



## The Written Case Presentation



The written case presentation (referred to as the written case) evaluates a candidate's ability to effectively present a clinical case study. The written case is reviewed to determine if the candidate appropriately addresses essential information related to the treatment process and to ensure they follow the required format. Although originally used to prepare candidates for the IC&RC Oral Exam which is now part of the IC&RC written examination process, the written case is still required by the CCB of all candidates applying for **CAC – Certified Addiction Counselor** certification.

The written case is submitted by candidates as part of their application packet for CAC certification and is reviewed by the CCB (Connecticut Certification Board) to determine if the written case meets the current standards set by the CCB. Review of the written case is evaluated based upon the criteria listed in this document and verifies the applicant adheres not only to format style and submission criteria, but also the candidate presents relevant information and demonstrates their knowledge of and competency with the addiction treatment process.

If the written case is found not to meet existing standards, it will be returned to the candidate with an explanation of the areas of deficiency. The CCB may impart additional criteria to evaluate the quality of the content of the written case or require clarification or further content as part of this review. Candidates will be allowed to resubmit the written case only after the necessary changes have been made to address the cited deficiency and a new face sheet is submitted with a supervisor's signature indicating a date after the initial review was completed. If the written case is found to be adequate, the candidate will be notified the case has been accepted.

A critical element of the written case presentation process is the collaboration between the candidate and the supervisor around the development of the written case. One of the primary goals of the written case is to ensure the candidate has worked closely with a supervisor not only on the written case (which should be based upon an actual person treated by the candidate), but also on the counseling and treatment planning process while the client/patient was under the care of the candidate in a clinical setting. The supervisor is required to review the written case and sign the written case face sheet stipulating that they have read, consulted on and assisted the candidate in the development of the written case and the clinical services described/delivered in the case. Only a supervisor that has collaborated on the development of the written case as well as the clinical services should sign the written case.

### **Important things for you to know about the written case:**

- 1) *The written case should be prepared from an actual/typical client from your case load and with the permission of your agency and supervisor.*
- 2) *The client cannot currently be in your care and should be discharged from your agency/program.*
- 3) *The name used in the case should be fictitious; however, other information should be real unless there is a danger of violating the client's confidentiality.*
- 4) *The written case must be typed and be between 6 – 12 pages double spaced*
- 5) *The written case should be free of any typographical, spelling and formatting errors and should contain only relevant information related to the counseling and treatment planning process.*
- 6) *The face sheet must contain the appropriate information and signatures.*

The format of the written case presentation must follow the outlined format below and include each of the following sections with sufficient detail and content (please see sample provided):

**HEADINGS IN BOLD MUST BE USED AS LISTED IN THE WRITTEN CASE SUBMITTED**

**I. Substance Abuse History**

1. Substances used
2. Frequency
3. Progression
4. Severity and amount used
5. Onset - when they started
6. Primary substance/secondary substance
7. Route of administration
8. Effects - blackouts, tremors, tolerance, DTs, seizures, other medical complications  
(some of these may be included in the Physical History Section)

**II. Cognitive/Emotional/Behavioral Functioning**

1. Cognitive/Mental Status - oriented, insight, presentation, judgment
2. Symptoms: Past or present hallucinations, delusions, suicidal, homicidal
3. Emotional disturbances or issues
4. Behavioral problems and issues

**III. Educational/Vocational/Financial**

1. Educational and work history
2. Educational level
3. Disciplinary action (at school or work)
4. Reasons for termination
5. Current and past financial status

**IV. Legal History (associated with, or not associated with, mood altering chemicals)**

1. Charges, arrests, convictions
2. Current status
3. Pending

**V. Social History**

1. Parents and Siblings/rank
2. Psychological functioning in family
3. Substance use in family
4. History of social functioning from childhood to present
5. Family functioning including physical, sexual, and emotional Abuse
6. Relationship history
7. Children
8. Cultural, spiritual/religious, sexual identity, other special population issues

**VI. Physical History**

1. Both alcohol and drug, non-alcohol and drug problems
2. Past and present major medical problems - i.e., disabilities, pregnancy and related issues, STD, alcohol and drug-related problems

**VII. Recovery, Treatment and Self-Help/Mutual Support Group History related to substance use and mental disorders**

### **VIII. Assessment**

Identifying and evaluating an individual's strengths, weaknesses, problems, readiness for change/stage(s) of change and needs for the development of the treatment plan including mention of specific screening/assessment tools used and the findings from each

### **IX. Treatment Plan**

Identifying and ranking problems needing resolution; establishing agreed upon immediate and long-term goals; deciding on a treatment process appropriate for the individuals readiness for change/stage(s) of change and the resources to be utilized.

### **X. Course of Treatment**

Describe the counseling approaches you used, your rationale for their use and any revisions you made based on the client's unique problems and responses to treatment

### **XI. Discharge Summary**

Concise description of the client's overall response to treatment, including alcohol/drug status at discharge

#### ***IMPORTANT NOTE:***

*The written case must be typed and be between 6 – 12 pages double spaced and should be free of any typographical, spelling and formatting errors & should contain only relevant information related to the counseling & treatment planning process. All written cases not adhering to these requirements will be rejected and returned for revision which will delay the certification process. DO NOT SUBMIT a written case that has not be reviewed and approved by you clinical supervisor.*

CCB P&S Committee Approved January 26, 2010  
CCB Approved March 11, 2010

*Portions of this document are taken from the IC&RC Candidate Guide - Case Presentation Method and Certification Examination for Alcohol and Others Drug Abuse Counselors (2001)Published by IC&RC and Columbia Assessment Services, Inc.*

*IMPORTANT NOTE: The IC&RC no longer endorses or supports the Oral Examination as a standalone exam.*