

DIMENSION 3 – EMOTIONAL, BEHAVIORAL, OR COGNITIVE CONDITIONS AND COMPLICATIONS

1. Interviewer observation: Is the patient disoriented? Does the patient endorse, or do you suspect cognitive or memory issues? Yes No
Please describe:

<p>2. Have you ever been told by a physical or mental health clinician that you have a mental health problem or brain injury? Please describe: (e.g., diagnosis, date, and type of injury, if known)</p>	<input type="radio"/> Yes* <input type="radio"/> No	Notes:
<p>3. Are you currently in treatment, or have you previously received treatment, for mental health or emotional problems? Please describe: (e.g., treatment setting, hospitalizations, duration of treatment)</p>	<input type="radio"/> Yes* <input type="radio"/> No	
<p>4. If yes*: Have your mental health symptoms been stable (check all that apply)?</p>	<input type="radio"/> N/A <input type="radio"/> Stable with treatment/meds <input type="radio"/> Stable without treatment/meds <input type="radio"/> Unstable <input type="radio"/> Not sure	
<p>5. This next question can be sensitive, and you can choose to skip the question or respond with just a yes or no if you prefer. Have you ever experienced any abuse (this can include physical, emotional, or sexual abuse) or any other traumatic events?</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Skipped	

6. List all current medication(s) for psychiatric condition(s): N/A

MEDICATION(S)	DOSE (if known)	FREQUENCY e.g., 1, 2, 3, 4 x/day	PURPOSE (to treat what symptom/illness)

*Do you use marijuana or marijuana-related products (including CBD [cannabidiol] or other extracts) as medicine for any psychiatric condition(s): Yes No

Specify type: _____ Frequency: _____

Purpose: _____

<p>7. Do you have a mental health care provider? [Mental health care providers should be identified for collaboration and releases of information obtained] Provider name: _____ Provider contact: _____</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
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8. I am going to read you a list of mental health symptoms and behaviors that might be concerning to some people. Can you tell me if any of these have been bothering you in the last 30 days? Also, if you have these symptoms, please let me know if they happen only when using or withdrawing from alcohol or other drug use. (Please include symptoms observed by interviewer, even if patient is not aware)

MOOD	PAST 30 DAYS	Only when using or withdrawing from alcohol or other drugs	Notes:
Depression/Sadness	<input type="radio"/>	<input type="radio"/>	
Loss of pleasure/interest	<input type="radio"/>	<input type="radio"/>	
Hopelessness	<input type="radio"/>	<input type="radio"/>	
Irritability/Anger	<input type="radio"/>	<input type="radio"/>	
Impulsivity	<input type="radio"/>	<input type="radio"/>	
Interviewer observation: Pressured speech	<input type="radio"/>	<input type="radio"/>	
Feeling unusually important/Grandiosity	<input type="radio"/>	<input type="radio"/>	
Racing thoughts	<input type="radio"/>	<input type="radio"/>	
Anxiety	<input type="radio"/>	<input type="radio"/>	
Anxiety/Excessive worry	<input type="radio"/>	<input type="radio"/>	
Thoughts that you cannot stop if you want to/Obsessive thoughts (Not including thoughts about using substances)	<input type="radio"/>	<input type="radio"/>	
Behaviors that you cannot stop if you want to/Compulsive behaviors (Not including using substances)	<input type="radio"/>	<input type="radio"/>	
Flashbacks	<input type="radio"/>	<input type="radio"/>	
Psychosis- Include interviewer observation	<input type="radio"/>	<input type="radio"/>	
Paranoia (e.g., feeling like you are being watched or followed)	<input type="radio"/>	<input type="radio"/>	
Delusions, feeling you were especially important in some way, or that you were receiving special messages, or that people were out to harm you (false beliefs inconsistent with culture)	<input type="radio"/>	<input type="radio"/>	
OTHER			
Sleep problems	<input type="radio"/>	<input type="radio"/>	
Memory/Concentration	<input type="radio"/>	<input type="radio"/>	
Gambling	<input type="radio"/>	<input type="radio"/>	
Risky sex behaviors	<input type="radio"/>	<input type="radio"/>	
Physical aggression towards people or property, describe: (e.g., what happened?)	<input type="radio"/>	<input type="radio"/>	
Other:	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	
	<input type="radio"/>	<input type="radio"/>	

<p>9. Are these issues (<i>listed in the table above</i>) either caused or made worse by alcohol and/or other drug use? Please describe:</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not sure	<p>Notes:</p>
<p>10. Do you ever see or hear things that other people say they do not see or hear (e.g., hearing voices. <i>Probe, does this occur only while using or withdrawing from alcohol or other drugs?</i>) Please describe:</p>	<input type="radio"/> Yes <input type="radio"/> No	
<p>11. Have you had thoughts of hurting yourself? Have you had thoughts that you would be better off dead? Please describe:</p> <p>a. *If yes: Are you having these thoughts today? ► Note to interviewer: Seek immediate clinical consultation and/or contact emergency services for imminent danger of harm to self or others. Assess acute suicidality, homicidality, and risk (e.g., plans, firearm access, etc.).</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	
<p>b. Have you ever acted on these feelings to hurt yourself?</p> <p>12. Have you had thoughts of harming others? Please describe: a. If yes: Are you having these thoughts today? b. Have you ever acted on these feelings to harm others? ► Interviewer instructions: Follow all local laws and procedures for disclosing any reportable events regarding harm to self, others, elders or children.</p>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> No	

Self-Report Scales

For the next questions, the response options are "Not at all," "A Little," "Somewhat," "Very," or "Extremely."

	Not at all	A Little	Somewhat	Very	Extremely
<p>13. How much do any of these emotional health symptoms <i>from the list we discussed above</i> make it harder for you to take care of yourself? (e.g., hygiene, grooming, dressing, eating, housework, living independently, etc.) Please describe:</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>14. How much do any of these emotional health symptoms make it harder for you to go to school, work, socialize or engage in hobbies or other interests? Please describe:</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<p>15. How much do these emotional health symptoms make it harder for you to go to SUD treatment or stay in SUD treatment? Please describe:</p>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/> Not applicable				

Problem Statements and Goals (Optional, for treatment planning purposes)

<p>16. What major problems (if any) have been caused by these mental health or emotional symptoms? Problem: is there one issue or symptom that is the worst for you?</p>	<p>Problem(s):</p>	<p>Notes:</p>
<p>17. What concerns or worries do you have about getting treatment for your mental health or emotional symptoms or issues?</p>	<p>Goal(s):</p>	
<p>18. What goals do you have for your mental and emotional health?</p>	<p>Goal(s):</p>	

19. Interviewer observation: Is further assessment of mental health needed? Yes No

Please describe:

Please circle the intensity and urgency of the patient's CURRENT needs for services based on the information collected in Dimension 3:

Severity Rating – Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications)

0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
<ul style="list-style-type: none"> No dangerous symptoms Good social functioning Good self-care No symptoms interfering with recovery 	<ul style="list-style-type: none"> Possible diagnosis of emotional, behavioral, cognitive condition Requires monitoring for stable mental health condition Symptoms do not interfere with recovery Some relationship impairments 	<ul style="list-style-type: none"> Symptoms distract from recovery Requires treatment and management of mental health condition No immediate threat to self/others Symptoms do not prevent independent functioning 	<ul style="list-style-type: none"> Inability to care for self at home May include dangerous impulse to harm self/others Does require 24-hr support At risk of becoming a 4/ Very Severe without treatment 	<ul style="list-style-type: none"> Life-threatening symptoms including active suicidal ideation Psychosis Imminent danger to self/others
	Further assessment and referral or follow-up with existing mental health (MH) provider	Prioritize follow up or new evaluation with MH provider for new/uncontrolled conditions	Urgent assessment and treatment for unstable signs and symptoms	Emergency Department-immediate assessment

► Interviewer Instructions:

- Take into account cognitive impairments.
- Choose the score that is closest to your overall impression. Patients may not exhibit every symptom within a severity rating. The patient's historical functioning does **NOT** override the status. Current level of functioning **DOES** override historical functioning (see ASAM Criteria, 3rd Ed. page 56).

Interviewer Instructions:

For guidance assessing Dimension 3, see ASAM Criteria, 3rd Ed. p. 46-48 and p. 77-81.

For guidance assessing cognitive impact on placement, see ASAM Criteria, 3rd Ed. p. 234.