine screens.

Urine screens were utilized in this program as "clinically determined," and not in every case, based on the belief that providing regular urine screens creates an environment that looks like the therapist is trying to "catch" the client using. History at this clinic showed clients tampering with the urine screen to provide a sample of urine that is not representative of their drug use. The researcher determined a more accurate picture of use could be gained through client self-report documented in the client chart. There seems to be no completely objective way to show drug use over time. Urine screens were utilized when available in the chart to compare self-report with urine screen results.

OASAS admission and discharge reports.

The OASAS forms collect patient information, including a record of drug use when treatment starts and ends (see appendix B for OASAS admission form and appendix C for OASAS discharge form). The OASAS forms indicated five use options: "no use in 30 days", "use 1-3 times per month", "use 1-2 times per week", " use 3-6 times per week" or "daily use." The client's top three drugs of choice are indicated on the intake form and again on the discharge form. Demographic information including age, race, and number of treatment sessions was documented on the admission and discharge forms. Client use was then documented in a spreadsheet indicated in table 1:

Table 1: Documented Client Report of Drug Use

Client Report	Documented as:
"No use in over 30 days"	0
"1-3 times in the past month"	.5
"1-2 times per week"	1.5
"3-6 times per week"	4.5
"Daily"	7
"Multiple times daily"	14
"Daily use of marijuana" and "alcohol use 1-2 times per week"	8.5

The information on the admission form was gathered by the therapist in the pre-admission assessment and documented after admission into the program. The discharge form indicates that a patient is no longer active in the treatment program. The information documented on the form can be used to gauge the success of the client's treatment by comparing the information collected at admission with the information that was collected at discharge.

Comprehensive evaluation.

The comprehensive evaluation was completed at six weeks by the primary therapist utilizing a self-report from the client to document any changes in use pattern during treatment and last use dates. The therapists have three sessions at the beginning of treatment to complete the pre-assessment with the initial drug use history. The therapist has 90 days after admission to the program to complete the comprehensive evaluation.

The comprehensive evaluation gives a use update and the client has an opportunity to be honest about one's drug use history. Any changes in initial report are noted. The drug use history update was the only section of the comprehensive evaluation that was utilized in the study due to the goal of measuring change in drug use over time (see appendix D for drug use history form).

Client satisfaction survey.

A client satisfaction survey was utilized in this outpatient agency to aid in program evaluation. The survey asked seven questions about the client's overall treatment experience. The survey utilized a Likert type scale with 34 points as the highest possible total. The first six questions were out of four total points with 0 = "*Very dissatisfied*", and 4 = "*Very satisfied*". The seventh question asked about likelihood of recommending the outpatient program to a friend in need and was scored out of a possible 10 points. The researcher calculated each satisfaction score by getting the sum of all responses and dividing by 34 to create a total satisfaction score where a score of 34 would equal 1 and means a client was 100 percent satisfied, a score of 17 on the satisfaction survey would equal .5 meaning the client was 50 percent satisfied, and so on.

Procedure

The researcher reviewed charts from two outpatient therapists who were currently employed by the clinic at the time of the study. Participants selected for review were clients in the clinic between January 2013 and October 2013. All records reviewed were kept in a double locked facility with the main doors locked and the file cabinets locked with a separate key to protect client confidentiality. All client information was de-identified through using a database (DB) number and recorded on a client information

sheet. Documents utilized for each client information sheet were: urine screen results, self report of drug use found in the comprehensive evaluation and pre-admission assessment (see appendix E for pre-admission assessment), OASAS admission and discharge forms, and client satisfaction surveys.

Clients were randomly assigned to work with one of the two therapists beginning with the pre-admission assessment. Therapists administered a pre-assessment to their respective clients before admission to the outpatient program. The pre-assessment and the LOCATOR, an instrument to determine level of care, were used to determine the level of care to meet the clients' needs. After the LOCATOR determined a client to be appropriate for outpatient services, the pre-assessment was brought to the multidisciplinary treatment team to determine the appropriate treatment intensity.

Treatment intensity varied from 30 to 90 minutes per week. Depending on the level of care needed for the individual, determined by the multi-disciplinary treatment team, clients were either seen for individual therapy only, or individual therapy and group therapy. There was no "group therapy only" category in this clinic.

Treatments used were broken into two main categories: eclectic therapy interventions and the evidence based practice, The Seven Challenges. Clients who were admitted into the outpatient program before July 2013 received the "eclectic therapy" intervention, and clients admitted into the outpatient program between August 2013 and October 2013 received "The Seven Challenges" intervention. In the eclectic counseling category the mode of treatment varied between individual therapy only, or individual therapy combined with group therapy. The eclectic therapy, individual therapy only and the eclectic therapy individual and group therapy included a mix of the following

interventions: cognitive behavioral therapy, motivational interviewing, narrative approaches, person-centered approaches, and psychoeducation. None of the interventions for the "eclectic therapy" treatment category followed a treatment manual and cannot be identified as an evidence-based practice.

The Seven Challenges program was implemented by the agency in July 2013 for newly admitted clients. Based on limited time available in the study, limited client cases in The Seven Challenges program were reviewed and none followed through on their entire course of treatment. In The Seven Challenges intervention the mode of treatments varied between individual therapy only, and individual therapy combined with group therapy. The Seven Challenges intervention followed fidelity to the model, utilizing The Seven Challenges manual, The Seven Challenges journals, and The Seven Challenges reader. The counselors implementing The Seven Challenges program received sufficient training for implementation of the program according to the founders of The Seven Challenges. Weekly supervision, fidelity checklists, monthly conference calls with OASAS, and monthly live supervision with a Seven Challenges leader trained to provide clinical supervision for the program, were utilized to ensure fidelity to the model.

Clients who were selected to be in The Seven Challenges and the eclectic group counseling were both willing and able to participate in the group setting. Client refusals and appropriateness for group treatment seemed to limit the number of clients in group treatment. Some factors that prevented group participation were: schedule conflicts, transportation conflicts, clients evaluated to be a danger to other group members based on previous violent conflict with others in the group, and client refusal to attend group. Due

to the factors limiting group participation, this category had fewer participants than the "individual therapy only" mode of treatment.

Data Analysis

The impact of treatment methods were compared for overall change in drug use, represented by positive numbers for increase drug use and negative numbers for decreased drug use during treatment. Success in treatment was determined by the multidisciplinary treatment team and documented as "successful completion" on the OASAS discharge form. Clients who were successfully discharged had met over half of their treatment goals documented on their initial treatment plan and had maintained abstinence for over thirty days. Finally, client satisfaction was measured by the total satisfaction score. Inferential analyses including independent samples t-tests, ANOVA, and a chi-square test, were conducted to see how treatment interventions impacted treatment outcome. A correlation was used to measure the relationship between client satisfaction and change in drug use during treatment.

Results

The main hypothesis in this study was that utilizing individual therapy only interventions with adolescents would result in higher treatment satisfaction scores, more significant decreases in substance use, increased treatment retention, and increased success rates. The second hypothesis looked at the impact of The Seven Challenges program on treatment outcomes.

A total of 48 client records were pulled for review. The clinic discharge list from January 2013-October 2013 was used to identify charts for review. The variance for each of the dependent variables was separated into four treatment categories in the

independent variable*: Individual therapy only utilizing an eclectic counseling style* (n = 32), *group therapy and individual therapy utilizing an eclectic counseling style* (n = 9), *individual therapy only utilizing The Seven Challenges program* (n = 3), and *individual and group therapy utilizing The Seven Challenges program* (n = 4).

Individual Versus Group Therapy

Overall drug use decreased more in the eclectic individual therapy only (n = 32, M = -1.17) uses per week compared to the eclectic individual plus group (n = 9, M = -.94) uses per week. An independent samples t-test was run and although the individual therapy only eclectic category shows a decrease in drug use, this was not found to be statistically different between the individual and group category. The Seven Challenges category had few participants in individual therapy only (n=3) and in individual combined with group therapy (n=4), which did not allow for inferential statistics.

Success rates.

There were 12 unsuccessful discharges and 20 successful discharges in the individual therapy only eclectic category. There were 7 unsuccessful and only 2 successful discharges in the individual and group eclectic category. A statistically significant difference χ^2 (1) = 4.58, p = .03 was found analyzing successful discharges versus unsuccessful discharges between individual only eclectic and individual plus group eclectic therapy. However, the relationship shown in the chi square test cannot be trusted as reliable based on the small sample size in the group treatment category. The Fisher's exact test shows a more reliable p-value. In the 2-sided significance test p = .057 indicated that there is not a statistically significant relationship.

Drop out and satisfaction.

A total of 68.75 percent (n = 33) of clients dropped out of treatment or were discharged to a higher level of care. A total of 77.78 percent (n = 7) of all group therapy participants dropped out or were referred to a higher level of care and 65.62 percent (n = 21) of all individual clients dropped out of treatment or were referred to a higher level of care. A crosstabs analysis showed no statistical difference in drop out rates between individual and individual plus group therapy. The average satisfaction score for individual therapy was M = 89.80% and for individual plus group therapy was M = 81.00% for individual combined with group therapy. With a t-test it was determined that this was not a statistically significant difference.

The Seven Challenges Versus Eclectic Counseling

In The Seven Challenges individual therapy only intervention (n = 3), use decreased in the first six weeks of treatment from M = 2.08 times per week to M = .58 times per week for a total change in use of -1.5 compared to the individual only eclectic with a mean change of -1.17 at six weeks. The Seven Challenges group and individual category (n = 4) however increased from 1.13 times per week to 1.38 times per week in the first six weeks.

Drop out.

The hypothesis that stated The Seven Challenges program would result in lower drop out rates was not supported by the data. Thirty percent (n = 11) of clients in the eclectic therapy intervention dropped out of treatment and 29 percent (n = 2) clients in The Seven Challenges program dropped out of treatment. There were limited numbers (n = 7) in The Seven Challenges program.

Other Factors Impacting Treatment Outcome

Time in treatment was also impacted by treatment category. The overall number of sessions for a successful discharge from this program was 24.38. There was a significant difference (t 3.03, p = .004) between individual therapy eclectic (M = 22.42) and group and individual eclectic combined (M = 41.78). In the individual therapy only eclectic category it took on average 24 sessions for a successful discharge whereas it took 28 sessions in the group and individual category. The average number of sessions before an unsuccessful discharge was 19.92 sessions for individual therapy only and 45.71 sessions for group and individual combined (t 2.40, p = .04).

Race also had an impact on overall drug use change. The main factor associated with the difference in use over time was not treatment intervention or client satisfaction, but race. White clients (n = 21) were found to have the greatest change over time and decreased use by 2.04 times per week. Entering into treatment their use was M = 2.99 uses per week. Black clients (n = 13) increased use by .01 times per week with a use of M = 1.17 entering into treatment. A Pearson product correlation of -.870 (p = .001) for all clients was found between use at intake and change in use over time. This suggested higher likelihood of Black clients to have lower use at intake with less change over time compared to white clients who reported more use at intake and greater decrease of use over time. Race did not impact success rates in treatment (as defined by a "successful discharge" from the treatment program documented on OASAS forms). There was not a statistically significant difference between racial group and successful discharges from outpatient treatment.

Discussion

This study looked in depth at one outpatient clinic in an effort to learn about effective treatment interventions and factors that influenced positive outcomes with the adolescent substance abusing population. This is a high-risk population with high drop out rates, and low success rates in treatment. Clients with substance abuse are some of the hardest to retain in treatment. Current literature shows there is as low as five percent of eligible clients entering treatment and as low as 50 percent of clients successfully completing treatment (Najavitis, 2002). The goal was to find treatments that decrease drop out rates, increase client satisfaction, and improve overall treatment outcomes.

Interpretation of the Results

It was hypothesized that individual therapy only would result in more significant decreases in drug use, lower drop out rates, and higher satisfaction. Additionally, it was predicted that a new treatment model, The Seven Challenges would result in greater treatment satisfaction, more significant decreases in drug use, and lower drop out rates. This study was unable to find conclusive data regarding The Seven Challenges program based on late implementation in the clinic and time constraints of the study.

The study found that individual therapy produced greater decreases in drug use, and more successful discharges than individual therapy combined with group therapy, although not significant decreases. The inferential statistics were unable to support the hypothesis due to a small sample size, despite the descriptive statistics showing a difference between groups.

Group versus individual.

For the individual therapy only category greater decreases in drug use and higher rates of successful discharge were accomplished in fewer treatment sessions in this study. Additionally, in the unsuccessful category it took over double the sessions compared to successful discharges. This indicates several possibilities. There may be more time spent in treatment without recognition of the client needing a higher level of care before discharge, or it is possible that clients spend much longer in treatment without seeing results, and eventually a discharge needs to be made. Clients who received individual therapy only were in treatment for a total of 44.81 fewer days on average, producing higher success rates in a shorter period of time. It is speculated that the therapeutic relationship may not be as strong in the group and individual category compared with the individual only treatment category. The impact of each individual therapy session may have a more lasting impact compared to group therapy.

It is proposed that less use at intake may be related to lower motivation to make changes and fewer changes made with drug use over the course of treatment. This study only looked at change in use over time and successful discharge and did not measure abstinence rates (although, in the eclectic category one criteria for successful discharge included abstinence). Group treatment may be less effective with some clients when there is low motivation to make changes throughout the group. Individual therapy only may provide a space for clients to work on maintaining progress while group treatment may provide other variables that impact client treatment. Adding clients with more severe addictions may expose group members to drugs they have not used before and could pose risk for iatrogenic effects and “deviancy training” (Wood, 2009; Burleson,

Kaminer, & Dennis, 2006). Current research suggests that group provides an area for healthy social learning to occur, including the development of socializing techniques, role modeling, rehearsing, and giving and receiving feedback if there are some members present who are willing and wanting to make changes. Some clients came into treatment with minimal use and may have had lower motivation to make changes. If it is true that lower use at intake means less motivation to make changes, these individuals may not benefit as much from the group treatment experience and may actually be impacted more by the iatrogenic effects. This study did not show a positive impact from group treatment compared to individual therapy only.

Drop out.

There was no significant difference in drop out rates found between group and individual treatment. This lack of significance may be due to the limited number of group participants studied. The eclectic counseling category continued to have difficulties in retention in treatment and showed similar statistics to the current literature suggesting that as low as 50 percent of clients are retained in treatment (Najavits, 2002). The eclectic counseling style versus The Seven Challenges did not show a statistically significant difference in drop out rate. Again, this may be due to limitations with number of participants in The Seven Challenges program.

Satisfaction.

It was hypothesized that higher satisfaction would result in better treatment outcomes, and that clients receiving individual therapy only would have a greater satisfaction score than clients in group and individual therapy combined. The descriptive data suggest an average satisfaction score for individual therapy only as 84% and an

average score of 81% for individual combined with group therapy. This is not a statistically significant difference. The results showed that satisfaction scores were related to treatment outcome with female adolescents, but were not significant with male clients. Eighty-one percent of female clients had a history of trauma, compared to only 45 percent of male clients. Male and female clients had no difference in success rate so this may be ruled out as a possible cause for the difference in satisfaction scores between genders.

Other variables.

Race.

Black, Hispanic, and Bi-racial clients had significantly less change in use over time compared to White clients. There are several factors that may be related to this finding. First, it should be noted that at intake the average use for White clients was 2.99 uses per week and the average use for Black clients was 1.17 uses per week. This suggests higher severity of use for the White clients at intake, which could impact motivation to make changes, and impacts the amount of room for their use to change over time.

As mentioned previously, there was not a significant difference for treatment success rates between races, only changes in drug use over time. Black, Hispanic, and Bi-Racial clients were just as likely to complete the program successfully. White clients took longer on average in the program (M = 141.10 days and 30.15 sessions). Black clients took more days but fewer sessions (M = 149 days and 22.9 sessions) suggesting fewer sessions per week based on the decreased severity of use, but possible lower motivation to make changes in their use due to decreased severity. Hispanic clients

received 22.92 sessions on average but only spent 94.75 days in treatment. Finally, Bi-Racial clients received on average 20.10 sessions over 123.10 days in treatment.

Legal involvement.

Mandating treatment and coercing adolescents to stop using through legal persuasion does not seem to be as effective as it has been with adult populations (Johnson et al., 2004). This may be due to the defiance and process of individuation in adolescent development. Adolescents are working to learn decision making and may oppose direction from authority figures. Being told to quit for legal reasons did not seem to make a difference in this study. The research found that there was no difference in success rate or change in use between clients who did and did not have legal involvement. Clients without legal involvement may have had more internal motivation to make changes or pressures from other external sources such as their parents, being in residential services or being in foster care. The clients without legal involvement also may have internalized wanting to make changes for themselves rather than just wanting to appease the legal system and avoid getting into trouble. This study was not able to measure follow up with clients, but it would be suspected that clients with legal involvements may have higher relapse rates when they get off of probation and it is possible that the clients who did not have legal involvement would have more long term changes.

Limitations of the Study and Recommendations for Future Research

Program review does not allow for a true experiment or random assignment to different treatment conditions. Client records were reviewed from two different outpatient therapists in the outpatient clinic. One therapist had one-year post-graduate

experience, LMSW and CASAC-T, the other therapist was in the practicum stages of a masters counseling program and held a CASAC. Two different counselors provided services for clients using the eclectic style individual therapy, and eclectic style individual and group therapy. However, The Seven Challenges individual therapy, and The Seven Challenges individual and group therapy group was run by only one of the counselors. This intervention was utilized after clients' receiving eclectic counseling only was complete. Interventions occurred at different times of year and may have provided additional external factors that impacted the results.

Treatment intensity varied, but the level of treatment intensity was determined appropriate for each individual based on his or her report of use. The treatment intensity should have matched the client need; however, self-report methods are not always reliable, especially during the evaluation. The researcher faced limitations in the measurement of use due to potential misrepresentations in client report of use. Possible minimizations of drug use in the beginning of treatment may have led to skewed results if the client became honest over time reporting their full current use. Urine screen results were used to try and confirm the clients' report of drug use, but urine screens were not regularly administered to all clients due to refusals or therapist discretion that it would not be therapeutically beneficial to urine screen every time a client was seen. If urine screens were administered, they at times may have been altered and were not always accurate representations of drug use.

Measurement of client use at discharge and client satisfaction may have been influenced due to attrition. For clients who left treatment unsuccessfully, it was not always fully possible to have an exact "use at discharge." Therefore, the recorded "use at

discharge" was based on the last report of use by the client. Additionally, the majority of satisfaction surveys completed were by successfully discharged clients, which may have skewed the results, showing more favorable client satisfaction than if all clients were able to take the survey. All clients who completed the satisfaction survey were in the eclectic counseling category due to time constraints between the implementation of The Seven Challenges program and the end of the research study. This did not allow for analysis of satisfaction scores between the eclectic counseling style and The Seven Challenges program.

The Seven Challenges category had limited results and inconclusive data based on late implementation of the treatment model into programming. Due to the late implementation of The Seven Challenges program, there were fewer total participants, which may make the data less reliable. This is an area that could continue to be explored. It is still hypothesized that The Seven Challenges program will result in a greater successful discharge rate. Further research could be done to see how The Seven Challenges program compares to eclectic counseling regarding treatment drop out rates. The Seven Challenges may be one possible solution for addressing the current struggle to prevent treatment drop out.

The difference in change of drug use over time by race may be rooted in cultural issues that will need to be addressed and researched in the future. It may be helpful to find treatment interventions that are culturally sensitive and promote building motivation to change behaviors. The Seven Challenges provides a culturally sensitive treatment approach that may be able to meet the gap in needs that was shown regarding change in use by race. Matsumoto et al. (2011) suggest that working to meet the client where they

are at by consciousness raising may be the beginning of building motivation to change. This is consistent with the theory of The Seven Challenges program, which focuses on meeting the client where they are at currently in the stages of change process. The Seven Challenges helps adolescents to identify their problems and work toward their own solutions and has shown some promising outcomes despite the limited data not allowing for statistically significant results. The existing research shows The Seven Challenges program resulting in significant drug use changes (Smith et al., 2006). Effectiveness of The Seven Challenges program in the clinic studied will need continued research to see if it can show the positive outcomes suggested in prior research.

There was a significant difference between males and females on the impact of the counseling relationship on use outcomes. It is likely that the prevalence of trauma history is related to the relationship between client satisfaction and treatment outcome for adolescent females. A program that can promote the therapeutic relationship, specifically with female clients would be ideal. One study found that using Seeking Safety, a trauma treatment model for co-occurring substance use disorders and PTSD, showed significantly higher ratings of the therapeutic relationship compared to interventions not using the Seeking Safety model. The relationship was related to significant decreases in PTSD symptoms and increased attendance, but did not find a significant difference in substance use related to the therapeutic alliance (Ruglass, 2012). With 81 percent of female clients having a history of trauma it is essential that a trauma informed model is used with female adolescents such as Seeking Safety combined with The Seven Challenges. The impact of the therapeutic alliance on substance use outcome in women and girls with trauma would be an important area for further research.

Conclusion

In this study, clients in individual therapy only seemed to build a relationship that allowed for higher success rates and greater decreases in use. Successful discharge was achieved in fewer treatment sessions. This shows that there may be some evidence for providing more individualized services, limited in number, for adolescents rather than the group therapy, often high in number, which has traditionally been the primary mode of substance abuse treatment. With the population studied it seems that iatrogenic effects may have had more of an impact than the positive group effects that have been proposed in the literature. The fact that this population saw greater decreases in drug use with fewer treatment sessions in individual therapy may suggest that clients in individual therapy were able to build motivation to make changes that may have been impacted by the therapeutic relationship. Research should focus on whether it is truly more beneficial to treat adolescents for addiction needs primarily in the group setting. Additionally it would be beneficial to explore if The Seven Challenges program combined with the Seeking Safety model increases client success rates in outpatient treatment with adolescents.

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Appendix A

Client satisfaction survey

A. Overall, how satisfied were you with the services provided by Addiction Treatment Services Outpatient Clinic?				
Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied
B. How high would you rate the quality of services provided by Addiction Treatment Services Outpatient Clinic?				
Highest	High	Fair	Low	Lowest
C. Overall, how well are you doing since beginning services at Addiction Treatment Services Outpatient Clinic?				
Excellent	Well	Fair	Poor	Terrible
D. To what extent were you treated with respect?				
Very Much	Much	Some	Little	Not at all
E. How much caring did the staff show toward you?				
Very Much	Much	Some	Little	Not at all
F. How do you view your future?				
Very Hopeful	Hopeful	Neither Hopeful nor Hopeless	Hopeless	Very Hopeless
G. How likely is it that you would recommend Addiction Treatment Services Outpatient Clinic to a friend in need of treatment?				
Extremely Likely	10 9 8 7 6 5 4 3 2 1 0			Not at all likely

Appendix B

OASAS admission form

NYS Office of Alcoholism and Substance Abuse Services
Client Admission Report
FOR ADMISSIONS DATED 4/1/2009 AND BEYOND

Provider Number _____ **Program Number** _____

Provider Client ID _____ **Special Project (See instructions):** _____

Sex ☐ Male ☐ Female **Birth Date** __/__/____ **Last 4 SSN** ____ **Last Name First 2 Letters** __ (Birth Name)

Admission Date __/__/____ **Last Name First 2 Letters** __ (Current Name)

NYSID _____ **CJ Consent Date** __/__/____ **CJ Consent Revoke Date** __/__/____

No. of Assessment Visits/Days __ **Significant Other** ◯ Yes ◯ No

Race ☐ Alaska Native ☐ American Indian ☐ Asian ☐ Black or African American ☐ Hawaiian or other Pacific Islander ☐ White ☐ Other

Hispanic Origin ☐ Cuban ☐ Mexican ☐ Other Hispanic ☐ Hispanic, Not Specified ☐ Puerto Rican ☐ Not of Hispanic Origin

Primary Language
☐ Arabic ☐ Chinese ☐ English ☐ French ☐ Greek ☐ Hindi ☐ Japanese ☐ Portuguese ☐ Russian ☐ Sign Language ☐ Spanish ☐ Other

Veteran Status
Veteran ◯ Yes ◯ No

Zip Code of Residence _____ (For Canada use 88888)
County of Residence _____

U.S. Military Status (if applicable, select one; if not, skip)
☐ Active Duty
☐ Reserves/National Guard
☐ Both Active Duty and Reserves/National Guard

Type of Residence
☐ Private Residence ☐ Homeless, Shelter ☐ Homeless, No Shelter ☐ Single Resident Occupancy ☐ CD Community Residence ☐ CD Supportive Living ☐ MH/MRDD Community Residence ☐ Other Group Residential Setting ☐ Institution, Other (jail, hospital) ☐ Other

Living Arrangements ☐ Living Alone ☐ Living w/ Non-Related Persons ☐ Living with Spouse/Relatives

Principal Referral Source

Criminal Justice Services
☐ DLR District Attorney
☐ DLR Court
☐ DLR Probation
☐ DLR Parole General
☐ DLR Parole Release Shock
☐ DLR Parole Release Willard
☐ DLR Parole Release Resentence
☐ Drinking Driver Referral
☐ Police
☐ Family Court
☐ Other Court
☐ Alternatives to Incarceration
☐ City/County Jail
☐ NYS Department of Correctional Services
☐ Office of Children and Family Services

Self, Family, Other
☐ Self-Referral
☐ Family, Friends, Other Individuals
☐ AA/NA and Other Self-Help

Chemical Dependence Treatment
☐ CD Program in New York State
☐ CD Program Out of State
☐ CD VA Program
☐ CD Private Practitioner

Prevention/Intervention Services
☐ School-Based Prevention Program
☐ Community-Based Prevention Program
☐ Employee Assistance Program
☐ Other Prevention/Intervention Program

NYS Office of Alcoholism and Substance Abuse Services
Client Admission Report
FOR ADMISSIONS DATED 4/1/2009 AND BEYOND

Health Care Services
- ☐ Developmental Disabilities Program
- ☐ Mental Health Provider
- ☐ Managed Care Provider
- ☐ Health Care Provider
- ☐ AIDS Related Services

Employer/Educational/Special Services
- ☐ Employer/Union (Non-EAP)
- ☐ School (Other than Prevention Program)
- ☐ Special Services (Homeless/Shelters)

Social Services
- ☐ Local Social Services-Child Protect Services/CWA
- ☐ Local Social Services Dist-Income Maintenance
- ☐ Local Social Services Dist Treatment Mandate/Public Assistance
- ☐ Local Social Services Dist Treatment Mandate/Medicaid Only
- ☐ Other Social Services Provider
- *****
- ☐ Other

Highest Grade Completed

☐ No education	☐ 7th	☐ Vocational Cert w/o Diploma/GED
☐ 1st	☐ 8th	☐ Vocational Cert w/ Diploma/GED
☐ 2nd	☐ 9th	☐ Some College-No degree
☐ 3rd	☐ 10th	☐ Associates Degree
☐ 4th	☐ 11th	☐ Bachelors Degree
☐ 5th	☐ High School Diploma	☐ Graduate Degree
☐ 6th	☐ General Equivalency Diploma	

Employment Status

☐ Employed Full Time-35+ hrs/wk	☐ Not in Labor Force, In Training
☐ Employed Part Time-<35 hrs/wk	☐ Not in Labor Force, Inmate
☐ Employed in Sheltered Workshop	☐ Not in Labor Force, Retired
☐ Unemployed, In Treatment	☐ Not in Labor Force, Student
☐ Unemployed, Looking for Work	☐ Not in Labor Force, Other
☐ Unemployed, Not Looking for Work	☐ Soc Srvcs Work Exp Program
☐ Not in Labor Force, Child Care	☐ Soc Srvcs Determined, Not Employed/Able to Work
☐ Not in Labor Force, Disabled	☐ Soc Srvcs Determined, Unable to Work, Mandated Treatment

Primary Source of Income at Admission

- ☐ None
- ☐ Wages/Salary
- ☐ Alimony/Child Support
- ☐ Department of Veterans Affairs
- ☐ Family and/or Spouse Contribution
- ☐ SSI/SSDI or SSA
- ☐ Safety Net Assistance (SNA)
- ☐ Temp Asst for Needy Families (TANF)
- ☐ Other

Family History

Marital Status ☐ Married ☐ Never Married ☐ Living as Married ☐ Separated ☐ Divorced ☐ Widowed

Child of Alcoholic/Substance Abuser ☐ No ☐ Both ☐ Child of Alcoholic(s) ☐ Child of Substance Abuser(s)

No. of children ___ No. of children living with Client ___ No. of Children living in Foster Care ___

Case with Child Protective Services ◯ Yes ◯ No

Criminal Justice Information

Criminal Justice Status (check all that apply)

☐ None	☐ Work Release	☐ Charges Pending
☐ Probation	☐ In Prison/Jail	☐ Any Treatment or Specialty Court
☐ Parole	☐ In OCFS Facility	☐ Other (e.g., District Attorney)

NYS Office of Alcoholism and Substance Abuse Services
Client Admission Report
FOR ADMISSIONS DATED 4/1/2009 AND BEYOND

Arrests/Incarceration

Is this admission a result of an alternative to incarceration? ◯ Yes ◯ No

No. of Arrests in Prior 30 Days ___ ___
No. of Arrests in Prior 6 Months ___ ___ **No. of Days Incarcerated in Prior 6 Months** ___ ___ ___

Primary Substance

☐ None	☐ OxyContin	☐ GHB	☐ Other Hallucinogen
☐ Alcohol	☐ Other Opiate/Synthetic	☐ Khat	☐ Ephedrine
☐ Cocaine	☐ Alprazolam (Xanax)	☐ Other Tranquillizer	☐ Inhalant
☐ Crack	☐ Barbiturate	☐ Methamphetamine	☐ Ketamine
☐ Marijuana/Hashish	☐ Benzodiazepine (Klonopin)	☐ Other Amphetamine	☐ ROHYPNOL
☐ Heroin	☐ Catapres (Clonidine)	☐ Other Stimulant	☐ Viagra
☐ Buprenorphine	☐ Other Sedative /Hypnotic	☐ PCP	☐ Over-the-Counter
☐ Non-Rx Methadone	☐ Elavil	☐ Ectasy	☐ Other

Primary Route ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Primary Frequency ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily
Primary Age of First Use ___ ___

Secondary Substance

☐ None	☐ OxyContin	☐ GHB	☐ Other Hallucinogen
☐ Alcohol	☐ Other Opiate/Synthetic	☐ Khat	☐ Ephedrine
☐ Cocaine	☐ Alprazolam (Xanax)	☐ Other Tranquillizer	☐ Inhalant
☐ Crack	☐ Barbiturate	☐ Methamphetamine	☐ Ketamine
☐ Marijuana/Hashish	☐ Benzodiazepine (Klonopin)	☐ Other Amphetamine	☐ ROHYPNOL
☐ Heroin	☐ Catapres (Clonidine)	☐ Other Stimulant	☐ Viagra
☐ Buprenorphine	☐ Other Sedative /Hypnotic	☐ PCP	☐ Over-the-Counter
☐ Non-Rx Methadone	☐ Elavil	☐ Ectasy	☐ Other

Secondary Route ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Secondary Frequency ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily
Secondary Age of First Use ___ ___

Tertiary Substance

☐ None	☐ OxyContin	☐ GHB	☐ Other Hallucinogen
☐ Alcohol	☐ Other Opiate/Synthetic	☐ Khat	☐ Ephedrine
☐ Cocaine	☐ Alprazolam (Xanax)	☐ Other Tranquillizer	☐ Inhalant
☐ Crack	☐ Barbiturate	☐ Methamphetamine	☐ Ketamine
☐ Marijuana/Hashish	☐ Benzodiazepine (Klonopin)	☐ Other Amphetamine	☐ ROHYPNOL
☐ Heroin	☐ Catapres (Clonidine)	☐ Other Stimulant	☐ Viagra
☐ Buprenorphine	☐ Other Sedative /Hypnotic	☐ PCP	☐ Over-the-Counter
☐ Non-Rx Methadone	☐ Elavil	☐ Ectasy	☐ Other

Tertiary Route ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Tertiary Frequency ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily
Tertiary Age of First Use ___ ___

Self-Help

Is the client currently attending 12-step or other self-help group meetings (last 30 days)? ◯ Yes ◯ No

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Client Admission Report
FOR ADMISSIONS DATED 4/1/2009 AND BEYOND

Tobacco

Has the client ever used tobacco (nicotine)? ◯ Yes ◯ No

Age of First Use ___ ___

Frequency of Use (in past 30 days):
☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily

Date Last Used: Month __ __ **Year** __ __ __ __

Primary Route of Administration: ☐ Smoking ☐ Chewing

Prior Treatment Episodes

Enter the number of prior Substance/Alcohol Abuse treatment episodes __ *(Enter 0 to 5).*
If the number of prior treatment episodes is greater than 5, use 5.

Physical Health Related Conditions

Pregnant	◯ Yes	◯ No	Speech Impairment	◯ Yes	◯ No
Hearing Impairment	◯ Yes	◯ No	Sight Impairment	◯ Yes	◯ No
Mobility Impairment	◯ Yes	◯ No	Other Major Physical Health Condition	◯ Yes	◯ No

---

Mental Health Related Conditions
Mental Retardation/Developmental Disability ◯ Yes ◯ No Co-existing Psychiatric Disorder ◯ Yes ◯ No

History of Mental Health Treatment

Ever Treated for Mental Illness Problem	◯ Yes	◯ No
Ever Hospitalized for Mental Illness	◯ Yes	◯ No
Ever Hospitalized 30 or More Days for Mental Illness	◯ Yes	◯ No

Six Months Prior to Admission
No. Days in Inpatient Detox ___ ___ No. of Emergency Room Episodes ___ ___
No. of Days Hospitalized for Non-Detox Services ___ ___
Reason for Hospitalization ☐ Medical ☐ Psychiatric ☐ Both

Gambling

Did the client screen positive for a gambling problem? ◯ Yes ◯ No ◯ Not Screened

---

Orientation to Change *(For use only by Residential Rehabilitation Services for Youth Programs or Other Program Types Participating in Special Projects With OASAS)*

Which statement best characterizes this patient's orientation to change with respect to alcohol/drug use at the time of admission?

☐ Ambivalent
☐ Change Oriented
☐ Planning Change
☐ Active Early Recovery
☐ Ongoing Recovery and Relapse Prevention

For Provider Use (Optional)

Signature	Title	Date

Appendix C

OASAS discharge form

NYS Office of Alcoholism and Substance Abuse Services
Client Discharge Report
***FOR DISCHARGES DATED 4/1/2009 AND BEYOND**

Provider Number __ __ __ __ __ __ **Program Number** __ __ __ __ __ __

Provider Client ID __ __ __ __ __ __ __ __ __ __ __ __

Sex | | Male Female **Birth Date** __ __/__ __/__ __ __ __ **Last 4 SSN** __ __ __ __ **Last Name 2 Letters** __ __ (Birth Name)

Date Last Treated __ __ / __ __ / __ __ __ __

Education at Discharge (if education at admission was entered incorrectly, it must be updated in "Client Management" online)

☐ No education	☐ 5th	☐ 10th	☐ Vocational Cert w/ Diploma/GED
☐ 1st	☐ 6th	☐ 11th	☐ Some College-No degree
☐ 2nd	☐ 7th	☐ High School Diploma	☐ Associates Degree
☐ 3rd	☐ 8th	☐ General Equivalency Diploma	☐ Bachelors Degree
☐ 4th	☐ 9th	☐ Vocational Cert w/o Diploma/GED	☐ Graduate Degree

Employment

Employment Status

☐ Employed Full Time-35+ hrs/wk	☐ Not in Labor Force, Disabled	☐ Social Services Determined, Not Employed/Able to Work
☐ Employed Part Time-<35 hrs/wk	☐ Not in Labor Force, In Training	☐ Social Services Determined, Unable to Work, Mandated Treatment
☐ Employed in Sheltered Workshop	☐ Not in Labor Force, Inmate	☐ Unknown
☐ Unemployed, In Treatment	☐ Not in Labor Force, Retired	
☐ Unemployed, Looking for Work	☐ Not in Labor Force, Student	
☐ Unemployed, Not Looking for Work	☐ Not in Labor Force, Other	
☐ Not in Labor Force, Child Care	☐ Social Services Work Exp Program	

Length of Employment at Discharge: ☐ 0-30 Days ☐ 31-60 Days ☐ 61-90 Days ☐ 91-120 Days ☐ 121+ Days

Type of Residence

☐ Private Residence	☐ CD Community Residence	☐ Institution, Other (jail, hospital)
☐ Homeless, Shelter	☐ CD Supportive Living	☐ Other
☐ Homeless, No Shelter	☐ MH/MRDD Community Residence	
☐ Single Resident Occupancy	☐ Other Group Residential Setting	

Living Arrangements ☐ Living Alone ☐ Living w/ Non-Related Persons ☐ Living with Spouse/Relatives

Primary Payment Source

☐ None	☐ Medicaid Pending	☐ Private Insurance – Fee for Service
☐ Self-Pay	☐ Medicare	☐ Private Insurance – Managed Care
☐ Medicaid	☐ DSS Congregate Care	☐ Other
☐ Medicaid Managed Care	☐ Department of Veterans Affairs	

Mental Health

Co-existing Psychiatric disorder	☐ Yes	☐ No
Ever Treated for a mental illness problem	☐ Yes	☐ No
Ever Hospitalized for mental illness	☐ Yes	☐ No
Ever Hospitalized 30 or more days for mental illness	☐ Yes	☐ No

Gambling & Tobacco Goal Achievemen

Gambling	Tobacco (Nico
☐ Achieved	☐ Achieved
☐ Partial Achievement	☐ Partial Achiev
☐ Not Achieved	☐ Not Achieved
☐ Not Applicable	☐ Not Applicable

***Total Treatment Visits* – For use only by Outpatient Programs (Excluding Methadone Maintenance Programs)**

Total Treatment Visits ___ ___ ___ ___

Individual Counseling Sessions ___ ___ ___ ___ (Provided by a primary counselor)

Group Counseling Sessions ___ ___ ___ ___ (Provided by a primary counselor)

Family Counseling Sessions ___ ___ ___ ___ (Provided by any direct care staff)

Recent History:

No. of Arrests in Prior 30 Days ___ ___ ***(or during treatment if stay was less than 30 days)***

Six Months Prior to Discharge (or during treatment if stay was less than 6 months)

Number of Arrests ___ ___ Days Incarcerated ___ ___ ___

Days Hospitalized ___ ___ Days in Inpatient Detox ___ ___

Number of ER Episodes ___ ___

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NYS Office of Alcoholism and Substance Abuse Services
Client Discharge Report
FOR DISCHARGES DATED 4/1/2009 AND BEYOND

Status of Alcohol and Other Drug Use at Discharge

Status of Problem Substances Reported at Admission		
	Substance*	Frequency of Use at Discharge
Primary		
Secondary		
Tertiary		

**Note: Substance(s) reported at admission will be pre-filled on the Client Data System*

Frequency of Use
No use in last 30 days
1-3 times last 30 days
1-2 times per week
3-6 times per week
Daily

Status of Different Problem Substances Used and Not Reported at Admission (if any)

First Problem Substance

☐ None	☐ OxyContin	☐ GHB	☐ Other Hallucinogen
☐ Alcohol	☐ Other Opiate/Synthetic	☐ Khat	☐ Ephedrine
☐ Cocaine	☐ Alprazolam (Xanax)	☐ Other Tranquillizer	☐ Inhalant
☐ Crack	☐ Barbiturate	☐ Methamphetamine	☐ Ketamine
☐ Marijuana/Hashish	☐ Benzodiazepine (e.g., Klonopin)	☐ Other Amphetamine	☐ ROHYPNOL
☐ Heroin	☐ Catapres (Clonidine)	☐ Other Stimulant	☐ Viagra
☐ Buprenorphine	☐ Other Sedative /Hypnotic	☐ PCP	☐ Over-the-Counter
☐ Non-Rx Methadone	☐ Elavil	☐ Ecstasy	☐ Other

Route of Administration ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Frequency of Use ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily

Second Problem Substance

☐ None	☐ OxyContin	☐ GHB	☐ Other Hallucinogen
☐ Alcohol	☐ Other Opiate/Synthetic	☐ Khat	☐ Ephedrine
☐ Cocaine	☐ Alprazolam (Xanax)	☐ Other Tranquillizer	☐ Inhalant
☐ Crack	☐ Barbiturate	☐ Methamphetamine	☐ Ketamine
☐ Marijuana/Hashish	☐ Benzodiazepine (e.g., Klonopin)	☐ Other Amphetamine	☐ ROHYPNOL
☐ Heroin	☐ Catapres (Clonidine)	☐ Other Stimulant	☐ Viagra
☐ Buprenorphine	☐ Other Sedative /Hypnotic	☐ PCP	☐ Over-the-Counter
☐ Non-Rx Methadone	☐ Elavil	☐ Ecstasy	☐ Other

Route of Administration ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Frequency of Use ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily

Third Problem Substance

☐ None	☐ OxyContin	☐ GHB	☐ Other Hallucinogen
☐ Alcohol	☐ Other Opiate/Synthetic	☐ Khat	☐ Ephedrine
☐ Cocaine	☐ Alprazolam (Xanax)	☐ Other Tranquillizer	☐ Inhalant
☐ Crack	☐ Barbiturate	☐ Methamphetamine	☐ Ketamine
☐ Marijuana/Hashish	☐ Benzodiazepine (e.g., Klonopin)	☐ Other Amphetamine	☐ ROHYPNOL
☐ Heroin	☐ Catapres (Clonidine)	☐ Other Stimulant	☐ Viagra
☐ Buprenorphine	☐ Other Sedative /Hypnotic	☐ PCP	☐ Over-the-Counter
☐ Non-Rx Methadone	☐ Elavil	☐ Ecstasy	☐ Other

Route of Administration ☐ Inhalation ☐ Injection ☐ Oral ☐ Smoking ☐ Other
Frequency of Use ☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily

Tobacco

Frequency of Use in Past 30 Days (if stay is less than 30 days report use since admission or since last MCAS (for methadone programs)):
☐ No use last 30 days ☐ 1-3 times last 30 days ☐ 1-2 times per week ☐ 3-6 times per week ☐ Daily

Date Last Used: Month __ __ Year __ __ __ __ (not entered if stay is less than 30 days)

Primary Route of Administration: ☐ Smoking ☐ Chewing

Discharge Reason & Referral Information

NYS Office of Alcoholism and Substance Abuse Services
Client Discharge Report
FOR DISCHARGES DATED 4/1/2009 AND BEYOND

Discharge Status
☐ Completed Treatment: All Goals Met
☐ Completed Treatment: Half or More Goals Met
☐ Treatment Not Completed: Maximum Benefit/Clinical Discharge
☐ Treatment Not Completed: Some Goals Met
☐ Treatment Not Completed: No Goals Met

Discharge Disposition (CHECK ONE)
☐ Additional treatment at this level of care no longer necessary
☐ Further treatment at this level unlikely to yield added clinical gains
☐ Left against clinical advice: Formal referral made/offered
☐ Left against clinical advice: Lost to contact (no referral possible)
☐ Left against clinical advice: Termination of third party funds
☐ Discharged due to non-compliance with program rules
☐ Discharged due to regulatory requirements (note: *crisis programs*)
☐ Client arrested/incarcerated
☐ Client could no longer participate for medical/psych. reasons
☐ Client death
☐ Client relocated
☐ Program closed

Referral Disposition (CHECK ONE)
☐ No referral made
☐ Client not in need of additional services
☐ Referred back to CD* program
☐ Referred to other CD* program
☐ Referred to Mental Health Program
☐ Referred to non-CD* or non-MH treatment
☐ Referred to Gambling Program
☐ Refused referral

**CD=chemical dependence*

Is the client currently Attending 12-Step or Other Self-help Group Meetings (last 30 days)?
☐ ***Yes*** ☐ ***No***

Referral Category (CHECK ONE)

Chemical Dependency (CD) Programs
☐ CD Program in New York State
☐ CD Program Out of State
☐ CD VA Program
☐ CD Private Practitioner

Health Institutions
☐ Hospital
☐ Hospital (Long Term)/ Nursing Home
☐ Nursing Home, Long Term Care
☐ Group Home, Foster Care

Mental Health Programs
☐ Mental Health Community Residence
☐ Mental Health Inpatient
☐ Mental Health Outpatient
☐ Mental Retardation/Dev Disabilities
****
☐ Other Referral
****
☐ No Referral Made
☐ Refused Referral

Evaluation of Client's Goal Achievement

Drug Use
☐ Achieved
☐ Partial Achievement
☐ Not Achieved
☐ Not Applicable

Social Functioning
☐ Achieved
☐ Partial Achievement
☐ Not Achieved
☐ Not Applicable

Family Situation
☐ Achieved
☐ Partial Achievement
☐ Not Achieved
☐ Not Applicable

Alcohol Use
☐ Achieved
☐ Partial Achievement
☐ Not Achieved
☐ Not Applicable

Vocational/Educational
☐ Achieved
☐ Partial Achievement
☐ Not Achieved
☐ Not Applicable

Emotional Functioning
☐ Achieved
☐ Partial Achievement
☐ Not Achieved
☐ Not Applicable

Medical Conditions
☐ Achieved
☐ Partial Achievement
☐ Not Achieved
☐ Not Applicable

Legal
☐ Achieved
☐ Partial Achievement
☐ Not Achieved
☐ Not Applicable

NYS Office of Alcoholism and Substance Abuse Services
Client Discharge Report
FOR DISCHARGES DATED 4/1/2009 AND BEYOND

Addiction Medications Used During Treatment
CHECK ALL THAT APPLY. *Select* ***"NONE"*** *if no addiction medications were used.*

- ☐ Methadone
- ☐ Buprenorphine
- ☐ Zyban/Wellbutrin
- ☐ Naltrexone/Revia/Vivitrol
- ☐ Antabuse
- ☐ Nicotine Lozenges
- ☐ Nicotine Gum
- ☐ Nicotine Patch
- ☐ Chantix
- ☐ Campral
- ☐ Other Addiction Medications
- ☐ None

Domestic Violence

Client ever a victim of domestic violence? ☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer
Client ever a perpetrator of domestic violence? ☐ Yes ☐ No ☐ Don't Know ☐ Refused to Answer

---

Orientation to Change *(For use only by Residential Rehabilitation for Youth Programs or Other Program Types Participating in Special Projects With OASAS)*

Which statement best characterizes this patient's orientation to change with respect to alcohol/drug use at the time of discharge?

- ☐ Ambivalent
- ☐ Change Oriented
- ☐ Planning Change
- ☐ Active Early Recovery
- ☐ Ongoing Recovery and Relapse Prevention

For Provider Use (Optional)

Signature	Title	Date

Appendix D

Drug use history

PART 822-4 CHEMICAL DEPENDENCE OUTPATIENT SERVICES
COMPREHENSIVE PSYCHOSOCIAL EVALUATION

PATIENT NAME:	PATIENT ID #	ADMISSION DATE:

Chemical Dependence /Abuse Update: *Please update the information below with any changes found since admissions assessment*

Substance Type	Age of Onset	Frequency/Amount/Progression	Date of last use
Alcohol ☐			
Amphetamines ☐			
Cannabis ☐			
Cocaine ☐			
Hallucinogens ☐			
Inhalants ☐			
Nicotine ☐			
Opioids ☐			
PCP ☐			
Sedatives/Hypnotics ☐			
Other ☐			

Previous Treatment History: ***Please update with any information in addition to the admissions assessment:***

Date	Treatment Providers	Completed Y/N	Signed Release Y/N

Previous Recovery/Abstinence History: ***Please list previous periods of sustained recovery/abstinence and methods of attainment:***

DATE(S)	Methods of attainment (i.e. AA/NA; Smart Recovery; other self help; church; jail;)

Clinician's findings and conclusions in this functional area:

Patient's identified needs in this functional area and level of motivation:

Appendix E

Pre-admission assessment

PART 822-4 CHEMICAL DEPENDENCE OUTPATIENT SERVICES
Admissions Assessment

Patient Name	**Patient ID #**
Presenting Problems: (Priority Issue(s) and any other patient-identified priority issues that include any emergencies or issues that may impact the individual's ability to participate in outpatient treatment):	

History of Alcohol and Drug Usage (Check All That Apply)

Substance Type		Age of Onset	Frequency/Amount/Progression	Date of last use
Alcohol	☐			
Amphetamines	☐			
Cannabis	☐			
OTC	☐			
Cocaine	☐			
Hallucinogens	☐			
Inhalants	☐			
Nicotine	☐			
Opioids	☐			
PCP	☐			
Sedative/Hypnotics	☐			
Other:				

Gambling: Lie-Bet (*if patient answers yes to either of these questions complete SOGS as part of Comprehensive Evaluation)*

☐ Yes	☐ No	Have you ever felt the need to bet more and more money?
☐ Yes	☐ No	Have you ever had to lie to people important to you about how much you gambled?

Previous Substance Abuse or Problem Gambling Treatment History:

Signed consent(s) for release?	☐ Yes	☐ No

Preliminary Substance Abuse/Gambling Diagnosis (if any)

Please list any addictions related issues the patient needs to address between now and until the development of the treatment/recovery plan

PART 822 CHEMICAL DEPENDENCE OUTPATIENT SERVICES
Admissions Assessment

Mental Health Screening					
Are you now or have you ever received Mental Health Counseling?	◯ **Yes**	☐ **No**			
If so what is/was your Mental Health Provider's Name and where are they located?					
What is/was your diagnosis or reason for counseling?					
Signed consent(s) for release?	☐ **Yes**	☐ **No**			
Have you ever been admitted into a Psychiatric Hospital?	☐ **Yes**	☐ **No**	**If yes, please give the following information:**		
Date	Name of Hospital	Reason for Hospitalization			
Please list any mental health medications the patient has taken and indicate whether they are current or past (approximate date)					
	☐ **current**	☐ **past**		☐ **current**	☐ **past**
	☐ **current**	☐ **past**		☐ **current**	☐ **past**
	☐ **current**	☐ **past**		☐ **current**	☐ **past**
	☐ **current**	☐ **past**		☐ **current**	☐ **past**
****Attach completed Modified Mini Screen (MMS)****			**Score on Modified Mini:**		
Score of 1-5 Low Likelihood Mental Health Issues			**Score of 6-8 Moderate Likelihood**		
Score of 9+ High Likelihood	**Patient referred for further assessment?**		☐ **Yes**	☐ **No**	
Question #4 answered:	☐ **Yes**	☐ **No**	**If yes patient referred for further assessment**	☐ **Yes**	☐ **No**
#14 and #15 Both Yes?	☐ **Yes**	◯ **No**	**If yes patient referred for further assessment**	☐ **Yes**	☐ **No**
Based on the results of the Modified Mini Screen and the information given above is there any indication that the patient's mental health may adversely affect their ability to succeed in the outpatient level of care?					
Please list any mental health related issues the patient needs to address between now and until the development of the treatment/recovery plan:					

PART 822 CHEMICAL DEPENDENCE OUTPATIENT SERVICES
Admissions Assessment

Preliminary Goals (initial goals to cover from admission to Comprehensive Treatment Plan)					
Initial Services	**TYPE**		**Frequency**		
	☐ **Individual Counseling**			X per	
		Group Counseling (specify)		X per	
		Group Counseling (specify)		X per	
		Group Counseling (specify)		X per	
		Group Counseling (specify)		X per	
		Family Counseling		X per	
		Intensive Outpatient Services (IOS)		X per	
		Outpatient Rehabilitation		X per	
		Other (specify)		X per	

RULES/REGULATIONS, PATIENT RIGHTS AND VOLUNTARY BASIS

- **I have been provided with a copy of the Patient Handbook which contains Program Rules and Regulations, Patient Rights, a Summary of Federal Confidentiality Laws and Tobacco Policies. I have been given the opportunity to discuss these rules and to have my questions answered. By signing this form I am indicating that I understand these rules and rights.**
- **I also understand that all treatment services are provided on a voluntary basis and that I have the right to discharge myself from treatment at any time.**
- **I have participated in the development of my preliminary treatment goals.**

Patient Signature	**Date**
Parent/Guardian Signature if applicable	**Date**
Counselor Signature	**Date**

PART 822 CHEMICAL DEPENDENCE OUTPATIENT SERVICES
Admissions Assessment

Level of Care determined by	◯ **LOCADTR**	**ASAM**
☐		
☐		
QHP Signature:		**Date:**