CASE EXAMPLES

Patient One: In this scenario, you are the group facilitator. You have Casey in group three times daily, five days a week.

Casey is a 42 year-old female that presents for residential treatment for amphetamine use disorder. Casey is often focused on others in the group rather than self. While she is helpful to others, group facilitators in the treatment team have started to notice that she truly hasn't completed a lot of her step-work yet spends time helping others. She appears social, but when she attempts to communicate, she often struggles to articulate what she is thinking and feeling. When she is not engaging socially, group facilitators and her primary therapist have noticed that she seems to "stare off" and presents sad. She has significant trauma history per her primary clinician and began using with her mother when she was fourteen. Despite this being a huge element of her story, she doesn't talk about it much. In fact, she often just talks about "staying positive" and remaining in gratitude. She additionally stated in processing group today, "I am certain that I will never use again."

Group Note: Casey participated at an above average level in group session and contributed to group discussion on relapse triggers. She presents with euthymic mood and congruent affect.

Revised Group Note:

Patient Two: In this scenario, you are the case manager. You meet with Daniel individually two times weekly to discuss progress in IOP level of care and continued care resources. You are responsible for completing a treatment overview note in his chart weekly.

Daniel is a 25 year-old male that presents for IOP level of care. Despite Daniel being able to hold his job throughout this year, he has withdrawn from most all social events and is significantly disconnected from his family. His strongest social connection is with his brother, whom he drinks alcohol and uses stimulants with. Daniel lives alone. He has never been to therapy before and is not sure he “believes in the whole therapy thing.” Daniel has been to jail 3x for simple possession charges and two DUIs. Daniel often has nightmares and flashbacks but refuses to educate primary therapist, physicians, or CPRS on elements of these intrusive images. He has struggled with severe alcohol use disorder since he was sixteen and began drinking with his mother, who since has passed due to cirrhosis. He appears to talk about drinking in group sessions but does not disclose stimulant use. He is often closed off with his peers and remains guarded when he does share. He is unsure about his willingness to participate in trauma therapy services despite recommendations from his treatment team.

Case Management Note: Daniel shows limited motivation to change. He appears to be closed off in groups, although his attendance is good overall. He has an alcohol use disorder, severe along with stimulant use disorder, unspecified. He often won’t speak with our peer support specialists or primary therapist offered to him in our program. He won’t talk about his legal consequences of addiction.

Revised Case Management Note:

Patient Three: In this scenario, you are the primary therapist. You are responsible for meeting with Jim once biweekly for individual therapy sessions and you have him in group twice daily, four times a week. You are responsible for completing an individual therapy note.

Jim is a coal miner presenting for court-mandated treatment at a PHP level of care. He has extensive history of use, including: methamphetamines, fentanyl, MDMA, alcohol, and benzodiazepines. Jim does not want to be in treatment and states he is here because he “has to be” at every morning spiritual group. He presents as disengaged from treatment and has been overheard by staff encouraging peers to disengage from treatment programming as well. He often talks about his using days with happiness and reports no willingness to stop his use. Despite this almost bragging behavior about his use and resell days, he was clean on his urinary drug screen from remaining abstinent when he was incarcerated prior to treatment. He has a brother that died by suicide in 2019. During his H&P, the physician noticed that this was the same year he began using heavily. He cannot speak his brother’s name without crying. He presents to your session with low mood and constricted affect. He reports muscle aches and pains, and says “not really” to various PAWS listed, including: headaches, nausea, restless legs, tremors, and mood swings. He says depression is not real when you ask about his struggles with low mood and withdrawn behaviors. He refuses to complete questions on individualized rating scales. He speaks so fast you have difficulty understanding him at times. Jim states he is working on his first-step but doesn’t know how it’s relevant to him staying sober long-term. He states he is, “damn sure not going to present in front of the other lost souls in group.” He leaves individual therapy session within fifteen minutes stating, “he is done” when you inquire about his grief.

Complete a Clinical Case Note Using the SIMPLE Acronym: