EMPACT–Suicide Prevention Center

Teen Substance Abuse Treatment Program

Treatment Manual

A guide to providing comprehensive, intensive, and effective outpatient services to youth with mental illness and substance-related disorders and their families.

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This manual was prepared under funding provided by grant no. TI11892-03 from the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA) (Sally Stevens, Ph.D., Principal Investigator, University of Arizona). The model and approaches described in this document are those of the authors and do not necessarily reflect views or policies of CSAT or SAMHSA..

TABLE OF CONTENTS

Preface

This manual is intended to be used as a guide for replicating the Emergency Mobile Pediatric and Crisis Team Suicide Prevention Center (EMPACT-SPC) Teen Substance Abuse Treatment (TSAT) program. Although the essential points have been covered, variables may occur depending upon funding, location, and the specific needs of your community.

Three primary individuals developed the manual: Suzanne Taylor, Melissa Smith, and Mark Senior. The document originated as a simple outline and gradually became the manual. A number of other remarkable people contributed to and assisted in this team effort, including: Nancy Groppenbacher, Denise Krup, David Larimer, Rosemary LeClair, Christine Maxey, Lynn Reinardy, Sally Stevens, and Rosi Andrade.

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Chapter 1: Overview of the Treatment

1. History of the Provider

This manual describes the Teen Substance Abuse Treatment (TSAT) program, located in Maricopa County, Arizona. TSAT is a program administered by the Emergency Mobile Pediatric and Crisis Team Suicide Prevention Center (EMPACT-SPC), a non-profit behavioral health organization offering counseling, crisis intervention, prevention, and aftercare to youth, adults, and families. EMPACT-SPC's mission is to build strong families and communities by helping Arizona youth and families cope effectively with the challenges of life. This is achieved through compassionate and innovative prevention, counseling, crisis, and training services.

EMPACT-SPC began in 1987 as the Suicide Prevention Center, under the auspices of Interfaith Counseling Services, which was located southeast of Phoenix in Tempe, Arizona. By early 1989, as a result of the children's mental health bill, the agency became one of the first local agencies to offer in-home family counseling services. Services expanded with the addition of a mobile crisis staff who intervened by phone or in person, 24 hours a day, in behavioral crises involving youth and families. In 1990, when these services became independent of Interfaith Counseling Services, the name was changed to EMPACT-SPC. Because of the phenomenal growth in Maricopa County, EMPACT-SPC added a second office located in Glendale, Arizona. The two locations provide prevention programs for 11 of the 29 cities in Maricopa County. Maricopa County covers 9,226 square miles and has a population of 2,913,475 (World Wide Maps, 2000).

Additionally, EMPACT-SPC is the only provider in Arizona credentialed by the American Association of Suicidology. EMPACT-SPC provides 24-hour crisis phone and mobile team services to all of Maricopa County. EMPACT-SPC utilizes a brief, systemic, solution-focused approach. The future of this service is essential for quality care to individuals in crisis. EMPACT-SPC will continue to deliver this vital service to the community of Maricopa County.

2. History of the Program

Early in EMPACT-SPC's history, substance abuse treatment was identified as a key area of need, and funding was obtained to provide it. In 1994, EMPACT-SPC developed a treatment program through a grant from the Center for Substance Abuse Treatment. This program, Positive Alternatives to Drugs Requires Encouragement and Support (PADRES), was a three-year collaborative effort among EMPACT-SPC, the Department of Youth Treatment and Rehabilitation, and the Treatment Assessment Screening Center, Inc. (TASC). It provided a specialized treatment intervention to juveniles age 13 to 17. It was at the completion of the PADRES program in 1997 that the TSAT program was developed by EMPACT-SPC. The program will be discussed in greater detail in the section Overview of the Treatment.

3. Population Characteristics

Between February 2000 and December 2001, 136 adolescents were enrolled in the TSAT evaluation study. From the demographic data completed, it was found that the majority of TSAT clients are male (82%) and the average age of the participants is 15.6, ranging from age 13 to 17. Further, the teens are predominately Caucasian (50%), although a sizable portion is Hispanic (32%), including Mexicans, Puerto Ricans, and Cubans.

The following data reflect a sample size of 84 TSAT youth. The participants display extensive drug use and a limited history of treatment. All of the youth reported getting drunk or using a drug before age 15. The majority (84%) had used drugs or alcohol by age 12. The mean age of onset was 10 years old. Forty-one percent had never received substance abuse treatment prior to their present TSAT treatment. Fifty-four of the participants (64%) identified marijuana as their drug of choice, followed by methamphetamines with eleven participants (13%). Marijuana is the most common drug of choice across all ethnicities. For example, 62% of Caucasians and 69% of Hispanics identified marijuana as being their drug of choice. Forty-one (49%) reported that the drug they most need treatment for is marijuana, with smaller percentages reporting needing treatment for methamphetamine (16%). Sixteen (19%) of the participants reported not needing treatment for any drug use problems. Eighty-two percent of the population was drunk or high at least an entire day in the 90 days prior to treatment.

Thirty-seven (44%) reported that alcohol/drug problems kept them from meeting responsibilities in the past 90 days.

TSAT youth experienced family dysfunction. Forty-nine of the youth (58%) live in single parent households. Sixty-six teens (79%) reported a family history of problems because of alcohol use. Sixty-four (76%) reported a family history of problems because of drug use. Forty-two (50%) of the adolescents reported a family history of psychological problems.

TSAT youth frequently engage in high-risk behaviors. Seventy-six of the youth (90%) smoke cigarettes. Six (27%) of the 22 female adolescents enrolled reported being pregnant or having been pregnant. Three of the females had experienced miscarriages, two had given birth and one had undergone an abortion. Sixty-four youth (76%) reported being sexually active within the previous 90 days. Of these, 50 (59%) used some sort of barrier to prevent pregnancy or disease. Eleven of the males (14%) reported having gotten a female pregnant.

The TSAT youth typically are criminally involved. Fifty-two percent have been arrested for selling, distributing, or possessing illegal drugs. TSAT youth have also committed violent crimes, including aggravated assault (31%) and robbery (14%). Nearly a third (29%) have stolen a vehicle. In addition, the youth have committed property crimes such as vandalism (41%) and burglary (26%).

Consequently, the participants have dysfunction in the legal aspects of their lives. The vast majority (81%) of the referrals come through the juvenile justice system in some form (e.g., probation officers and judges). Seventy-nine (94%) of the participants have been arrested at least once in their lifetimes.

The TSAT youth come from troublesome social environments. Sixty-five percent reported having been attacked with a gun, knife, or other weapon during their lifetime. In addition to the physical dangers, the youth have had to contend with emotional abuse. Forty-six percent reported having been emotionally abused at some time.

The youth usually have exacerbating mental conditions. Seventy-three (87%) of the participants had difficulties controlling behavior within the 90 days prior to treatment. In fact, 48% had taken psychotropic medications in their lifetime. Twenty-one (25%) reported currently taking medications for psychological problems. The most common psychological disorder noted was depression (25%), evidenced by self-reports of symptoms consistent with depression, such as a loss of interest in activities, sleep disturbances, and suicidal ideation. Sadly, 18% of the youth reported suicidal ideation in the past year.

4. Overview of the Treatment Process

TSAT was designed to meet the need for an intensive outpatient program for substance-abusing juveniles ages 13 through 17 and their families. This is of significance to the treatment process in that intensive outpatient treatment is defined as any counseling service in which participants receive nine or more hours of service per week in Maricopa County.

TSAT is a 90-day intensive program from intake to graduation. It is a multi-component intervention that involves in-home family therapy; teen group meetings that include a combination of cognitive, behavioral, and educational procedures; other types of activities; monthly multi-family group meetings; and transportation.

In-home family counseling involving all family members is provided from intake up to six months. Motivational interviewing and brief, solution-focused therapy are combined with a family systems perspective to treat substance abuse and to enhance coping, communication, appropriate behavior, self esteem, and conflict resolution skills. The teen group curriculum provides skills training related to values clarification, relationship issues, career goal exploration, medical effects, consequences of drug and alcohol abuse, denial and other defenses, relapse signs, and prevention and self-help community programs.

The TSAT program provides level II intensive outpatient treatment. Youth between the ages of 13 and 17 are eligible for the TSAT program if they meet intensive outpatient program criteria according to the American Society of Addiction Medicine (ASAM) Patient Placement Criteria (PPC-2R) for co-occurring mental and substance-related disorders (dual diagnosis).

According to ASAM, “a client is matched into a program or service based on their clinical severity, not only diagnostic needs.”

Chapter 2: Recruitment, Assessment, and Treatment Placement

1. Recruitment

Potential TSAT youth may be referred by the juvenile court system. When a juvenile probation officer is assigned an adolescent client, an informal staffing is conducted with the probation department's program services coordinator to determine what services may be appropriate for that youth. Some criteria utilized by the juvenile court that may determine a client's eligibility to be assigned to TSAT are: geographic location, previous substance abuse treatment, the juvenile's willingness to participate in the program, the family's ability and willingness to participate, and whether there are other juvenile court demands. If the adolescent client is determined to be eligible, the probation officer uses a referral form to place the adolescent on a waiting list until EMPACT-SPC assigns a start date for the client.

When the TSAT program therapists are not able to take more clients because of a full caseload, the clients are placed on the waitlist. A client's start date is dependent on the date the referral was sent to the program coordinator and the date the client is available to start services. If an adolescent was referred to the program but is unable to start because he/she is in detention, someone who was referred subsequently will be placed in the program. When the detained client is released, he/she becomes the first client on the waitlist. The program coordinator is responsible for keeping track of the new referrals and waitlists.

2. Referral Process

2.1. Probation Department. A probation officer staffs his/her case list in collaboration with departmental staffing coordinators. When an adolescent is determined to be appropriate for TSAT, the probation officer sends a request for services form to the probation finance department. The request for services form is then faxed to EMPACT-SPC along with an enrollment form.

2.2. Regional Behavioral Health Authority (RBHA)–Value Options (VO). TSAT clients have entered the program through VO/Arizona Partners for Youth and Family (APYF). VO is the funding source for APYF, the administrative agency in Maricopa County that contracts for behavioral health for children and adolescents. EMPACT-SPC is a member

agency of APYF. Any APYF agency can refer a client to TSAT based on Behavioral Health Level of Care Guidelines. The assigned therapist who is working with a client calls the TSAT program coordinator to staff the case. If the adolescent is deemed appropriate, the therapist will call the network coordinator for financial approval. If approved, an enrollment form is given to the TSAT program coordinator.

3. Entry Into the Program

The TSAT program/group is open-entry, with a desired group size of 10 to 12 teens. Open-entry means that when a current client graduates from the program or is terminated, the group or in-home therapist notes the low group census, recognizes the ability to take an additional client, and notifies the TSAT coordinator. The TSAT coordinator identifies the next client on the waitlist, assigns a family therapist, and then calls the probation officer for the authorization.

Upon arrival of the authorization form, agency support staff give copies to the program coordinator, the group therapist, the in-home therapist, and the program assistant/driver. Client information is entered into the database; authorization is signed and faxed back to the probation officer (probation protocol). The in-home therapist then sets an initial appointment with the family and notifies the TSAT coordinator of the start date.

4. Treatment Placement

All adolescents accepted into the TSAT program are evaluated as having significant substance abuse problems or diagnosed as being alcohol or drug dependent. Clients are not accepted into the program if the level of their substance involvement has been experimental or relatively minor. Such intense contact with longer-term addicted or heavily using clients is seen as being a threat to inducting early users into, not out of, the drug culture. In addition to a substance-related diagnosis, clients are also accepted for treatment with co-occurring disorders such as unipolar or bipolar depression, ADHD, conduct disorder, oppositional defiant disorder, eating disorders, anxiety and panic disorders, and post-traumatic stress disorder. However, clients experiencing significant psychotic symptoms that would otherwise hinder their ability to participate in and benefit from the TSAT program are screened as inappropriate for enrollment. In addition, adolescents who are evaluated as needing inpatient services (i.e.,

hospitalization, long-term residential) are not admitted into the TSAT program. Adolescents referred by juvenile probation and needing inpatient services work with their probation officers to find an appropriate placement, while those referred from VO work with TSAT staff to secure an appropriate inpatient placement.

5. Criteria

In order to assess whether or not an adolescent is appropriate for the TSAT program, the adolescent must qualify based on each of the six dimensions defined by ASAM PPC-2R. Adolescents who do not fit into the ASAM criteria may be considered for the program with a supervisor's approval. Using the Behavioral Health Level of Care Guidelines, a TSAT adolescent would qualify for intensive outpatient treatment level II. The client must, therefore, match the need for level II of the six criteria dimensions as stated below:

Dimension 1, Level II.1 (IOP) Acute Intoxication and/or Withdrawal Potential:
The adolescent is experiencing minimal withdrawal or is at risk of experiencing withdrawal.

Dimension 2, Level II.01 (IOP) Biomedical Conditions and Complications:
None, stable, or distracting from treatment at a less intensive level of care. Such problems are manageable.

Dimension 3, Level II.01 (IOP) Emotional, Behavioral, or Cognitive Conditions and Complications:
The adolescent's status in dimension 3 features one or more of the following:

1. The adolescent is at low risk of harm, and he or she is safe between sessions.
2. Mild interference requires the intensity of this level of care to support treatment engagement.
3. The adolescent evidences mild to moderate impairment but can sustain responsibilities.
4. The adolescent is experiencing mild to moderate difficulties with activities of daily living and requires frequent monitoring of interventions.
5. The adolescent's history (combined with the present situation) predicts the need for frequent monitoring or interventions.

Dimension 4, Level II.01 (IOP) Readiness to Change:

The adolescent requires close monitoring and support several times a week to promote progress through the stages of change because of variable treatment engagement or a lack of recognition for the need of assistance.

Dimension 5, Level II.01 (IOP) Relapse, Continued Use, or Continued Problem Potential:

The adolescent needs close monitoring and support because of a significant risk of relapse or continued use and deterioration in his or her level of functioning. He or she has poor relapse prevention skills.

Dimension 6, Level II.01 (IOP) Recovery Environment:

The adolescent's environment is impeding his or her recovery, and the adolescent requires close monitoring and support to overcome that barrier.

A. Medical Necessity Admission and Transfer to Level of Care Criteria

- DSM IV Axis I or Axis II diagnosis; and
- Least intrusive/restrictive level of care necessary to safely handle treatment needs; and
- Likelihood of out-of-home placement, rapid deterioration in functioning, or unsuccessful reintroduction to the home without this level of treatment; and
- Likelihood of return to more effective level of functioning as a result of this level of treatment or to prevent deterioration in level of functioning.

6. Admission Session

The first contact a TSAT client has with the TSAT program staff is through a phone call made by the home-based therapist. The initial phone call is made to the client's guardian and is intended to set the initial intake appointment and provide a brief description of the TSAT program. The therapist ensures that the intake appointment will include the client and the client's guardian(s).

The intake must occur before the client can attend any part of the TSAT program. The assigned home-based therapist generally completes the intake. Included in the intake appointment are: 1) introductions, 2) a description of confidentiality and limits to confidentiality, 3) a description of the TSAT program and services, 4) a review of TSAT rules, 5) obtaining the client and guardian signatures, and 6) a comprehensive assessment. Following is a description of each of these components.

6.1. The Introduction. The home-based therapist introduces her/himself to the client and all members attending the intake session. The therapist describes his/her role in the client's and family's treatment and gives a brief background of his/her training, experience, and history with the TSAT program. The intake appointment is the most important session in establishing the therapeutic climate for the client and the client's family. This session gives the therapist an opportunity to build rapport, join with the client, and establish trust with the client and with the family. The therapist can do this by inquiring into the client's perception of counseling, discussing and validating past therapeutic experiences the client may have had, and having the client identify what he/she believes will be helpful, as well as not helpful, in the therapeutic experience.

Another aspect of setting the therapeutic climate is getting the client and the family to buy in to being a member on the therapeutic team. This approach helps to give the clients control of their treatment by emphasizing the importance of their role on the team and how it relates to, for example, successfully completing probation. The individual roles for the therapist, the client, and the family members are established and clarified. The therapist's role is to keep the client focused, to facilitate the session, to mediate and reframe issues, and also to model effective communication. The role of the client is to identify what he/she wants to work on, to make necessary changes, and to begin to learn how to take responsibility for his/her part in the stated problem. Family members' roles are to become part of the treatment, to identify their part in the stated problem, and to address how changes will affect their family. The therapist can also elicit feedback regarding the therapist's role and direction of treatment from the other members at any time during treatment. This builds trust between the client, family,

and therapist and provides a comfortable setting for the client and/or family members to provide input into treatment.

6.2. Confidentiality. Confidentiality and limits to confidentiality are explained in this intake appointment. It is made very clear, in this first session, that everything that is disclosed in the individual and family sessions is kept confidential, within the limits of confidentiality. The limits are described as follows: TSAT staff breach confidentiality to probation officers or case managers only at the benefit of the client and the family, such as disclosure of danger to self, danger to others, or dangerous and/or harmful substance abuse by the client. Urine analysis/drug screening results are sent to the client's probation officer only with a consent form signed by the client and the guardian. Because of limits to confidentiality in family and group counseling, only brief monthly reports are sent to the probation officer regarding client progress or lack of progress.

6.3. Description of the TSAT Program. All components of the program are explained fully to the client and guardians. The therapist first details the times, location, and typical content of the group meetings. It is also made clear to the youth and the youth's family that the TSAT program is a 90-day program. The description includes the monthly mandatory family night meeting along with details on the time and location. It is important for the therapist to get a general sense of how the client responds to group interaction, using this as an opportunity to build rapport with the client and set the client's potential anxiety at ease by validating and/or emphasizing the informal setting and support within the group. The therapist explains that each client is required to provide a random urinalysis test each week, adding that transportation is provided to the Treatment Assessment Screening Center, Inc. (TASC), the urinalysis testing facility, during group time. The client and family are informed that a copy of the urinalysis drug screening result is sent automatically to the respective probation officer only when both the client and the guardian(s) have given written consent.

At this time, it is usually beneficial to assure the client that any information about substance use that is disclosed within the counseling setting will not be disclosed to the probation officer or the guardians, unless this use is potentially fatal to the client. It is important at this time to begin building and establishing trust with the client so that he/she may

feel comfortable disclosing and being honest about his/her substance use. This establishes an optimal therapeutic setting for the client. The step-down, individual/family counseling component and the time allotted for individual and family therapy sessions is described. It is also made clear that individualized needs will be discussed, in a collaborative effort, during the treatment planning process. The therapist then explains that upon successful completion of the program, the client is awarded a certificate in a formal graduation ceremony. At this point, the therapist gives the client and guardian(s) the names and phone numbers of the TSAT director, group facilitator, program assistants, and assigned home-based therapist.

6.4. Signatures. TSAT rules are described in length and presented in a printed contract. The therapist, client, and guardian(s) discuss these rules, and signatures by both the client and guardian(s) are obtained. The therapist then obtains necessary signatures on consent forms and all other paperwork. The cancellation/no-show policy is reviewed in detail, and the guardian then signs a contract. It is important for the therapist to emphasize that if the TSAT program is court-ordered, then the client could be in violation of probation if he/she does not attend as mandated.

6.5. Assessment. A comprehensive assessment is then completed by obtaining the history of the presenting problem and issues, including onset, duration, frequency, and severity. The assessment also includes a complete description of the client's substance use history and legal and criminal history. Other topics include, but are not limited to, the client's and guardians' strengths to help resolve the problems, family history of substance use and/or mental illness, client and family support systems, history of treatment including counseling and psychotropic medications, current/past medical conditions, and client's hobbies.

7. Other Clinical Recommendations

Female clients are usually assigned to a female therapist. Since sexuality issues are often associated with substance use, female clients tend to feel more comfortable speaking with a female therapist, especially about emotional trauma, sexual abuse, and relationship issues. A male client is assigned to either a female or male therapist unless otherwise requested (on the enrollment form that places the client on the waitlist for the program, there is a line that asks if the client prefers a male or female therapist). If there are no therapists

available in the TSAT program who have availability for an extended period of time, the program coordinator will seek out other therapists at EMPACT-SPC who have experience with substance use and adolescents. If there are more than three females in a group, one of the three weekly group sessions will be divided into separate groups to address female concerns and male concerns separately.

8. Confidentiality of Records

According to EMPACT-SPC policy, client information shall not be released verbally or in written form to a third party without a signed authorization from the client's legal guardian(s). This restriction against release of information includes acknowledging or indicating in any way that a client is receiving services at EMPACT-SPC. Additionally, all written authorizations must be obtained prior to any release of information. Release of alcohol and/or drug records and communicable disease records requires specific authorization.

Information requested by third parties and appropriately authorized by the client's legal guardian(s) is sent directly to the party requesting the information. The information usually is not released to the client for delivery to the person requesting the information. In rare cases when delivery by the client is authorized, the medical records are delivered under seal and addressed to the requester. A letter with the name of the person authorized to pick up and deliver information to a specific requester for an identified client must be signed, dated, documented with identification (i.e., valid driver's license), and witnessed by EMPACT-SPC staff. The letter is to be filed with copies in the chart.

Family/youth information from a client chart is not released to a third party without obtaining a signed consent form from all participants/family members involved in the treatment process, including all minors involved in the treatment. Care is taken to ensure that the authorized person signing the release form(s) has legal custody or proof of the establishment of a guardianship by the court, permitting the parent/guardian to make decisions regarding the minor's medical records. In the case of alcohol and drug use records, the parent/legal guardian and the minor (12 years or older) must sign the release.

During the intake assessment, the therapist asks the client and his/her parents to sign consents to release information to all persons who may be helpful in communicating with regard to treatment. If there is a probation officer, consent must be signed for the probation officer and agency to communicate about the client's substance abuse. The reasons for this consent are explained in detail, as are the possible repercussions of this consent. If a client is court-ordered into the program, the parent and client must sign this release in order to participate in the program. If the client has a mental health case manager, the client is asked to sign a consent to release information between the case manager and the agency. Other individuals that may need to be specified on release forms include, but are not limited to, psychiatrists, previous therapists or treatment programs, teachers, extended family members, and the court. If the therapist receives a request to appear in court, the parent and client must sign a consent to release substance abuse information to the court. This consent must specifically state that the therapist will testify in court about the client's substance use. If the parent and/or client do not agree to this consent, the court must obtain a court order for the therapist to testify.

Clients and their families are notified of informed consent and are given a document explaining the client's rights, confidentiality of alcohol and substance use, and the limits on confidentiality. The parent signs one document that is placed in the client's file, and they are given a copy.

During group therapy, clients are reminded about the agency's policies regarding confidentiality. They are further told that copies of their urinalysis tests will be sent to their respective probation officers if they have one. In order to encourage and provide a safe clinical environment, the clients are told that whatever they say during group about their use and personal lives will not be reported to their probation officers. The only information released includes their urinalysis results, attendance, and level of participation. Furthermore, if a client poses an expressed danger to self or to another person, the proper authorities will be notified. In order to maintain a positive therapeutic relationship between the client and the therapist, the parent/guardian is told that the therapist would prefer to abstain from sharing all client/therapist information.

Chapter 3: Overview of Treatment Components

The TSAT program is a 90-day structured outpatient program comprised of three components: 1) intensive in-home individual/family therapy, 2) teen group therapy, and 3) multi-family group therapy.

1. Intensive In-Home Individual/Family Therapy

Three months of in-home individual/family therapy sessions are scheduled around the family's routine, sometimes in the early evenings and on Saturdays. Month one consists of up to six hours per week of therapy. Month two consists of up to four hours per week. Month three consists of up to two hours per week. In-home individual/family counseling uses a brief, solution-focused approach, combining cognitive-behavioral and family systems modalities with techniques that allow clients to become aware of their feelings and the motivating forces for their behaviors. Family strengths are identified and interventions are designed to build on the strengths of the client and family. An underlying belief of this approach is that successful treatment begins with a clear understanding and agreement between the therapist, the client, and the family members regarding the goals of the therapy.

2. Teen Group Therapy

The teen group is held three times a week for three hours, from 3:00 to 6:00 p.m. Both Eastside (Tempe office) and Westside (Glendale) sites hold teen groups on Mondays, Tuesdays, and Thursdays. Teen groups address value clarification, relationship issues, career goal exploration, medical effects, consequences of drug and alcohol abuse, denial and other defenses, relapse signs and prevention, and self-help community programs.

3. Multi-Family Group Therapy

A three-hour multi-family group meeting occurs the first Tuesday of each month, taking the place of the teen group. Because family members typically cannot attend a 3:00 to 6:00 p.m. session, the multi-family group is scheduled from 6:00 to 9:00 p.m. Parents, teens, and significant others discuss issues such as how parents can work with their teens to learn coping skills, develop effective discipline techniques, and find ways in which family members can engage with each other more positively.

4. Staffing

4.1. Client Staffing. In an effort to collaborate treatment among all team members, client staffings are held once monthly at the agency. A letter is sent out by the group and family therapist to each client and guardian, probation officer, surveillance officer, case manager, psychiatrist, and whomever is participating in the client's treatment. Along with this letter is an invitation and list of questions that will be discussed during the staffing. In the event the attendee is unable to attend, the attendee may answer the questions and return the form to the therapist. The treatment plan is done and reviewed during this staffing with all team members' input. This staffing is also documented.

4.2. Agency Staffing. Each month a meeting is held with all TSAT program therapists to staff the clients. This allows the therapists to collaborate on ideas and staff concerns and to become apprised all clients. Treatment challenges, interventions, suggestions, transportation arrangements, and other issues are brought up during this time. This staffing is seen as invaluable as it allows all therapists to work together as a team for the benefit of one program and its clients.

5. Special Services

Teens and parents are encouraged to move toward self-sufficiency. Therapists help the adolescent clients connect to social service agencies and self-help or 12-Step groups and agencies that provide health care, assistance with enrollment into school, and enrollment into job skills programs or agencies that assist with obtaining employment. When appropriate, families are referred to community resources such as churches, the Department of Economic Security (for food stamps), child support, medical coverage, and parenting and support groups. The therapy staff also addresses many related needs of the clients and their immediate family members, such as health care, transportation, housing, and recreational resources.

Urine samples are gathered and analyzed once per week at TASC, the local independent testing facility used also by adult and juvenile parole/probation. While the results are sent to the clients' probation officers/case managers, they are also used by the staff in discussions with the clients and their families. The standard urinalysis test is a five-panel screening for amphetamines, cocaine, opiates, phencyclidine, and THC. Additional tests can be requested as necessary. For example, if a test result shows there is a possibility that the client was taking a medication, a gas chromatography/mass spectrometry (GCMS) test can be done to determine whether or not the substance was a prescribed or over-the-counter drug.

Chapter 4: In-Home Individual and Family Counseling

1. Purpose

While abstinence from substance use is the ideal goal of TSAT, the program also focuses on the needs of the family system and of the client holistically, recognizing that other changes may precede a client's motivation for sobriety. Objectives for a TSAT family could include improving parenting skills, restoring an appropriate family structure, resolving family conflicts and/or past issues, and improving family communication. The treatment plan, which is created during the initial family sessions, guides the in-home therapist and the family members in shaping their objectives for the family for the duration of the program. The goal of treatment may shift as objectives are met or as new issues arise during the 90 days of treatment.

The engagement and establishment of an effective relationship between the client and the counselor is the essential foundation of the helping process. The TSAT therapist, both in-home and in-group, is non-confrontational but takes an active role in order to build trust, set goals, and identify and explore problems. The therapist expresses empathy, develops discrepancy, avoids argument, adapts with the client's resistance, and supports self-efficacy (five principles of motivational interviewing).

2. Method

Therapeutic interventions are developed from motivational enhancement, systemic, and solution-focused approaches to therapy. For example, the substance abuse of the teen is understood primarily as a symptom of the entire family system's dysfunction, not as the solitary problem of the client. While there may be intervening factors such as a hereditary predisposition, peer pressure, or a learned behavior, the family systems theory employed by TSAT functions as a tool to uncover the role any symptomatic behavior serves within its system. Thus, solutions focus on resolving problems within this system (e.g., trauma, developmental changes in the family, family structure, marital status or parenting roles) and restoring the functioning level of the entire system.

3. Treatment Planning

Treatment planning and goal and objective setting are done as a collaborative effort, involving the client, the family, and the therapist. In this process the therapist has the client identify, in his/her own words, the problems he/she would like to work on. If the client is resistant to this (e.g., states, "I don't have any problems"), the therapist can use this as a therapeutic opportunity. For example, the therapist could engage the client and establish rapport by reframing the more obvious problem (e.g., "the problem is probation and your parents seem to be on your back to quit using"). In another example, the therapist could play a "one-down" position and ask the client "what would you do if you were a therapist and had to help a teenager like yourself?" Once a problem statement has been made, goals are established based on the problem. Again, these goals are established within the team and written in the client's words. The team then brainstorms several ideas for objectives, and the client and family pick only the objectives they are most willing to try.

Methodology for treatment is established in the forms of group treatment, individual counseling, and family counseling. At this point, the team also discusses the unique needs of the individual client and the number of individual and/or family counseling sessions available per week. The intake session often provides the therapist with a good sense of the appropriateness of beginning family sessions early in the treatment plan, based on the family's ability to communicate. However, if the client and parents are having extreme difficulty with communicating during a session, it may be necessary to begin individual sessions and then work into family sessions. The therapist explains the time frame for the treatment plan and obtains an agreement from the team to review and re-evaluate the treatment plan within that time frame. This part of the intake session is a prime opportunity to instill hope for improvement with the client and with the family. The therapist then wraps up the intake session and asks the client and the family if they have any further questions. Before conducting the individual/family session, the next individual or family session is established and the therapist gives the client and/or family an appointment card.

4. Session Content

Once the treatment plan has been created, individual and family sessions begin as outlined by the treatment plan. Treatment plans are individualized according to client and family needs, which are established during the intake appointment. Further, the determination of how many individual sessions and how many family sessions should take place is dependent on how well the family communicates during a session. This can usually be determined during intake, and quite often, all team members are in agreement. As in all family therapy, some families have such ingrained and dysfunctional communication patterns that family members become quite hostile at any attempts at therapy, and therapy becomes almost impossible. Therefore, some families benefit from individualized sessions early on, followed by a gradual increase in family sessions. During these individualized sessions, each member can work through some of the issues that have led to such hostility. In addition, clients can learn from individual sessions as the therapist can be observed to model positive and more effective communication skills.

Each session, either individualized or family, begins by setting a general agenda based on the client's current needs and the treatment plan. Given that the client participates in group counseling three times per week, which primarily addresses substance abuse issues, the home-based treatment focuses on those issues that may underlie the addiction problem. The therapist encourages the client or the family to identify their needs and initiate the session agenda. This teaches the client and/or the family that they are in control of the treatment program and encourages them to assert themselves when or if their needs are not being met.

Once family therapy begins, past communication processes become apparent. Some ineffective communication patterns are observed and discussed. This is vitally important to treatment, because the main goal of treatment is for the client and family to learn more positive modes of communication and to begin solving problems within their family and support system, thereby weaning the client from the treatment program. Initially, most families benefit from a session on basic communication skills that includes "I" statements (e.g., "I feel angry when you yell at me and I would like it better if you would talk to me") listening skills, and paraphrasing and reflecting back (e.g., "What I heard you say is you feel angry when I yell and you would prefer that I talk to you using a normal tone of voice").

Throughout the treatment, all team members are encouraged to use basic communication skills while in session and to practice these skills on their own while outside of treatment sessions. Other topics typically covered during family therapy may include specific parent-child relational issues, establishing and negotiating behavioral contracts, handling substance abuse relapses in recovery, identifying familial triggers to client's substance abuse, parenting skills, co-dependency issues within the family, and unresolved childhood issues the parents may have.

Individual sessions are arranged depending on the adolescent's ability or willingness to participate in treatment. Structure within an individual session with an adolescent may include worksheets on particular topics, lessons on cognitive distortions and emotional awareness, coping skills, social skills, activities on establishing drug-free interests, and various psychoeducational topics. Other topics that may arise spontaneously include status of addiction recovery, relapse prevention, issues with parents, social issues, self-esteem issues, and emotional issues. Often the client in treatment feels overwhelmed by being on probation and being mandated to participate in a treatment program, in addition to school, social issues, parental problems, family conflicts, or emotional issues. Another common concern voiced by clients is that their parents are too busy or uninvolved in their lives. Consequently, the adolescent learns to isolate from his/her family and not ask for their help. Part of treatment involves engaging the parents in the treatment and improving communication within the family in order to teach the client how to ask for help. It is imperative that the therapist listens and validates the difficulty the adolescent may be experiencing, thus building rapport and establishing trust with the client.

Most sessions begin by discussing progress made to date, both by the client and the family. This solution-focused approach teaches the client and family to emphasize the positive and identify effective strategies used by all. Each family or individual session ends with the therapist highlighting the main points of the session. Each team member identifies what has been gained from the session and is assigned relevant homework. Homework usually involves journaling, researching schools or GED programs, and practicing self-talk and coping skills.

Each successive session begins with 1) highlights of progress made, 2) discussion of the areas of slow or no progress, 3) review of the previous session and assigned homework, and 4) creation of an agenda for the current session.

Chapter 5: Teen Group

1. Purpose

Broader goals for clients participating in the group include increasing motivation for sobriety; helping clients to process feelings and make good decisions on a many-times-per week basis; providing encouragement, support, a sense of hope, and concrete information on recovery; teaching healthy coping skills; helping clients understand their drug abuse/addiction within the context of their own lives; and exposing clients to vicarious learning through their contact with one another, as each struggles with many of the same problems.

2. Method

Group techniques incorporate a range of possible activities and topics including individual processing, art or music activities, experiential exercises, use of movies or videotapes, teen and adult speakers who share personal stories of recovery, and workshops on relevant topics or skills.

Group approaches also reflect the primary therapeutic paradigm of the agency. While processing feelings about the problem may be helpful at times, much attention is focused on finding solutions that make sense with a client's personal, family, and cultural context. Particular attention is given to problem solving, setting personal goals, and taking responsibility for one's own actions, utilizing coping skills, and making lifestyle changes that support sobriety.

3. Transportation

EMPACT provides all TSAT clients transportation to and from the TSAT groups. TSAT program assistants drive assigned routes on group days to pick up and drop off clients to and from the group. Additionally, TSAT staff are often able to pick up the clients from their schools. Transportation is provided for all clients within the geographical range (a pick-up/drop-off point is arranged for those outside this range who cannot otherwise get to group independently).

4. Group Rules

Group rules are devised to instill structure and safety within the group setting (see appendix).

5. Curriculum

5.1. Implementation of the Stages of Change Into the Group Process. The TSAT program curriculum is based on the trans-theoretical model of behavior change developed by Prochaska and DiClemente. In this model, treatment is devised by looking at what stage of change a client is in (i.e., how ready an adolescent is to work on his or her substance abuse problems). Accordingly, there are five stages of change. The first is the pre-contemplation stage of change, which focuses on discovery and consciousness-raising activities. The second stage is the contemplation stage of change, which also focuses on discovery and consciousness-raising activities as well as emotional arousal and self re-evaluation. Preparation and action are seen as the third stage, which involves mixing the discovery and recovery tracks. The goal is emotional arousal, self re-evaluation, commitment, and rewards. The fifth state is maintenance. During this stage the client is in the recovery track of treatment. Treatment focuses on commitment, changes sustained, and relapse prevention techniques. The fifth stage of change is the relapse/recycling stage, which is usually the time when a client relapses in treatment. During relapse, the program looks at which stage the client was in when he/she regressed or relapsed. Relapse or regression can happen during any stage. The stages of change are viewed as a cycle of treatment (versus a linear progress in treatment). A client can move back and forth between stages and jump between the relapse stage to the stage he or she was in prior to the relapse.

The curriculum for this program is designed to help facilitate change through the stages of change cycle. It represents a collaboration of therapeutic styles and resources. Group interventions and exercises used vary throughout the program, depending on where the clients are in their stage of change. For example, the group therapist may have eight clients in the group in three different stages. Specific activities for each stage of change individualize group treatment.

A cycle of change diagram is represented on a white board in the group room. Each client is aware of what stage he or she is in; often they are in more than one stage for different substances depending on their goals.

During the first group of the week, clients choose a goal that they would like to work on for the week. They explore what the goal is, how they plan to reach the goal, what might get in the way, and what they are going to do to overcome the obstacle that may inhibit them from reaching that goal. The clients are encouraged to choose goals that are attainable, so they can experience positive reinforcement and success in their lives. Furthermore, choosing one weekly goal helps clients stay focused on what they want to work on during the week.

During the last group of the week, clients are asked to review their goals and assess whether or not they accomplished them. Clients are encouraged to explore what steps helped them to reach their goal and what they will do differently next time if they did not. The purpose of these questions is to help deconstruct the week into individual actions or thoughts. Clients are not penalized or confronted if they did not reach their goal but rather supported and motivated to use different skills next time.

The TSAT group is open-ended and ongoing, which means that a client may enter the group at any given time during the 12-week group period, and that clients may graduate at any given time during the 90 days if they have completed the program. The group facilitator frequently reviews rules, topics, and exercises and introduces new material regularly.

5.2. Group Topics by Week.

WEEK ONE

Group 1: The first group of the 12-week curriculum consists of a client check-in, discussion of rules and confidentiality, a weekly goal-setting, and an introduction to the stages of change. The goal of the first group is to define the stages of change and to introduce the concept of establishing realistic and achievable goals. A written exercise and open discussion complete the first group. (Group facilitator notes and curriculum exercises are attached for the 12-week group.)

Group 2: The second group this week is a Family Night consisting of a check-in and discussion of family roles. The goal of Family Night is to introduce how a family system works and how our behavior affects others. A game highlighting family role interactions may be played, or clients may create a genogram with their family. A lengthy discussion and processing of these activities follows.

Group 3: The topic of the third group is consciousness raising. The goal of this group session is to increase self-knowledge and to recognize and acknowledge problems. Open discussion is encouraged. A short trip to a local park is an optional activity.

WEEK TWO

Group 4: The goal of this group is to look for social alternatives in order to effect change. The topic is social liberation. The group participants also set a weekly goal and take part in a written exercise and open discussion.

Group 5: The stages of change are reviewed. A presentation is provided by a community resource, such as the Center Against Sexual Assault or the Tobacco Prevention Agency. The goal of this group is to begin to access community resources and self-education. Open discussion follows.

Group 6: Emotional arousal is the topic of this group. The goal is to experience and to express feelings about problems and their solutions. The last hour of group might involve going to the park.

WEEK THREE

Group 7: The first group of week three features a review of rules and confidentiality, check-in, and the establishment of a weekly goal. The topic of self re-evaluation is on the agenda. The goal of this group is to think about and evaluate one's progress. The session includes a written exercise and open discussion.

Group 8: After check-in, a movie is shown and then discussed and processed by the group. The purpose of watching a movie in-group is to provide clients with insight into and

increase awareness of their personal lives. Movies selected for viewing often portray real-life experiences that reflect the experiences clients may have dealt with, or potential situations that they may endure if they do not make lifestyle changes. Movies are shown once per month. Before the movie is shown, the group leader watches the movie and takes note of key points that are important to raise during the follow-up discussion. Questions that are raised include, but are not limited to, key figures in the movie the clients may relate to, feelings the clients may experience while watching certain scenes and the reasons for those feelings, and asking the clients if they ever experienced a similar situation and how they handled it. The program coordinator has a list of 200 recommended movies to choose from (Gary Solomon's "The Motion Picture Prescription"), with references to help guide the group leader toward key points in each respective movie.

Group 9: The third group of this week consists of goal review and discussion of the signs of substance abuse. The goal of this topic is to identify the differences between substance abuse and drug dependence. An exercise and discussion follow.

WEEK FOUR

Group 10: The first group of the week is reserved for checking in, discussing rules and issues of confidentiality, and setting the weekly goal. The topic is commitment. The goal of this group is to acknowledge one's ability to change and make a commitment to it. A written exercise and discussion/process follow.

Group 11: Countering is the topic of this group. The goal is to counter or substitute alternative behaviors to drug use. The group goes on a field trip to, for example, a library or a museum or to play laser tag.

Group 12: After check-in and goal review, the topic of environmental control is addressed. The goal of environmental control is to restructure one's surroundings to avoid the probability of a problem-causing event. Discussion and an art project are part of the day's agenda.

WEEK FIVE

Group 13: During the first group of the second month of treatment, the group will check in, establish a weekly goal, and discuss raising awareness: the good things and the not-so-good things. The goal is to discuss pros and cons of problem behavior and what it means to change. The group will process the "Awareness Window," a written exercise.

Group 14: The second group of the month is Family Night and, as the title suggests, includes clients and their families. After introductions and check-in, the topic of "Defense Mechanisms" is explored. The inclusion of significant others to develop discrepancy and support is essential.

Group 15: The objective of this group is to assist members in focusing ahead and thinking about their possible futures; the topic is looking forward. A worksheet, which helps develop a picture of how we would like things to be, is used to promote discussion. Goal review is processed. During the last part of group, we may go to the park as a method of showing the youth fun activities that are drug-free.

WEEK SIX

Group 16: The first group of the week usually requires a lengthy check-in before developing a weekly goal. The topic of values is introduced and discussed. The goal is to process where values come from and how they develop.

Group 17: The goal of this group is to educate clients on the dangerous effects of drugs. This is a monthly activity used throughout the program to remind clients of the damage that using chemicals can cause.

Group 18: Value clarification is the topic for the day. The goal of the group is to define the concept of values and the role values play in our lives, particularly in relation to change. A written exercise is used. The weekly goal is also reviewed, and a trip to the park is left to the group leader's discretion.

WEEK SEVEN

Group 19: Again, the first group of the week is used to check in, discuss rules and issues of confidentiality, and set the weekly goal. The stages of change continuum is also reviewed. Today's topic—supporting self-efficacy: change success stories—is introduced. The goal of this topic is to encourage members to be hopeful about the possibility of change.

Group 20: Following check-in, a movie is shown and then discussed and processed by the group. (See Group 8)

Group 21: Planning for change is the day's topic. Following the check-in and weekly goal review, the topic is presented. The goal is to develop a plan to change one thing in a person's life. A written exercise and open discussion reaffirm successful decisions.
A trip to the park is optional.

WEEK EIGHT

Group 22: The group starts off with check-in, reviewing rules and issues of confidentiality, setting the weekly goal, and introducing a new topic: exploring importance, confidence, and desire for change. The goal is to define the clients' feelings about the importance of making changes, feelings of confidence that they can succeed, and feelings of desire or excitement about making changes. An in-group exercise is written and processed.

Group 23: A presentation from a community resource is on the agenda for today. The goal of this group is to begin to access community resources and to provide factual information and make it personally relevant.

Group 24: Ten common thinking errors is the topic for the day. The goal is to normalize, explore and process ambivalence, resistance, and denial. The weekly goal is also reviewed and discussed.

WEEK NINE

Group 25: During this group session, rules are reviewed. The group then checks in and establishes a weekly goal. The topic of the day is feeling healthy. The goal is to focus on

physical health as part of recovery and identification of some healthy behaviors. Therapists explore how healthy clients feel when they use versus when they are clean.

Group 26: This is the last Family Night of the 90-day treatment program. The topic is communication. Families check in, and the exercise is explained. The goal is self-evaluation with an emphasis on clients' self-determination for change.

Group 27: After reviewing the weekly goal, the topic—all about you—is introduced. The goal is discovery and helping to develop discrepancy between clients' current behaviors and their goals. A short, fun activity (e.g., a trip to the park) may take place. Weekend plans to facilitate sobriety are discussed.

WEEK TEN

Group 28: At the first group of the week, we check in, discuss issues of confidentiality, review rules, and set a weekly goal. The day's topic and exercise is "What Makes You Angry?" The goal is self-appraisal: to explore barriers, to learn sources of anger, and to develop choices.

Group 29: Ten common thinking errors are reviewed today, and an exercise is processed. The goal is to emphasize clients' personal choices. The stages of change may also be reviewed and discussed. A urinalysis may be included as part of the group.

Group 30: Following check-in and review of the weekly goal, a relevant movie is shown, then discussed and processed by the group (see group 8).

WEEK ELEVEN

Group 31: Following an extended check-in, the topic of consequences is discussed. The goal is to clarify beliefs about actions and consequences. A weekly goal is also established.

Group 32: "What Keeps Me From Having Fun?" is the topic for this group. The goal is to evaluate pros and cons of changing problem behavior. Reviewing the stages of change may be in order.

Group 33: A presentation from a community resource is on the agenda for the day. The goal of the group is to continue to access community resources. A review of the weekly goal is also completed. When no presenter is available, the topic of chemical vs. drug-free high may be explored.

WEEK TWELVE

Group 34: Normalizing and processing the clients' ambivalence and resistance is the strategy for discussing the day's topic of resistance. Check-in and weekly goal settings are also on the agenda.

Group 35: Emphasizing personal choices and responsibility for change, this group addresses the concept of thought-stopping as a technique and tool.

Group 36: Today is the last group of the ongoing 90-day group. This group identifies relapse warning signs. Recognizing clients' goals and strategies for change are the focus of this group.

Chapter 6: Multi-Family Group

1. Purpose

Families in TSAT are seen to have unique strengths while sharing certain commonalities of their shared struggles. During the multi-family groups, family members are guided to learn about potential solutions and to decrease any experience of isolation or stigma as a result of substance abuse and family problems.

2. Method

The multi-family group, or Family Night, is held on the first Tuesday evening of every month. As with the in-home individual and family therapy and teen group components, the multi-family group begins with checking in. During the check-in, family members share with each other their current progress, solutions, support, and resources. Information is shared on topics such as adolescent development, post-acute withdrawal, and roles in addicted families. The parents, teens, and significant others discuss issues, such as how parents can work with their teens to learn coping skills or effective discipline techniques, and ways in which family members can engage with each other more positively. Activities are provided based on communication, values, cooperation, and trust. Occasionally, events such as an art or talent show are organized. A potluck dinner is served during the multi-family group, and transportation is arranged for those who need this service.

Chapter 7: Transfer/Discharge Process

1. Discharge

Clients successfully finish the TSAT program when they complete 90 days of treatment. When clients miss groups, they are required to make up those groups and thus will extend beyond 90 days of treatment. If a client misses three groups in a row or five groups within the 90-day period, he or she is terminated from the program unless an agreement is made among the client, parent or guardian, probation officer or case manager, therapist, and program coordinator. A client will also be terminated if detained or placed into an inpatient program. If a probation officer or case manager wants the client to continue upon his or her release, this can be arranged with the understanding that the client needs to start the entire program over (i.e., 90 days of treatment). EMPACT-SPC agency policy states a client can be terminated after three no-shows in a row or within the three months of treatment. Home-based services also may be terminated, at the discretion of the in-home therapist.

2. Graduation Ceremony

The graduation ceremony focuses on the achievement of completing the 90-day treatment program. The graduating clients are the guests of honor at this group. The group members speak independently to each graduate to express their respective thoughts and feelings about the graduating client and their hopes for his/her continued success. Each client also gives the graduate a "gift," such as courage or strength, and talks about his or her appreciation of the graduate. The client is presented with a certificate for his or her participation and accomplishment.

3. Aftercare

Clients usually continue with seven to fourteen hours of home-based counseling services after the 90 days of treatment end. The program coordinator, in-home therapist, and probation officer or case manager will determine when this is necessary, based on individual clinical need. This will continue until the client accomplishes his or her goals on the individualized service plan or treatment plan, or until team members agree that the client has reached his or her potential.

Chapter 8: Staff Characteristics and Requirements

1. Program Supervisor

The program supervisor is the individual who oversees the counseling department and various counseling groups under the auspices of EMPACT-SPC. This individual acts as the advocate and liaison for the TSAT program and the counseling department's needs. The program supervisor provides weekly individual supervision to the TSAT coordinator, as well as group supervision to all clinical coordinators regarding handling clinical and administrative issues. The program supervisor disseminates all policy changes, contractual changes with funding sources, and departmental and agency updates. The final approval of all new counseling department personnel hired rests with this person, as do ongoing performance evaluations of the TSAT coordinator.

2. TSAT Coordinator

The TSAT program is a team effort. The TSAT coordinator is the primary therapist and group leader. Beyond orchestrating the activities of the treatment team, it falls to the coordinator to be a liaison and sometimes an advocate for the client. The TSAT coordinator acts as the primary liaison with the Arizona Office of the Courts to manage customer service situations with its staffing coordinator, ensure that all contractual obligations are met, provide weekly lists of current and waitlisted clients, and decide on any programmatic changes.

The TSAT coordinator compiles monthly summaries for the courts from the in-home therapists. These summaries stimulate billing and must be collected from staff, then passed to relevant departments prior to billing.

The juvenile offender cases are staffed with probation officers to determine preliminary appropriateness of juveniles entering the TSAT program, and the need for extensions or premature terminations from the TSAT program. The TSAT coordinator troubleshoots potentially problematic situations, such as geographic barriers, work or school schedule conflicts, parental resistance, and inappropriate use of services (e.g., negative in-group behavior or a high no-show rate). The TSAT coordinator directs the proper flow of enrollment, authorizations, and termination forms, and ensures that family and group therapists

contact probation officers weekly to provide updates on juveniles' participation and progress in the TSAT program.

Clients are staffed weekly between the therapist and program coordinator. If an emergency occurs that cannot wait to be staffed, the therapist will call the program coordinator (office, cell, or pager) and staff the situation at that time. TSAT also has a 24-hour crisis department for after-hour emergencies. If the program coordinator needs further clinical guidance, the situation is staffed with the counseling department manager.

3. Family Therapist

The family therapist makes the initial contact with a family following authorization, to set up an intake time and introduce the client and family to the TSAT program's structure and procedures. The family therapist completes a full, comprehensive assessment with the adolescent participant and the family to determine the appropriateness of the client's participation in the program. A treatment plan is created, delineating both client and family goals.

The family therapist facilitates the family therapy toward the goals of the juvenile and the family members, and collaborates with the TSAT coordinator, group staff, probation staff, case management, psychiatrist, and other helping professionals regarding the status of the client and family in their progress toward treatment goals and emerging needs.

The ongoing needs of the client and his/her family are assessed by the family therapist for any ancillary services, such as applying for economic assistance, state-funded health care, learning disability screening, vocational assistance, family planning/reproductive health care, housing assistance, child care, legal aid, and 12-Step resources.

The family therapist completes progress notes for sessions, monthly summaries for the courts, treatment plan reviews every 30 days, and termination paperwork.

4. Program Assistant/Driver

The program assistant/driver establishes time and location for transportation to and from TSAT group through contact with the client, family, probation officer, or in-home therapist. Clients receive instructions from the program assistant/driver regarding vehicle rules and safety regulations while being transported in the van. The program assistant/driver also manages appropriate handling of vehicle emergencies, such as notifying the operations manager, vehicle coordinator, towing company, and service stations and filing incident reports. The program assistant/driver also provides clients and families with general protocol for transportation changes.

The program assistant/driver reports any rule infractions or suspicious/notable behavior to the coordinator (evidence of out-of-group liaisons, chemically altered appearance, bizarre or inappropriate behavior, situations at clients' homes). The program assistant/driver sends copies of the urinalysis reports to the probation department, case managers, home therapist, group therapist, and client. The program assistant/driver assists the group therapist in ensuring structure and discipline during group, upholding group rules and norms, providing feedback to clients, or de-escalating upset or angry clients.

Chapter 9: Quality Assurance

1. Clinical Supervision

Clinical supervision is required of all clinical personnel. All full-time therapists are required to receive weekly supervision. All part-time, certified, master's level staff meet for supervision one time per month. All full-time, non-certified, master's or bachelor's level staff meet weekly. Supervision time is used to staff TSAT cases, discuss policies and procedures, review any new or ongoing training needs, and process feedback.

2. Staff Training (See appendices for a table of Training Requirements)

3. Documentation Procedures

Ongoing progress notes for each group, individual, family, and multi-family therapy session are required. Billable and non-billable notes to document contact/conversations with clients, family members, probation officers, and case managers are also ongoing.

Every other week, a list of all current clients participating in TSAT is sent to the probation department's staffing coordinator (but does not include clients on probation, who are paid for through other funding sources). A monthly summary of court-authorized services is sent to the probation department.

Treatment plans are documented quarterly. Supervision documentation of all staff, as well as training documentation for all staff, is also submitted quarterly. Yearly evaluations of staff are documented.

Documentation to Child Protective Services and relevant EMPACT-SPC staff regarding any report made, information requested by probation or case management (i.e., attendance records), therapist recommendations, progress updates, internal incident reporting regarding any damage to property, or events incurring liability are documented on an as-needed basis.

4. State Regulations

The primary source of referrals to TSAT is the Arizona Office of the Courts (AOC). The Regional Behavioral Health Authority (RBHA) occasionally refers juveniles to TSAT. There is no formal reporting requirement regarding TSAT, since there is no formal contract between AOC and EMPACT-SPC to deliver services. However, any service provided to juveniles under the AOC funding source is subject to the single purchase of care (SPOC) auditing requirements. The audit typically reviews clinical record documentation regarding quality of care and financial reconciliation. This audit occurs once per fiscal year. Similarly, the RBHA has auditing requirements that occur depending on the outcome of the previous audit.

5. Accreditation

EMPACT-SPC applies to the Commission for Accreditation of Rehabilitation Facilities (CARF) for accreditation and pays a fee, and CARF auditors come to EMPACT to conduct inspections. Once an audit is successfully completed, CARF confers a three-year, one-year, or provisional accreditation. EMPACT- SPC has recently been audited and received a three-year accreditation from CARF.

The audit consists of a review of policies and procedures, site visits, chart reviews, personnel file reviews, financial reviews, interviews with staff, and interviews with clients to determine compliance. From these reviews, CARF makes recommendations (i.e., things that have to change) and suggestions (i.e., things they think might improve the agency but are not required) and also notes where the agency is performing in an exemplary way. This report is sent to the CARF commission, where it is reviewed and an accreditation determination is made.

Chapter 10: Implementing the TSAT Program

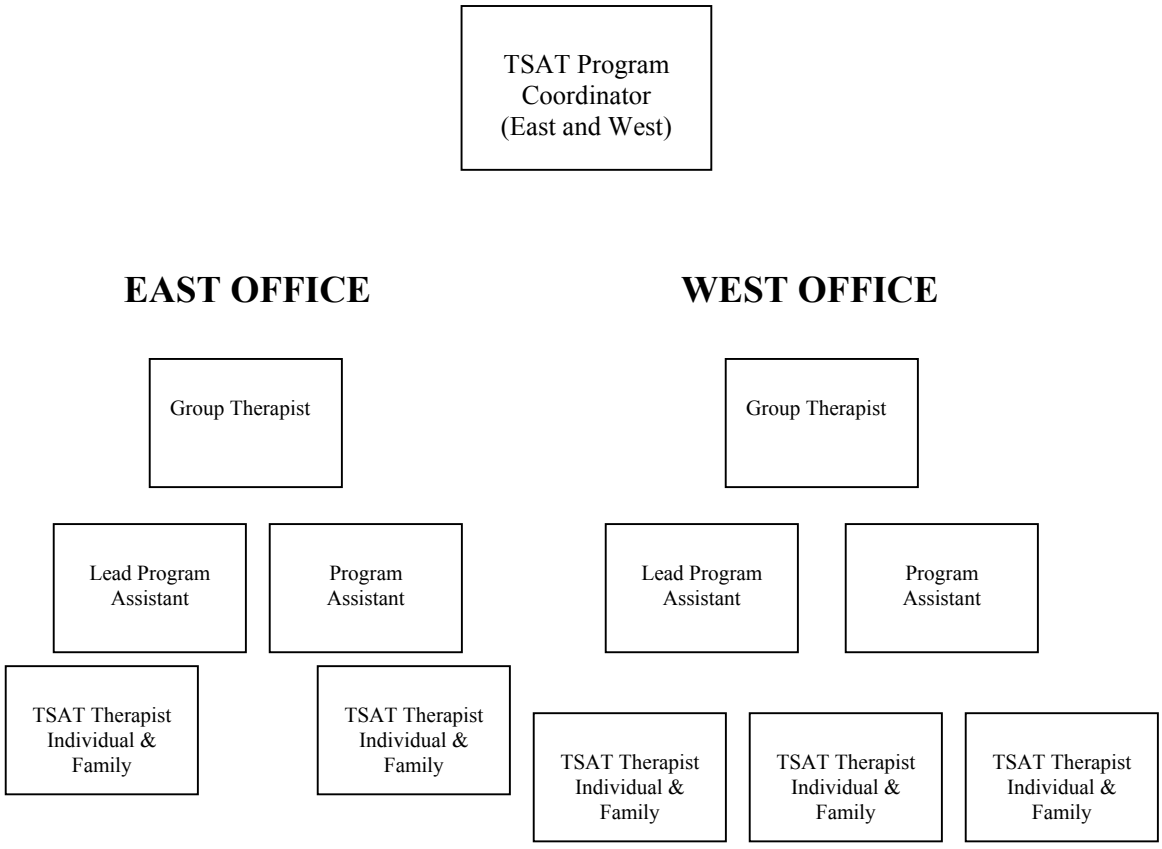
1. Facility Needs

The current TSAT programs are housed at EMPACT-SPC's facilities in Tempe, Arizona (East Office) and Glendale, Arizona (West Office). The East Office group room is 270 square feet, and the coordinator's office is 132 square feet. The West Office has a group room with 318 square feet of space and a staff room with 165 square feet. The staff room is equipped with telephones, a fax machine, and computers to aid the documentation process. Transportation is a key component of the TSAT program. The availability of late-model, safe, well-equipped, and well-maintained vehicles facilitates client participation.

It is recommended that the group room be 250 to 350 square feet to accommodate an active group of teenagers. In addition, the room needs to have comfortable yet sturdy seating, a bathroom facility, a drinking fountain, a TV and VCR, and, if possible, a kitchen facility or refrigerator. Sports equipment such as basketballs or volleyballs are appropriate to have for park use.

2. Organizational Structure

TSAT Program Organizational Chart



3. Staff Meetings

All TSAT program meetings are held quarterly. Site meetings (West TSAT or East TSAT) are held monthly. Weekly meetings of the group therapist and program assistants are conducted to organize curriculum and in-group activities and to staff current clients.

4. Scheduling

Family therapists schedule their own clients, based upon client and family availability and around group counseling sessions.

5. Challenges for Replication

The biggest challenge for those attempting to replicate the TSAT program will be financial. Other challenges to be expected include client detentions or absences and work or school schedules that conflict with group times. Families that are unwilling to participate with their adolescents in treatment are also a major challenge.

APPENDICES

EMPACT
Suicide Prevention Center

COMMUNICATION RECORD

Client Name: _____ Client Number: _____

Date	Description of phone contacts, paper trail, consultations; staff signature

EMPACT
Suicide Prevention Center

CLIENT AND FAMILY INFORMATION FORM

This form provides background information necessary to provide therapy. Please fill out the form completely and return it to the receptionist or your therapist upon completion. Your assistance is appreciated. While you wait for your interview, please read the attached client information. Thank you for choosing EMPACT. We will do our best to meet your needs.

---

*A7 Client Name (Person identified as needing help):_____

Phone(Home)_____ (Client/Parent Work)_____

*B13 Address_____ City_____ State_____ Zip_____

Place of Birth_____ Intake Date_____

9 Date of Birth _____Age _____ Social Security # _____

D Emergency Number/Contact:_____
Name Relationship Phone

E Client receiving Case Management? Yes ___ No____ Case Manager _____ Agency_____
Receiving other state services? Yes_____ No____ Courts_____ DES_____ Other

_____

*F10 Sex (circle) 1-Male 2-Female *M14 Is client a veteran? Yes___ No___

*G11 Ethnicity: 1-White 2-Black 3-Hispanic 4-Asian 5-Native American-Tribe_____

H Employment Status: 1-Full time 2-Part time 3-Housewife 4-Student 5-Retired 6-Unemployed

*I15 Residence (county): 04-Gila 08-Maricopa 12-Pinal 16-Out of State 20-Other

*J6 Primary Language: 1-English 2-Spanish 3-Native American 4-Other

*K22 Marital Status of Client: 1-Never married 2A-Married 2B-Partnered 3-Divorced 4-Widowed 5-Separated

L Marital History: No. of marriages of client (or parent) _____

---

*N20 Family Size (all persons in household) No. in home:

Name	Birth Date	Age	Grade	Relationship to Client	Gender	School yrs. complete
*24 CLIENT					M F	
					M F	
					M F	
					M F	
					M F	
					M F	

O Current Physicians: _____

Name City Phone

_____

Hospital Name Address Phone Number

P Please list all current medications (prescription and non-prescription):

Medication Dose & Frequency Taken Since Prescribed by For Treatment of

_____

_____

Q Handicaps: 1-Communication 2-Blindness 3-Deafness 4-Mobility 5-Severe Medical 9-None

*R28 DNHS Handicaps (circle) 1-Not Disabled 2-Physically Disabled 3-Physically Disabled/Work 4-Physically Disabled/Transportation 5-Physically Disabled/Both 6-Developmentally Disabled 7-Developmentally Disabled/Work 8-Developmentally Disabled/Transportation 9-Developmentally Disabled/Both

S30 Who referred you _____

T State the reason for seeking counseling (in your own words):

_____

_____

_____

U23 Number of days you waited to get appointment after calling EMPACT_____

---

*V21 Financial Statement – Fee-Setting Information:

(Please include yearly gross income of all persons in household unless individuals live on separate budgets)

Wages, Tips/Commissions	$_____	Pension	$_____
Alimony and Child Support	$_____	Unemployment	$_____
Veterans Benefits	$_____	Public Assistance	$_____
Social Security Income & SSDI	$_____	Other Income	$_____

How many live on this income?_____ TOTAL ANNUAL FAMILY INCOME_____

Employer (Client or Parent)_____Occupation_____

Employer (Spouse)_____Occupation (Spouse)_____

*W19 Income Sources (circle) 01-No Income 02-Employment 03-Retirement 04-Family 05-Unemployment Compensation 06-AFDC 07-Food Stamps 08-Gen. Assist. 09-Social Sec. 10-SSDI 11-SSI 12-Veterans Compensation 13-Other_____

*X18 Does your family have medical insurance? Yes_____ No_____

Insurance (circle) 1-Medicare 2-AHCCCS 3-Private 4-CHAMPUS/VA 5-Other 6-Blue Cross 7-HMO 9-None

*Y12 Insurance Plan Name_____ *W5 Plan ID #_____

Insurance ID #_____ Group# (If applicable) _____

My signature below indicates that the above information is true and correct to the best of my knowledge.

Client or Guardian (Print)	Signature	*04 Date	Therapist Signature or Designee

DESCRIPTION OF SERVICES

This service description has been prepared to acquaint you with the counseling and crisis services provided by EMPACT-SPC. Please feel free to ask your therapist or our SERV-U staff any further questions you may have regarding our services.

I. GENERAL INFORMATION

PURPOSE OF THE CENTER

EMPACT-SPC provides counseling for persons and families who are overwhelmed by the pressures and perplexities of daily living and family life. EMPACT-SPC seeks to improve the lives of adults, youths, and families throughout Maricopa County.

CRISIS SERVICES

EMERGENCIES - In the event you encounter an emergency or crisis situation and you need to speak to a therapist immediately, please call our crisis hotline – 480-784-1500. This line is answered 24 hours a day, seven days a week. A crisis therapist will work closely with you to ensure that you receive the best possible care.

OTHER CRISIS SERVICES - Crisis telephone services are available to all clients. In-home or on-site crisis interventions and in-office crisis counseling may be available based upon eligibility criteria and benefit plans. You can obtain phone counseling and eligibility assistance by calling 480-784-1500.

COUNSELING SERVICES

FOCUS - EMPACT-SPC provides counseling services to adults, youths, and families in accordance with eligibility criteria and benefit plans. EMPACT specializes in family therapy. Recognizing the variability of problems experienced by families, EMPACT provides flexibility in treatment and intensive services when authorized.

FIRST INTERVIEW - Your therapist will discuss with you the concerns that brought you to counseling and will ask you for a variety of information that best enables him/her to help you. Together, you will decide what issues to address and what type of counseling would be best for you (individual, group, marriage, family, or a combination of these).

TIME - Most counseling sessions are 45 minutes in length; family, in-home, and multi-family therapy sessions may last several hours; group sessions last between one and two hours. Your therapist will discuss with you the frequency and length of your appointments. Consistent attendance is essential for counseling to be effective. You may be charged for a missed appointment unless your appointment is canceled at least 24 hours in advance. Messages may be left after hours and on weekends and holidays by calling 480-784-1514.

HOME VISITS - Home visits may be available to families and youths. Home sessions will be of varying length according to the needs of the family. Home visits must be pre-authorized by your insurance company or funding source.

II. FEES AND PAYMENT INFORMATION

CLIENT FEES - EMPACT-SPC employs only highly skilled professionals and advanced supervised interns. In order to maintain this high quality, we must be attentive to fees. At the same time, our primary concern is for your well being, and we want to do everything possible to enable you to receive the help you need.

CHARGES - The normal and customary fee for a 45-minute individual, couple or family therapy session is $80.00 ($20.00 for a group session). (SERVICES MAY BE PROVIDED AT NO FEE TO THE CLIENT OR WITH A SMALL CO-PAYMENT BASED UPON ELIGIBILITY CRITERIA AND YOUR BENEFIT PLAN). Home-based services are charged at the rate of $80.00 per hour per staff person present. Eligibility and fees for psychological tests and psychiatric services vary based upon your benefit plan and should be discussed with the therapist. The normal and customary fees and services are restricted to vendor-status staff or staff approved by the associated insurance company. Special therapy packages are available for clients with minimal resources. These are described below. Payment is due at each visit, payable by cash, check, or credit card (MasterCard or Visa). There will be a $15.00 charge for checks returned for insufficient funds. We may refuse service if payments are not being made on a regular basis.

VALUE OPTIONS NON-TITLE XIX COPAYS - Clients applying for state subsidized services through Value Options are required to submit financial records to document income and determine eligibility for reduced fees. Copay will be assessed based upon a standardized fee scale. Copays are reassessed annually. Continuation of eligibility for state subsidized services is contingent upon submission of appropriate financial documentation as requested. All copays are due prior to or immediately following therapy sessions. Value Options copays are assessed as a percentage reduction of the cost of each session. The amount of the Value Options copay may vary by the service provided or the length of the therapy session.

PRIVATE INSURANCE PLANS - Many insurance companies partially pay for counseling and psychotherapy without designating a specific provider. If you have an insurance plan that does not contract directly with EMPACT-SPC for services, you will be charged the full fee. **PAYMENT IS DUE AT THE TIME OF EACH VISIT REGARDLESS OF INSURANCE REIMBURSEMENT. IT IS YOUR RESPONSIBILITY TO ENSURE THAT YOUR INSURANCE WILL REIMBURSE YOU FOR THE COST OF THE THERAPY.** You will need to review the details of your plan with your insurance company. You will want to inquire about copays, deductibles, maximum yearly benefits, provider credentials, covered diagnoses, and any other information that may affect your coverage. EMPACT will provide you with statements of account to assist you in obtaining reimbursement upon your request.

HMO/EPO HEALTH PLANS - EMPACT-SPC contracts with several managed care companies (BIODYNE, VALUE OPTIONS, PHCS) to provide behavioral health services. Services will be provided to HMO/EPO clients only upon receipt of a referral and formal authorization received directly from the health plan. Clients will be charged the appropriate co-payment based upon health plan benefits. EMPACT is required to collect co-payments at each visit. Co-payments cannot be waived or reduced.

AHCCCS/TITLE XIX GUIDELINES/FEES - If the client has AHCCCS coverage and an authorization for treatment has been received, the client will not be personally charged for any of the authorized services. Services requested by the client/family and provided by the agency which have not been authorized by the AHCCCS health care plan, may be charged to the family/client.

SPECIAL THERAPY PACKAGES - EMPACT-SPC offers the following packages for people without behavioral health benefits. These packages are based upon the training, education, and credentials of the associated therapist. These packages have been developed to help meet the needs of clients without behavioral health benefits who have limited financial resources. These packages also provide intensive training and supervision opportunities for EMPACT's staff.

PACKAGE A: $20.00/hour

STAFF LEVEL - Restricted to interns-in-training. This package provides up to 12 sessions of therapy with an intern-in-training. All interns receive supervision at EMPACT from vendor status staff. This rate applies to the following services: intake, family therapy, and individual therapy. No psychiatric services are available with this plan. These services are not eligible for insurance reimbursement. Minimum payment is $20.00 per visit.

PACKAGE B: In-office $45.00/hour In-Home $55.00/hour

STAFF LEVEL - Restricted to "associate level" EMPACT therapists who are under the supervision of vendor status supervisors. This rate applies to the following services: intake, family therapy, and individual therapy. Home-based therapy rate in this plan is $55.00 per hour. Group therapy rate is 50% of the individual rate. No psychiatric services are available with this package. These services are not eligible for insurance reimbursement. Minimum payment per visit is $45.00 for in-office therapy and $55.00 for in-home therapy.

PACKAGE C: $90.00/hour

STAFF LEVEL - Restricted to vendor status therapists. This rate is charged to all private insurance companies effective 9/1/94. This rate applies to the following services: intake, family therapy, individual therapy, and home-based therapy. Psychiatric services are available with this package. Minimum payment per visit with or without private insurance is $60.00.

CHANGES IN FEE SCHEDULE - If a new fee schedule or new criteria for payment becomes effective during the course of your treatment, you will be advised of such changes 30 days in advance of the effective date of the changes.

MISSED APPOINTMENTS - Appointments missed without 24-hour notice will be charged a fee of $40.00, or the amount designated by your health plan when applicable. Effective group therapy demands committed members; therefore, missed group sessions will be treated and charged as missed appointments regardless of notice provided. These charges must be paid before further services will be provided. Clients with AHCCCS coverage will not be charged for missed appointments but will be excluded from obtaining further services after two missed appointments in a six-month period.

SPECIAL REPORTS, LETTERS, OR TESTIMONIES - If the client requests a special report to be drawn up, a fee of $50.00 will be charged per report. Clients requesting a letter from their therapist regarding therapy services rendered, written recommendations, or written professional opinions will be assessed a fee of $20.00 per letter. Therapists requested to testify of the behalf of the client will assess a fee of $90.00 per hour (usual and customary) and will bill from portal to portal.

INSUFFICIENT FUNDS CHECKS - EMPACT will charge a processing fee of $15.00 for each check returned for insufficient funds.

III. CLIENTS' RIGHTS

RIGHT TO KNOW - You may ask any questions you have about the counseling process.

THERAPIST ASSIGNMENT - If you do not wish to see the therapist you met initially, you may ask for a different therapist at this agency or for a referral to another therapist or agency in the community.

ENDING THERAPY - You may end therapy at any time.

VIDEO/AUDIO TAPING/OBSERVATION - In the event that your therapist wants to record, videotape, or allow interns/supervisors to observe a session, he/she will ask for your written permission and explain to you the purpose for the recording/observation. You may refuse or withdraw your permission at any time.

LEAST RESTRICTIVE ENVIRONMENT - The client has the right to the provision of services in the least restrictive environment possible.

FAMILY INVOLVEMENT - The client has the right to involve parents, relatives, guardians, or friends in the planning and provision of treatment according to the wishes of the participants, unless such participation is clinically counter-indicated.

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS - The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal law and regulation. Generally, the program may not say to a person outside the program that a patient attends the program or disclose any information identifying a patient as an alcohol or drug abuser unless: 1) The patient consents in writing; 2) the disclosure is court ordered; and/or 3) the disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulation by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations. Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities.

BASIC CLIENT RIGHTS - As a client, guardian, or parent, you have the following additional legal rights.

1. The right to treatment and services under conditions that support the client's personal liberty and restrict such liberty only as necessary to comply with treatment needs.
2. The right to an individualized, written treatment plan, periodic review and reassessment of needs, and revisions of the plan including a description of the services that may be needed for follow-up.
3. The right to ongoing participation in the planning of services to be provided as well as participation in the development and the periodic revision of the treatment plan and the right to be provided with an explanation of all aspects of one's own condition and treatment.
4. The right to refuse treatment.
5. The right to refuse to participate in experimentation without the informed, voluntary, written consent of the client, parent, or guardian; the right to protection associated with such participation; and the right and opportunity to revoke such consent.
6. The right to freedom from restraint or seclusion. Restraint and seclusion may only be used in situations where there is imminent danger that the client will injure self or others or to prevent serious disruption of the therapeutic environment, and all other less restrictive methods of control have been exhausted.
7. The right to a humane treatment environment that affords reasonable protection from harm, appropriate privacy, and freedom from verbal and physical abuse.
8. The right to confidentiality of records.
9. The right to access, upon request, to the client's own records in accordance with state law.
10. The right to be informed, in appropriate language and terms, of one's rights including the right to legal counsel and all other requirements of due process.
11. The right to not be subjected to remarks that ridicule the clients or others.
12. The right to refuse to make public statements acknowledging gratitude to the program or to perform at public gatherings.
13. The right to assert grievances with respect to infringement of these rights, including the right to have such grievances considered in a fair, timely, and impartial procedure.
14. The right of access to a qualified advocate in order to understand, exercise, and protect the client's rights.
15. The right to be informed, in advance, of charges for services.
16. The right to all available services without discrimination because of race, spiritual beliefs, sexual orientation, gender, age, handicap, national origin, or marital status and the right to referral, as appropriate, to other providers of behavioral health services.
17. The right to exercise civil rights, including but not limited to the right to register and vote at elections, acquire and dispose of property, execute instruments, enter into contractual relationships, marry and obtain a divorce, and hold professional or occupational or vehicle

operator's licenses, unless the client has been adjudicated incompetent or there has been a specific finding that such individual is unable to exercise the specific rights or category of rights. In the case of a client having been adjudicated incompetent, these rights may be dissolved to the client's guardian, if so specified by the court.

18. The right to a smoke-free environment as stated in the agency's policies and procedures.

MEDICATIONS - The client has the following rights related to medications.

1. All clients receiving services in a licensed behavioral health service agency have a right to be free from unnecessary or excessive medication.
2. Medication shall not be used for punishment, for the convenience of the staff, as a substitute for treatment services, or in quantities that interfere with the client's treatment program.

IV. INFORMED CONSENT

LIMITS ON CONFIDENTIALITY - Information disclosed in counseling is kept strictly confidential and will not be revealed without your written consent, except in limited situations. These conditions are as follows:

1) If you threaten serious physical injury or death to another person, we are required to inform that person, his/her family, other potential victims, and appropriate law enforcement agencies. Involuntary hospitalization procedures may be implemented at this time.
2) If you threaten to commit suicide or seriously harm yourself, we may have to notify your family and other appropriate individuals or agencies. Involuntary hospitalization procedures may be implemented at this time.
3) If by talking to you we learn about or suspect abuse, neglect, or exploitation of a minor or an incapacitated adult, we are required by law to make a report to the appropriate authorities.
4) If a court of law issues a subpoena or court order, we may be required to provide the information or records specifically described in the subpoena or court order. Your therapist could be court ordered to testify in certain circumstances.
5) If you are in therapy or being tested by court order, we may be required to provide test results or reports about therapy to the appropriate authorities in accordance with the specific court order.
6) If a client files a legal or civil suit against this organization, any and all client records may be required to be released to the court.
7) If a client lodges a complaint against this organization or a therapist of this organization with a professional organization or licensing agency or organization, any or all client records associated with the complaint may be required to be released to the reviewing organization.
8) If a plea of insanity is entered into court on your behalf, any and all records may be required to be released to the court in accordance with the specific court order.

RELEASE OF INFORMATION - Upon your written request, we will release appropriate parts of your file to any person or agency that you designate. We will attempt to tell you at that time whether we think releasing the information could be harmful to you.

EMPACT-SPC provides primarily family therapy to the clients whom it serves. When a client record indicates that additional adults or minors have been present in therapy sessions, then separate consents to release confidential information must be obtained from each person present in the identified therapy sessions as well as for the identified client prior to the release of any information. If a couple that has received therapy together becomes estranged or divorced, it may be difficult to obtain consent to release confidential information from all participants in therapy. EMPACT will not release any information or records in these cases without the full written consent from all parties involved.

TREATMENT METHODOLOGY - EMPACT provides brief, resolution-focused treatment of behavioral health problems. Treatment is designed to strengthen client and family skills in handling life challenges. EMPACT's approach to therapy promotes independence as opposed to dependence, empowerment as opposed to victim focus, and behavior change as opposed to uncovering unconscious material. Long-term treatment, memory retrieval, and regression are not provided through EMPACT.

TREATMENT RISKS - Therapy promotes change in human behavior. Change can be somewhat unpredictable. As people change and grow as individuals, they may choose options that may not be agreeable to all parties. As an example an adolescent may choose to leave home after therapy, a couple may divorce, or a client may make a life choice that is not welcomed by other family members. Therapy does not guarantee a specific outcome but works toward relieving the symptoms identified by the client.

V. COMPLAINTS AND GRIEVANCE PROCEDURES

EMPACT-SPC is invested in providing quality client services. If the client has concerns related to interactions with agency staff or the quality of care provided by staff, or experiences a client rights violation, the following process is available to you.

1st. Concerns should be discussed directly with the client's therapist.

2nd. If the client remains unsatisfied, the client may contact the VP/clinical director - (480) 784-1514. The VP/clinical director or his designate should respond within 10 business days after receiving the grievance.

3rd. Contact your behavioral health plan representative. If you do not know whom to contact at your health plan, please call the EMPACT clinical director for information.

Value Options Clients can write or call: Value Options - Grievance Dept., 444 N. 44th Street, Suite 400, Phoenix, AZ 85008. Alleged violations of licensure rules can be reported to: Arizona Department of Health Services, Behavioral Health Licensure, Division of Health and Child Care Review Services, 1647 E. Morten, Suite 220, Phoenix, AZ, 85020, (602) 674-4300.

EMPACT-SPC staff are prohibited from discharging or discriminating in any way against any client by whom, or on whose behalf, a complaint has been submitted or who has participated in a complaint investigation process.

My signature below verifies that I have received a copy of the Description of Services provided by EMPACT-SPC, and the EMPACT representative has reviewed it with me. I have read the Description of Services, including the grievance procedures, and agree to abide by the provisions outlined. I consent to receive treatment from EMPACT-SPC.

_____	_____	_____
Client Name	Client/Guardian Signature	Date

CONSENT FOR COUNSELING A MINOR

I, (We)_____the undersigned parent(s) or guardian(s) of the _____ (number)

herein identified minor(s):

_____ age_____

_____ age_____

_____ age_____

_____ age_____

do hereby give my/our written consent for said minor(s) to be entered into counseling at EMPACT-SPC.

It is understood that this consent is subject to revocation by the undersigned at any time except to the extent that action has already been taken on that consent.

My signature below also verifies that I am a legal parent or guardian of the above identified minor(s) and have the legal right to consent for said minor(s) to receive treatment from EMPACT-SPC.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date

EMPACT
Suicide Prevention Center

SERVICE AGREEMENT/CONSENT TO TREATMENT

INSURANCE/FEE/CONTRACTS

Client Name: _____ ID: _____

I have been given and will read the client information pamphlet, including the section on fees, client rights, and grievance procedures. I have agreed to provide insurance forms and remit any insurance reimbursements promptly. I understand that all services are provided on a pro rata basis at the rate of $90.00 per 50-minute hour. EMPACT-SPC services and fees have been discussed with me, and I have agreed to the following services.

_____ Crisis/emergency services
_____ Family treatment
_____ Home-based treatment
_____ Psychiatric services
_____ Individual treatment
_____ Couple treatment
_____ Group treatment

I understand that failure to cancel appointments within 24 hours of a scheduled session will result in a charge to my account of $40.00 or the amount designated by my health plan when applicable. (AHCCCS clients are excluded from these fees but may become ineligible for additional services at EMPACT for failure to keep scheduled appointments.)

My signature below indicates that I understand and agree to the above conditions. I consent to receive routine evaluation and treatment services from EMPACT-SPC as deemed necessary for the diagnosis and care of myself and/or my immediate family.

I understand that my payment/co-payment amount is _____ _____ per (circle one) hour visit week.

Signed: _____ _____
Client/Legal Custodian Signature Date

STATE SUBSIDES (RELEASE OF INFORMATION)
(Complete only if you are seeking state subsidized services)

I am unable to independently cover the cost of the services requested and need financial assistance. I understand that in order to receive state subsidized services I must grant permission to EMPACT-SPC to release/exchange information to/with VALUE OPTIONS. **My signature below gives my permission for EMPACT-SPC to copy and send copies of all documents related to my family on file at EMPACT–SPC to VALUE OPTIONS for the purpose of coordinating treatment, obtaining authorizations for services, adjudicating claims, and evaluating services.** This authorization includes verbal and written information and shall be valid for 12 months following the close of services received through EMPACT-SPC or until all claims for services are closed, whichever is greater. I understand that a VALUE OPTIONS or state representative may contact me to coordinate, approve, or evaluate services.

Signed: _____ _____
Client/Legal Custodian Signature Date

_____ _____
Partner/Legal Custodian Signature Date

_____ _____
EMPACT-SPC Staff Date

TREATMENT PLAN

Client Name: _____

EMPACT ID #: _____

Date: _____

Primary Therapist: _____

AXIS I _____

AXIS II _____

AXIS III _____

AXIS IV _____

AXIS V _____

Problem #	Problem Statement	Goal/Solution	Objective	Methods/Frequency	Estimated Attainment Date	Date Goal Achieved

_____ _____ _____ _____ _____

STAFF SIGNATURE/TITLE DATE REVIEW DATE CLIENT SIGNATURE DATE

_____ _____ _____ _____

SUPERVISOR SIGNATURE/TITLE DATE (OPTIONAL) GUARDIAN SIGNATURE DATE

EMPACT
Suicide Prevention Center

CHILD AND ADOLESCENT COMPREHENSIVE ASSESSMENT

Assessment Date _____

Member Name _____ DOB _____ Phone _____

Address _____ City _____ State _____ Zip _____

Social Security # _____ Member ID# _____

AHCCCS ID# _____ Rate Code _____ Health Plan _____

PCP/Physician _____ Telephone # _____

PCP/Physician Address _____

Legal Guardian _____ Telephone # _____

Parent _____ Telephone # _____

Emergency Contact _____ Telephone # _____

Legal Status Voluntary ___ Involuntary___ Please Explain _____

Other Current County/State Agency Involvement _____

Primary/Preferred Language _____

Please identify sources of information (check all that apply):

☐ Member ☐ Records ☐ Other: _____ ☐ Agency (name): _____

☐ Family member (Name/relationship): _____ ☐ Guardian

If the member is unable/unwilling to provide information, please explain: _____

_____

R9-20-402-B1 PRESENTING ISSUES

What is the member/guardian here for? _____

_____

_____

_____

_____

_____

What prompted the member/guardian to seek help now? _____

How long has the above been going on? (current episode) _____

What current stressors may contribute to the onset or worsening of behavior problems? _____

What is currently being done about the problem? _____

What are the member's/guardian's strengths to resolve this issue? _____

What services does the guardian think the member needs? _____

What services does the member think he/she needs? _____

How will the member/guardian know when the problem is better? _____

PRESENTING ISSUES CONTINUATION/SUMMARY

R9-21-305-B3 SOCIAL HISTORY

Living arrangements: Parents ____Other ____ Please explain: _____

Does the member have contact with his/her natural parents? Yes ____ No ____ Please explain:

Was the member ever a victim of physical and/or sexual abuse? Yes ___ No ___ If yes, please explain:

Has there ever been CPS involvement: Yes ___ No ___ If yes, please explain: _____

Parent/Guardian's occupation/source of income: _____

Is the member currently in day care? Yes _____ No _____

Family history of mental illness and/or substance abuse: Yes _____ No _____ If yes, explain: _____

Family members and age: _____

Does the member have difficulty getting along with peers? Yes ____ No ____ If yes, explain: _____

What activities does the member enjoy: _____

Support Systems (please circle): Family Friends Church Self Help Groups School Other None

Does the member need assistance with self care and/or basic needs: Yes ___ No ___ If yes, explain: ____

R9-20-402-B3 MEDICAL HISTORY

Allergies (food, medications, animals, etc.): Yes ___ No ___ If yes, explain: _____

Special diet: Yes ___ No ___ If yes, explain: _____

Current medical conditions: No ___ Yes ___ If yes, explain: _____

_____

Current medications (prescriptions and over the counter) Yes ___ No ___ If yes, please list _____

_____

Current psychiatric medications (prescription) Yes ___ No ___ If yes, please list.

Name Dose Frequency Prescribing Physician Effective? (yes/no/how)

_____

_____

_____

Past Medications (name, does, frequency, if known):

_____

_____

_____

_____

Does the guardian think the member needs medication? Yes ___ No ___ Please explain: _____

_____

Does the member think he/she needs medication? Yes ___ No ___ Please explain: _____

_____

R9-21-305-B1 DEVELOPMENTAL HISTORY

Mental Retardation: Yes ___ No ___ Specific Learning Disabilities: Yes ___ No ___

Motor Skills Disorders: Yes ___ No ___ Communication Disorders: Yes ___ No ___

Pervasive Developmental Disorders: Yes ___ No ___ If yes, explain: _____

_____

Any other developmental delays which are interfering with capacity for independent functioning?

None ___ Yes ___ If yes, explain: _____

R9-21-305-B7 EDUCATION/VOCATION

Is the member currently attending school? Yes ___ No ___ If no, explain: _____

_____

Current grade: ____ Name of school: _____

Highest grade completed: _____ GED Yes _____ No _____

Reading Disorder	Yes _____	No _____	Motor Disorder	Yes _____	No _____
Math Disorder	Yes _____	No _____	Mental Retardation	Yes _____	No _____
Language Disorder	Yes _____	No _____	PCC/Autism	Yes _____	No _____
Articulation Disorder	Yes _____	No _____	Other: _____		

Special Ed: No _____ Yes ____ If yes: SEH ___ LD ___ MR ___ Gifted ___ Other _____

Has member been tested for Special Education? Yes _____ No _____ If yes, please explain: _____

_____

Does member have an IEP? Yes _____ No_____

Does the member demonstrate behavior problems at school? Yes ___ No ___ If yes, please explain: ____

_____

_____

Currently employed: Yes _____ No _____ If yes, position held: _____

Hours worked: _____ (per week)

R9-20-402-B7 BEHAVIORAL HEALTH TREATMENT (non-chemical dependency)

Current Treatment (last 30 days): No _____ Yes _____ If yes, explain:

	Agency/Hospital	Address	Problems/Diagnosis	Dates of Treatment
Outpatient				
Inpatient				
Residential				
Urgent Care/ER				

What is helpful in current treatment? _____

_____

_____

Past Treatment (lifetime): No _____ Yes _____ If yes, explain:

	Agency/Hospital	Address	Problems/Diagnosis	Dates of Treatment
Outpatient				
Inpatient				

Residential _____

_____

Urgent Care/ER _____

_____

Other _____

_____

What was helpful in past treatment and/or has helped to decrease symptoms? _____

_____

Has the member ever had psychological testing? Yes _____ No _____ If yes, please explain: _____

_____

Has the member ever had neurological testing? Yes _____ No _____ If yes, please explain: _____

_____

SUBSTANCE USE

Substance use (current or past): No _____ Yes _____ (If yes, please complete the following history; if no, please put a diagonal line through the history section and continue with the next section.)

Substance	Use in Last 30 Days (# of Days)	Amount Used	Date of Last Use	Primary Route of Administration	Lifetime Use (# of years)	Age of First Use	Comments
Alcohol							
Amphetamines/Speed							
Cocaine							
Downers Benzodiazepines							
Hallucinogens							
Heroin							
Inhalants (glue, paint, gas)							
Marijuana							
Methadone (maint/detox)							
Opiates/Analgesics							
Other (please list)							
Other (please list)							

Name of the above _____

Cigarette smoker: Yes ____ No ____ If yes, number of packs per day: _____

How much caffeine does the member consume per day?

# of ounces _____ Types _____ Time of day use stops _____

Has the member ever been told that he/she has a problem with alcohol or drugs? Yes ____ No ____

Has the member ever had withdrawal symptoms when use of alcohol or drug was decreased or stopped?

Yes ____ No ____ If yes, what were the withdrawal symptoms: _____

Has the member ever been in treatment for substance abuse/dependency? Yes ____ No ____

Name of Program: _____

Program Type: Outpatient ____ Inpatient ____ Residential ____ Detox ____

Date Attended: From _____ To _____ Successfully Completed: Yes ___ No ___

LEGAL ISSUES/CRIMINAL JUSTICE HISTORY

Criminal Justice History:	Current (last 30 days)	Past (lifetime)
Detention/Jail	No ___ Yes ___	No ___ Yes ___
Probation	No ___ Yes ___	No ___ Yes ___
Parole	No ___ Yes ___	No ___ Yes ___
Court Ordered Treatment (Criminal)	No ___ Yes ___	No ___ Yes ___

Does the member have any pending court dates? Yes ___ No ___ If yes, please list: _____

_____

If member has a current probation/parole officer: Name: _____

Address: _____

Has the member ever been arrested/charged and/or convicted of any of the following?

	Arrested	Convicted	Date
Arson	No ___ Yes ___	No ___ Yes ___	_____
Assault/Battery	No ___ Yes ___	No ___ Yes ___	_____
Auto Theft	No ___ Yes ___	No ___ Yes ___	_____
Burglary	No ___ Yes ___	No ___ Yes ___	_____
Child Molestation	No ___ Yes ___	No ___ Yes ___	_____
Domestic Violence	No ___ Yes ___	No ___ Yes ___	_____
Drugs (possession, distribution)	No ___ Yes ___	No ___ Yes ___	_____
DUI/DWI	No ___ Yes ___	No ___ Yes ___	_____
Endangerment/Weapons Offense	No ___ Yes ___	No ___ Yes ___	_____
Forgery	No ___ Yes ___	No ___ Yes ___	_____
Fraud	No ___ Yes ___	No ___ Yes ___	_____
Manslaughter	No ___ Yes ___	No ___ Yes ___	_____
Murder	No ___ Yes ___	No ___ Yes ___	_____
Probation/Parole Violation	No ___ Yes ___	No ___ Yes ___	_____
Prostitution	No ___ Yes ___	No ___ Yes ___	_____
Robbery	No ___ Yes ___	No ___ Yes ___	_____
Sexual Assault/Rape	No ___ Yes ___	No ___ Yes ___	_____
Shoplifting	No ___ Yes ___	No ___ Yes ___	_____
Theft	No ___ Yes ___	No ___ Yes ___	_____
Trespassing	No ___ Yes ___	No ___ Yes ___	_____
Other: _____	No ___ Yes ___	No ___ Yes ___	_____

Does the parent/guardian have a history of involvement with the legal system? No ___ Yes ___ If yes, explain:

_____

_____

R9-21-305-B1 BRIEF RISK ASSESSMENT

What career/life plans does the member have for the future?

Immediate _____

Long term _____

	Current (last 30 days)	Past (lifetime)
Has the member been thinking about hurting self?	Yes ___ No ___	Yes ___ No ___
Has the member been thinking about hurting others?	Yes ___ No ___	Yes ___ No ___

If yes in the last 30 days, complete full Risk Assessment. If yes was answered to "past but not current" and full assessment wasn't completed, please explain. _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

MENTAL STATUS EXAM (please circle)

Appearance:

Size for age:	Normal	Large	Small		
Body structure:	Normal	Asymmetry of face/head			
	Malformation of body/limbs				
Grooming:	Neat	Clean	Dirty	Disheveled	
Clothing:	Appropriate	Ragged	Dirty	Disheveled	
Mannerisms:	Appropriate	Tics	Picks Skin	Hand Flapping	
Special Features:	Hearing aid	Scars/Tattoos	Piercing	Other _____	
Attitude:	Cooperative	Comfortable	Calm	Pleasant	Avoiding
	Hostile	Uncooperative	Reserved/Cold	Fearful	
	Other _____				
Behavior:	Involuntary	Normal	Abnormal Gate	Tics	Awkward
	Other _____				
	Voluntary	Normal	Aggressive	Hyperactive	
	Hypoactive	Other _____			
Mood:	Euthymic	Depressed	Anxious	Angry	Euphoric
	Paranoid	Irritable	Indifferent	Labile	Demanding

Affect:	Appropriate	Inappropriate	Flat Labile	Depressed	Blunt
	Intense	Constricted	Anxious	Euphoric	
	Dysphoric				
Thought Process:	Logical	Illogical	Tangential	Coherent	
	Incoherent				
	Circumstantial	Other _____			
Thought Content:	Appropriate	Obsessions	Phobias	Suicidal/Homicidal Ideations	
	Paranoia	Delusions	Ideas of Reference		
Perception:	Normal	Hallucinations (auditory, visual, olfactory, tactile, gustatory)			
	Illusions	Other _____			
Orientation:	Oriented x 3	Disoriented			
Level of Consciousness:	Alert	Overly alert	Drowsy	Lethargic	Seated
	Stuporous				
Cognitive:					
Estimated Intelligence:	Average	Above	Below		
Concentration:	Average	Below average			
Memory:					
Immediate:	Normal	Impaired			
Recent:	Normal	Impaired			
Remote:	Normal	Impaired			
Judgment:	Normal	Impaired			

Insight:	Present	Partially present		Absent
Appetite:	Normal	Increased	Decreased	Inconsistent
	Other _____			
Sleep:	Normal	Increased	Decreased	Restless
	Other _____			
Current suicide risk	Yes ___	No ___	(If yes, complete Risk Assessment)	
Current homicide risk	Yes ___	No ___	(If yes, complete Risk Assessment)	

Evaluator _____ Date _____
(print name and credentials)

Signature _____
(signature and credentials)

Physician _____ Date _____
(print name and credentials)

Signature _____
(signature and credentials)

Designee _____ Date _____
(print name and credentials)

Signature _____
(signature and credentials)

PRENATAL/DEVELOPMENTAL

During pregnancy did this child's mother:

Have German Measles?	Yes _____	No _____
Have diabetes?	Yes _____	No _____
Have high blood pressure?	Yes _____	No _____
Receive prenatal care?	Yes _____	No _____
Drink alcohol?	Yes _____	No _____
Use any illegal drugs?	Yes _____	No _____
Use any medications?	Yes _____	No _____
Have any kidney problems?	Yes _____	No _____
Develop preeclampsia or toxemia?	Yes _____	No _____
Have any vaginal infection, discharge or bleeding?	Yes _____	No _____
Have high fever for 3 days or more (103 or higher)?	Yes _____	No _____
Have any severe emotional problems?	Yes _____	No _____
Suffer any physical abuse?	Yes _____	No _____

During labor or delivery?

Was mother in labor over 15 hours?	Yes _____	No _____
Was anesthetic used during delivery?	Yes _____	No _____
Did the baby have any problems breathing at birth?	Yes _____	No _____
Did the baby need blood at birth?	Yes _____	No _____
Were there any injuries to the baby at birth?	Yes _____	No _____
Was an operation performed to deliver the baby?	Yes _____	No _____
Was the baby a premature birth?	Yes _____	No _____
Did the baby require a stay in the Intensive Care Nursery?	Yes _____	No _____
Was the baby under five pounds at birth?	Yes _____	No _____

Has the child ever:

Had the mumps?	Yes _____	No _____
Had the measles?	Yes _____	No _____
Had chicken pox?	Yes _____	No _____
Had middle ear infection?	Yes _____	No _____
1. Long-term antibiotic therapy?	Yes _____	No _____
2. Tubes in ears?	Yes _____	No _____
Had asthma?	Yes _____	No _____
Had a high fever for 3 days or more? (104 or higher)	Yes _____	No _____
Had a blow to the head?	Yes _____	No _____
Suffered loss of consciousness?	Yes _____	No _____
Had seizures or convulsions?	Yes _____	No _____
Had difficult gaining weight?	Yes _____	No _____
Had repeated prolonged hospitalizations?	Yes _____	No _____
Complained or aches and pains frequently?	Yes _____	No _____

Faked being sick? Yes _____ No _____

Complained of feeling tired most of the time? Yes _____ No _____

Wet the bed/soiled his/her clothes? Yes _____ No _____

Been unable to speak well? Yes _____ No _____

Appeared clumsy or accident-prone? Yes _____ No _____

By 0-1 year of age, had the child:

Sat up? Yes _____ No _____

Crawled? Yes _____ No _____

By 1-3 years of age, had this child:

Walked? Yes _____ No _____

Talked in real words? Yes _____ No _____

Fed self with a spoon? Yes _____ No _____

By 3-5 years of age, had this child:

Become completely toilet trained? Yes _____ No _____

Talked in sentences? Yes _____ No _____

Learned to ride a tricycle? Yes _____ No _____

Other developmental issues:

Has this child ever been evaluated for failure to thrive? Yes _____ No _____

Has this child ever been evaluated for developmental delays? Yes _____ No _____

Has this child ever been evaluated for speech & language delays? Yes _____ No _____

Has this child ever been the victim of physical/sexual abuse? Yes _____ No _____

SOCIAL BEHAVIOR/FUNCTIONING

Relationships with other children:

Picks on other children Yes _____ No _____

Has few or no friends Yes _____ No _____

Is picked on by other children Yes _____ No _____

Plays alone most of the time Yes _____ No _____

Has sex play with other children Yes _____ No _____

Hangs around with bad crowd Yes _____ No _____

Other (please describe) _____

Relationships with others:

Talks back to grown-ups Yes _____ No _____

Disobeys parents Yes _____ No _____

Can't be trusted Yes _____ No _____

Has a chip on the shoulder Yes _____ No _____

Doesn't trust other people Yes _____ No _____

Other (please describe) Yes _____ No _____

Social Skills:

Afraid of many things	Yes _____	No _____
Very shy	Yes _____	No _____
Poor loser	Yes _____	No _____
Demands too much attention	Yes _____	No _____
Other (please describe) _____	Yes _____	No _____

Other Problems:

Hurts self on purpose	Yes _____	No _____
Acts younger than real age	Yes _____	No _____
Can't sit still	Yes _____	No _____
Acts without thinking	Yes _____	No _____
Wants things to be perfect	Yes _____	No _____
Says or does strange or peculiar things	Yes _____	No _____
Is often confused or in a daze	Yes _____	No _____
Daydreams a lot	Yes _____	No _____
Doesn't finish things (short attention span)	Yes _____	No _____
Other (please describe) _____	Yes _____	No _____

Behavior Problems:

Runs away from home	Yes _____	No _____
Lies	Yes _____	No _____
Steals	Yes _____	No _____
Sets fires	Yes _____	No _____
Breaks things	Yes _____	No _____
Truancy	Yes _____	No _____
Cruelty to animals	Yes _____	No _____
Provokes fights	Yes _____	No _____
Other (please describe) _____	Yes _____	No _____

Functioning:

Is the child's behavior so disruptive that he/she cannot attend school?	Yes _____	No _____
Does the child require special education or resource classroom for behavioral or emotional problems?	Yes _____	No _____
Is the child able to attend school full time without disruption?	Yes _____	No _____
Have the child's problems created serious problems in the home resulting in for example: divorce, parental job loss or bankruptcy?	Yes _____	No _____
Does the child require more supervision than the parent or caregiver can provide?	Yes _____	No _____
Is the family able to provide needed assistance without disruption to the family?	Yes _____	No _____
Is the child imminently dangerous to others?	Yes _____	No _____

Does the child have frequent contacts with the law, or history of incarceration?	Yes _____	No _____
Does the child disregard normal safety practices or the safety of others?	Yes _____	No _____
Is the child cooperative/shows concern for others?	Yes _____	No _____
Does the child lack age appropriate social skills?	Yes _____	No _____
Does the child have trouble making and keeping friends, or have trouble maintaining family relationships?	Yes _____	No _____
Does the child seem lonely or shy?	Yes _____	No _____
Has the child been removed from the home due to abuse or neglect?	Yes _____	No _____
Is there risk that the child will be removed from the home because of abuse or neglect?	Yes _____	No _____
Is the home environment conflictual, but there is no suspicion of abuse or neglect?	Yes _____	No _____
Is the family supportive and able to meet the child's needs?	Yes _____	No _____

_____ _____

Signature of Person Completing Signature of Reviewer

EMPACT
Suicide Prevention Center
1232 E. Broadway Road, Suite 120 – Tempe, AZ 85252
Office (480) 784-1514 – Crisis Line (480) 784-1500 – Fax (480) 967-3528

CONSENT TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

NAME OF CLIENT OR ATTENDANT IN SESSION_____

CLIENT DATE OF BIRTH_____

GUARDIAN OF CLIENT (if applicable)_____

SOCIAL SECURITY NO._____ DATES OF TREATMENT_____

I hereby authorize _____
to release and/or exchange the below identified information to/with:

Person & agency_____

Address_____

____Mental Health Records	_____Test Results	___Summary of Involvement
____Court/Legal Records	_____School Records	___AIDS/HIV Related Information
____Consultations	_____Discharge Summary	___Substance Abuse (drug/alcohol) Records
____Verbal Information	_____Progress Notes	___Medical Records (excluding HIV)
____Psychosocial History	_____Treatment Plan	___Communicable Disease Information
____Psychiatric Evaluation	_____Other (Specify) _____	

Purpose of release: _____

Extent of release: _____

EMPACT-SPC is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken on the consent. Without express revocation, this consent will expire 12 months from the date of signature, or three months after the date of termination of treatment at EMPACT-SPC, whichever is later.

_____ _____
Client Signature (including ages 12-18 Regarding Substance Abuse Records) Date Signed

_____ _____
Signature of Authorized Person Date Signed
(Specify Relationship to Client--Parent, Legal Guardian)

_____
Witness Signature

Notice: Federal regulations (42CFR Part 2) prohibit recipients from secondary disclosure/release of information to additional persons/organizations without the specific written consent of the client/guardian.

"Your partner for hope and solutions."

A non-profit agency accredited by CARF and the American Association of Suicidology. A United Way Agency.

EMPACT
Suicide Prevention Center

CLIENT EVALUATION OF SERVICES - INITIAL

Client Name: _____ Age:_____ Date:_____ Program:_____

Parent/Guardian:_____ Therapist: _____

EMPACT-SPC is committed to providing quality care. By answering the following questions, we can review our procedures and enhance our service to you.

1. What is the reason for seeking services at this time?

2. How would you rate your current level of functioning in the following areas:
   (1 = low 2 = fair 3 = moderate 4 = high)

Work/School	1	2	3	4
Family/Interpersonal	1	2	3	4
Self Care	1	2	3	4
Social	1	2	3	4

3. How would you rate your current health/physical well being?

   1 = poor health 2 = fair health 3 = good health 4 = excellent health

4. Overall, how would you rate your current quality of life/life satisfaction?

   1 = not satisfied 2 = somewhat satisfied 3 = satisfied 4 = very satisfied

5. Did you participate in any type of services prior to coming to EMPACT? Y N

6. If yes, to what degree did these services help?

   1 = not helpful 2 = somewhat helpful 3 = helpful 4 = very helpful

EMPACT-SPC would like the opportunity to contact you in a few months and after completion of services to review your satisfaction with services you received. Your signature below will authorize us to contact you regarding your experience at EMPACT-SPC

Signature: _____ Phone Number: _____

EMPACT
Suicide Prevention Center

CLIENT EVALUATION OF SERVICES - DURING

Client Name:_____ Age:_____ Date:_____ Program:_____

Parent/Guardian:_____ Therapist:_____

EMPACT-SPC is committed to providing quality care. By answering the following questions, we can review our procedures and enhance our service to you.

1. Have the symptoms that brought you to EMPACT-SPC improved?
   1 = not improved 2 = somewhat improved 3 = improved 4 = improved a lot

2. How would you rate your current level of functioning in the following areas:

(1 = low	2 = fair	3 = moderate	4 = high)
Work/School	1	2	3	4
Family/Interpersonal	1	2	3	4
Self Care	1	2	3	4
Social	1	2	3	4

3. How would you rate your current health/physical well being?
   1 = poor health 2 = fair health 3 = good health 4 = excellent health

4. Overall, how would you rate your current quality of life/life satisfaction?
   1 = not satisfied 2 = somewhat satisfied 3 = satisfied 4 = very satisfied

5. Currently, how satisfied are you with your counseling services?
   1 = not satisfied 2 = somewhat satisfied 3 = satisfied 4 = very satisfied

6. Presently, how are your concerns met?
   1 = not well 2 = somewhat well 3 = well 4 = very well

7. Are your concerns addressed in a respectful manner?
   1 = not respectfully 2 = somewhat respectfully 3 = respectfully 4 = very respectfully

8. Does your therapist consistently keep scheduled appointments? Y N

9. What overall rating would you give your services at EMPACT-SPC?
   1 = Poor 2 = Fair 3 = Good 4 = Excellent

10. Do you have any comments that you would like to make about the services you received at EMPACT-SPC? _____

Signature:_____ Phone Number:_____

EMPACT
Suicide Prevention Center

CLIENT EVALUATION OF SERVICES - COMPLETION

Client Name: _____ Age: _____ Date: _____ Program:_____
Parent/Guardian: _____ Therapist: _____

EMPACT-SPC is committed to providing quality care. By answering the following questions, we can review our procedures and enhance our service to you.

1. Have the symptoms that brought you to EMPACT-SPC improved?
   1 = not improved 2 = somewhat improved 3 = improved 4 = improved a lot

2. How would you rate your current level of functioning in the following areas:

	(1 = low	2 = fair	3 = moderate	4 = high)
Work/School	1	2	3	4
Family/Interpersonal	1	2	3	4
Self Care	1	2	3	4
Social	1	2	3	4

3. How would you rate your current health/physical well being?
   1 = poor health 2 = fair health 3 = good health 4 = excellent health

4. Overall, how would you rate your current quality of life/life satisfaction?
   1 = not satisfied 2 = somewhat satisfied 3 = satisfied 4 = very satisfied

5. How satisfied are you with the services you received?
   1 = not satisfied 2 = somewhat satisfied 3 = satisfied 4 = very satisfied

6. How well were your concerns met?
   1 = not well 2 = somewhat well 3 = well 4 = very well

7. Were your concerns addressed in a respectful manner?
   1 = not respectfully 2 = somewhat respectfully 3 = respectfully 4 = very respectfully

8. Did your therapist consistently keep scheduled appointments? Y N

9. What overall rating would you give your services at EMPACT-SPC?
   1 = Poor 2 = Fair 3 = Good 4 = Excellent

10. Do you have any comments that you would like to make about the services you received at EMPACT-SPC?_____

Signature:_____ Phone Number: _____

EMPACT
Suicide Prevention Center

CLIENT EVALUATION OF SERVICES – POST-COMPLETION

Client Name: _____ Age: _____ Date: _____ Program:_____
Parent/Guardian: _____ Therapist: _____

EMPACT-SPC is committed to providing quality care. By answering the following questions, we can review our procedures and enhance our service to you.

1. Have the symptoms that brought you to EMPACT-SPC improved?
   1 = not improved 2 = somewhat improved 3 = improved 4 = improved a lot

2. How would you rate your current level of functioning in the following areas:

	(1 = low	2 = fair	3 = moderate	4 = high)
Work/School	1	2	3	4
Family/Interpersonal	1	2	3	4
Self Care	1	2	3	4
Social	1	2	3	4

3. How would you rate your current health/physical well being?
   1 = poor health 2 = fair health 3 = good health 4 = excellent health

4. Overall, how would you rate your current quality of life/life satisfaction?
   1 = not satisfied 2 = somewhat satisfied 3 = satisfied 4 = very satisfied

5. How satisfied are you with the services you received?
   1 = not satisfied 2 = somewhat satisfied 3 = satisfied 4 = very satisfied

6. How well were your concerns met?
   1 = not well 2 = somewhat well 3 = well 4 = very well

7. Were your concerns addressed in a respectful manner?
   1 = not respectfully 2 = somewhat respectfully 3 = respectfully 4 = very respectfully

8. Did your therapist consistently keep scheduled appointments? Y N

9. What overall rating would you give your services at EMPACT-SPC?
   1 = Poor 2 = Fair 3 = Good 4 = Excellent

11. Do you have any comments that you would like to make about the services you received at EMPACT-SPC?_____

Signature:_____ Phone Number: _____

TSAT GROUP RULES

1. Respect self and other clients.
2. Clients need to use the entrance that leads into the group room, not the side entrance.
3. Clients are not to sleep in-group. If you are tired and cannot stay awake, a parent can pick you up and your P.O. will be called. If a teen is tired and does not want to participate, they need to sit quietly in the group.
4. Drugs. If a teen is suspected of using drugs, it is at the discretion of the group leader and program assistant whether or not to send the teen home. If the teen goes home, the P.O. will be called. If you appear to have illegal drugs or alcohol with you, if you have a P.O., s/he will be called, the police will be called, and you will leave group. This includes the illegal purchase or the arranging of the illegal purchase of tobacco to a minor.
5. Unexcused absences will be reported to your P.O., if applicable. If you cannot attend group, leave the group leader a message as soon as you know you will not be attending. Any reasons will be verified with your parent/ guardian, and invalid reasons result in an unexcused absence.
6. Do not ask to leave group early. If you have a valid reason to do so, have a parent/guardian leave the group leader a message prior to the time group starts.
7. No gang affiliation. Do not wear a rag on your head that shows your gang colors, flash signs, write your tags on the board, or ask to be called by a gang-related nickname. Please respect that there will be clients in-group from all over the valley.
8. No weapons of ANY kind. If you bring them, the police and your P.O., if applicable, will be called.
9. Respect property (chairs, tables, posters, etc.).
10. Do not bring out cigarettes or lighters in the building.
11. Side talking and laughing are disruptive. After you get one reminder, you will get a warning, then you will be temporarily removed from group. Once back, if you need to be removed again, you and a staff will call your P.O.
12. Use the bathroom on breaks only.
13. Housekeeping - clients are allowed to have food and drinks; however, they need to make sure to throw the trash away.

14. Breaks- there are two breaks per group. The clients cannot be without a program assistant at any time. Do not leave the premises once you are here because if you do, you will be considered AWOL, will be sent home, and if you have a P.O., s/he will be called.
15. NO smoking - if a teen smokes, the entire group will miss the next break.
16. Urinalyses - A missed UA = a dirty UA. All clients are required to drop weekly random UA's. While at TASC, clients need to stay with the program assistants at all times. There is NO smoking allowed at TASC.
17. Transportation - clients are to wear seatbelts in the vans and need to ask permission of the program assistant to touch the radio stations. No gang signs at other cars or inappropriate gestures. Clients need to keep their hands to themselves. No switching seats while the van is moving.
18. Clients can swear in-group as a means of expression, but not at each other.
19. Clients have the right to be quiet if they do not wish to take part in a particular discussion. Other members do not have the right to force them to participate but do have the right to ask them questions and encourage them to participate.
20. Clients should not accuse one another of stupidity when they describe their self-defeating behaviors.
21. If a teen needs to be picked up or dropped off at a location other than the one approved at their date of intake, either the TSAT coordinator or a program assistant needs a verbal request from the parent before the start of that group.

Group times are from 3:00 p.m. to 6:00 p.m. Clients are not excused earlier for any reason unless approved by the probation officer or parent, if there is a medical reason or another emergency. If you are more than 15 minutes late, your P.O. will be called, if you have one. If you have a valid reason, tell staff and have your parent or guardian call.

It is up to you to get something out of the TSAT experience. This may include challenging yourself to take the material seriously, have a positive attitude, and really look at the reasons you are here and the differences you can make in your life to live a sober lifestyle. You will get out of group what you put into it.

I welcome you to the TSAT Program and hope you will gain a lot from the group experience. If there are ever suggestions, comments, or concerns that you would like addressed, please contact me anytime at 480-784-1514, extension 1515.

Very truly yours,

Melissa Smith, MC/MFC, CSAC
TSAT Program Coordinator

JOB DESCRIPTIONS

DATE:

TITLE:	Program Clinical Coordinator I	**Grade:**	8
	Program Clinical Coordinator II	**Grade:**	9

DEPARTMENT: Family Centered Counseling & Support (FCCS)

STATUS: Full Time

CLASS: Exempt -- Benefits included with no overtime eligible.

REPORTS TO: FCCS Manager

SCOPE OF RESPONSIBILITIES:

Assure the quality of services to clients, coordinating day-to-day operations of the program, and recommending and implementing changes that would improve the delivery of services. Provide direct service counseling, ongoing counseling, prevention services, and education services to adults, families, and youth.

SPECIFIC RESPONSIBILITIES:

Assist manager with the administrative and clinical supervision of staff and volunteers. Evaluate staff and volunteer performance. Make recommendations of personnel actions to the manager. Provide direct client services as assigned by manager.

Provide and deliver at least 40 hours of work per week. As requested attend meetings and trainings outside of regularly scheduled work hours. Program coordinators will be required to work beyond scheduled work hours to complete required paperwork or to complete crisis stabilization tasks. Evening and night hours may be required. Overnight coverage may reduce face-to-face client contact requirements. Program coordinators may be required to provide rotations involving 24-hour availability.

Direct the day-to-day operations of the program and be responsible for scheduling of meetings, services, and staff time.

Provide for quality assurance of the program's service delivery including client chart and documentation. Monitor and maintain all client records in accordance with agency policies and procedures.

Direct the overall productivity of the program and monitor individual staff, contractor, intern, work study staff, and volunteer performance to meet productivity standards.

Recommend to the manager changes that would improve service delivery and ways of implementing changes and new programming as directed by the manager.

Ensure the continuity of care in providing comprehensive services and coordinate or facilitate communications with other departments of the agency.

Take an active role in standing and ad hoc committees and work groups as assigned by the vice president/clinical director.

Provide instruction and training for interns, contract staff, and regular staff in his/her respective discipline as opportunities permit or as assigned by the manager.

Adhere to the agency's policies and procedures and assure staff compliance.

Comply with and assure compliance by staff with the agency's standard of care for service delivery. Assist with quality management, quality assurance, and utilization review.

Develop and maintain effective working relationships with all related state, community mental health, and contracting organizations.

Develop, implement, and maintain at least one clearly defined program area.

Assure regular supervision and review of staff performance.

Maintain professional conduct consistent with ethical professional practice and the policies and procedures of the agency.

Maintain valid Arizona driver's license, appropriate liability insurance, and approval for liability coverage with EMPACT - SPC's liability insurance carrier.

Participate in agency fund-raising activities as requested by management.

Other duties as assigned by supervisor.

QUALIFICATIONS:

Grade 8 - Program Coordinator I:

Master's degree in marriage and family therapy, counseling, psychology, social work, or directly related field. Must be eligible for certification by AzBBHE with AMFT, CAC, CMSW, or CISW credential. Demonstrated experience in program development. Ability to assist with clinical supervision of program staff. Chemical dependency counseling training encouraged.

Demonstrated ability to remain calm in crisis situations; work independently and cooperatively; recognize personal limitations; understand and identify the feelings, needs, and concerns of children and adolescents; and relate positively and with empathy to all persons regardless of age, race, creed, gender, or sexual orientation.

Grade 9 - Program Coordinator II:

Master's degree in marriage and family therapy, counseling, psychology, social work, or directly related field. Must be certified by AzBBHE with CMFT, CPC, CISW credential. Demonstrated experience in program development and the implementation or at least one program area. Demonstrated excellent performance in all position responsibilities or a minimum of three years total related experience.

Demonstrated ability to remain calm in crisis situations; work independently and cooperatively; recognize personal limitations; understand and identify the feelings, needs, and concerns of children and adolescents; and relate positively and with empathy to all persons regardless of age, race, creed, gender, or sexual orientation.

I have read and agree to perform the duties as outlined in this job description.

_____ _____

Employee Signature Date

DATE:

TITLE:	Family Therapist I	**Grade:**	7
	Family Therapist II	**Grade:**	8

DEPARTMENT: Family Centered Counseling & Support (FCCS)

STATUS: Full Time

CLASS: Exempt -- Benefits included with no eligible overtime.

REPORTS TO: Program Coordinator

SCOPE OF RESPONSIBILITIES:

Provide direct service and education services to adults, families, and youth.

SPECIFIC RESPONSIBILITIES:

Provide direct in-home, in-office, and community ongoing counseling and follow-up counseling as assigned. Counseling services will be provided to youth, families, and adults. Services will be provided according to training, experience, and certification as assigned.

Provide and deliver assigned 40 hours of work per week. Evening and weekend hours may be required to accommodate the schedules of families. Attend meetings and trainings outside of regularly scheduled work hours as requested. Rotation coverage for services outside of normal business hours may be required. Productivity standards are established annually.

Ensure quality service delivery including clinical care and all associated documentation. Maintain all client records in accordance with agency policies and procedures. This includes appropriate intake documentation; endangerment triaging;

diagnosis; treatment planning; and referral, progress, risk planning, termination documentation, and interagency reports.

Participate in all regularly scheduled administrative, in-service, and staff meetings.

Recommend to the program coordinator or clinical manager changes that would improve service delivery and ways of implementing changes and new programming as directed by the program coordinator or clinical manager. Select and develop one specialized function related to the development of department services.

Provide comprehensive services to clients and assist the program coordinator or clinical manager in coordinating communication with other departments of the agency in accomplishing continuity of care.

Participate in standing and ad hoc committees and work groups as assigned by the program coordinator or clinical manager.

Provide instruction and training for interns, contract staff, and regular staff in his/her respective discipline as assigned by the program coordinator or clinical manager.

Adhere to the agency's policies and procedures. Comply with the agency's standard of care for service delivery. Assist with quality management, quality assurance, and utilization review.

Develop and maintain effective working relationships with all related state, community mental health, and contracting organizations.

Perform additional related duties as assigned by the program coordinator or clinical manager.

Maintain professional conduct consistent with ethical professional practice and the policies and procedures of the agency.

Maintain valid Arizona driver's license, appropriate liability insurance, and approval for liability coverage with EMPACT - SPC's liability insurance carrier.

Participate in agency fund-raising activities as requested by management.

Other duties as assigned by supervisor.

QUALIFICATIONS:

Grade 7 - Family Therapist I:

Master's degree in marriage and family therapy, counseling, psychology, social work, or directly related field. Must be certified by AzBBHE with CAC, AMFT, CMSW, CSAC, or higher. Chemical dependency counseling training encouraged.

Demonstrated ability to remain calm in crisis situations; work independently and cooperatively; recognize personal limitations; understand and identify the feelings, needs, and concerns of children and adolescents; and relate positively and with empathy to all persons regardless of age, race, creed, gender, or sexual orientation.

Grade 8 - Family Therapist II:

Master's degree in marriage and family therapy, counseling, psychology, social work, or directly related field and related experience. Will be required to train and provide guidance to other staff or interns. Ability to actively participate in at least one committee related to the operation of the organization. Must be certified by AzBBHE with CMFT, CPC, or CISW credential. Demonstrated experience in program development and the implementation of at least one program area. Demonstrated excellent performance in all position responsibilities with a minimum of three years total related experience.

Demonstrated ability to remain calm in crisis situations; work independently and cooperatively; recognize personal limitations; understand and identify the feelings,

needs, and concerns of children and adolescents; and relate positively and with empathy to all persons regardless of age, race, creed, gender, or sexual orientation.

I have read and agree to perform the duties as outlined in this job description.

_____ _____

Employee Signature Date

DATE:

TITLE: Program Assistant/Driver I - Pool **Grade:** 4
Program Assistant/Driver II - Pool **Grade:** 5

DEPARTMENT: Family Centered Counseling & Support (FCCS)

STATUS: Variable Hour

CLASS: Non-Exempt -- No benefits with overtime eligibility. This position is eligible for overtime pay, after 40 hours worked per week, with prior approval from department manager and/or director of programs.

REPORTS TO: Program Coordinator

SCOPE OF RESPONSIBILITIES:

Assist the lead instructor in evening support program. Drive the EMPACT - SPC van to assigned destinations and during assigned times based upon the needs of the EMPACT-SPC. Services shall originate and end at EMPACT-SPC offices.

SPECIFIC RESPONSIBILITIES:

Operate the van in accordance with all state regulations and EMPACT-SPC procedures.

Operate the vehicle in a safe manner and report vehicle problems immediately.

Perform a variety of basic office and support functions as assigned.

Perform tasks associated with monitoring/collecting urine specimens in a systematic, confidential, and well-documented manner as assigned.

Follow behavioral code of conduct in relation to maintaining order with youth in the vehicle.

Document and report all behavioral problems to the program coordinator.

Maintain professional conduct consistent with ethical professional practice and the policies and procedures of the agency.

Maintain valid Arizona driver's license, appropriate liability insurance, and approval for liability coverage with EMPACT - SPC's liability insurance carrier.

Participate in agency fund-raising activities as requested by management.

Perform additional job duties as assigned by supervisor.

QUALIFICATIONS:

Grade 4 - Program Assistant/Driver I - Pool:

One to two years experience as a driver/chauffeur with a clean motor vehicle record for the past 36 months. One to two years experience working with youth. Chemical dependency counseling training encouraged.

Demonstrated ability to remain calm in crisis situations; work independently and cooperatively; recognize personal limitations; understand and identify the feelings, needs, and concerns of children and adolescents; and relate positively and with empathy to all persons regardless of age, race, creed, gender, or sexual orientation.

Grade 5 - Program Assistant/Driver II - Pool:

Bachelor's degree in marriage, family therapy, counseling, social work, or directly related field or 10 years experience in specifically related activity. Chemical dependency counseling training encouraged.

Demonstrated ability to remain calm in crisis situations; work independently and cooperatively; recognize personal limitations; understand and identify the feelings, needs, and concerns of children and adolescents; and relate positively and with empathy to all persons regardless of age, race, creed, gender, or sexual orientation.

I have read and agree to perform the duties as outlined in this job description.

_____ _____

Employee Signature Date

TRAINING REQUIREMENTS

	How Soon After Hire-Date Required	How Often Is Re-Training Needed	Program Clinical Coordinator I	Home Based Therapist II	Family Therapist II	Provider Panel	Behavior Management	Program Assistant/ Driver I Pool	Research Technician I	
Absolute	1		Y	Y	Y	Y	Y	Y	Y	
Assessment, Treatment Plan, Progress Note Connection							Y			
Attachment: Foster Care, Adoption Issues										
Basic De-escalation Skills (non-clinical)							Y			
Behavior Management Skills	3						Y			
Child / Human Development	6		Y	Y	Y	Y	Y	Y	Y	
Communicable Diseases	12	Annually	Y	Y	Y	Y	Y	Y	Y	
Community Resources/ Wrap Around Approaches							Y	Y	Y	
Confidentiality: Clinical (Med. Rec./Duty to Warn)							Y	Y	Y	
Confidentiality: Non-Clinical	6	Annually	Y	Y	Y	Y	Y	Y	Y	
Consumer Rights and Responsibilities										
Co-Occurring D/O: ASAM, Stages of Change, MI							Y			
Coordination of Care	6									
Covered Services										
CPR/First Aid	2	Every 2 Years				Y	Y	Y	Y	
Crisis Assessment & Intervention	3		Y	Y	Y	Y	Y			
Critical Incident / Stress Debriefing	6									
Cultural Diversity & Gender Issues	6	At Least Annually	Y	Y	Y	Y	Y	Y	Y	
Customer Service / Phone Skills / Client Satisfaction										
Domestic Violence										

DSM IV	12			Y	Y	Y	Y	Y				
Early Periodic Screening, Diagnosis, & Treatment												
Eating Disorders												
Effective Prevention Skills (2 day training)												
Eligibility and Enrollment Verification												
Ethics and Boundaries												
Fraud and Abuse												
Grief & Loss												
Grievance and Request for Hearings												
Incident and Accident Reporting												
In-Home Safety	3			Y	Y	Y	Y	Y				
Life Skills												
Managed Care Concepts												
Motivational Interviewing												
MS: Word, Excel, PowerPoint, Access												
Narrative Therapy												
Neuro-Biological Disorders	12											
Non Violent Crisis Intervention (TCI)	6			Y	Y	Y		Y				
Outcomes	12			Y								
Parenting				Y	Y	Y	Y	Y				
Petitions	3			Y	Y	Y		Y				
Play Therapy												
Prevention Basics/ Risk & Resiliency												
Psychopharmacology	6	Annually		Y	Y	Y		Y				
PTSD												
Safety in the Workplace	12	Annually		Y	Y	Y	Y	Y	Y	Y		

Screening & Referring Non-title XIX/XXI Consumers for Eligibility												
Sexual Abuse Recovery												
Solution Focused												
Strategic / Structural Therapy												
Stress Management in the Workplace												
Substance Abuse Education	12			Y	Y	Y	Y	Y	Y	Y		
Suicide Assessment & Intervention	3			Y	Y	Y	Y	Y	Y	Y		
Supervision				Y	Y	Y	Y	Y	Y	Y		
Supervision & Management Skills	6			Y								
Systems Thinking & Family Dynamics								Y	Y	Y		
Team Building												
Tobacco Cessation												
Train-the-Trainer: Part 1												
Train-the-Trainer: Part 2												
Treatment Planning Theory and Practice								Y				
Understanding Childhood Psychiatric Illnesses												
Vehicle Safety												
Violence Assessment	3			Y	Y	Y		Y				
Windows NT												
Working with Developmentally Delayed Cts												
Working with Schools	12			Y	Y	Y	Y	Y				
Working with SMI Consumers												

STAGES OF CHANGE STRATEGIES AND INTERVENTIONS

Stages of Change	Strategies	Interventions
<u>Precontemplation</u> ♦ Discovery Track ♦ Consciousness-Raising Strategies	♦ Be accepting and non-judgmental ♦ Commend consumer for meeting with you ♦ Listen to and acknowledge the aspects of substance abuse the consumer enjoys ♦ Obtain consumer's perception of why they are in your office or seeking your assistance ♦ Ask consumer to self-diagnose ♦ Encourage questions by the consumer ♦ Examine discrepancies between consumer's and other's perceptions of the problem behavior ♦ Develop discrepancy between consumer's current behavior and their goals ♦ Express concern and hope and keep the door open for future discussion ♦ Provide continuity of care ♦ Provide unconditional commitment ♦ Provide welcoming environment at all times ♦ Reduce larger goals into more manageable steps ♦ View every step of treatment as an opportunity for engagement & change ♦ Express empathy ♦ Instill hope ♦ Explore barriers to change	♦ Assess for readiness to change (URICA) ♦ Refer to educational group and discuss the effects of drug use without lecturing ♦ Involve family/significant others with consumer's permission ♦ Ask client if they are happy/satisfied with the way they are currently living their life. If not, then discuss barriers to achieving their goal. ♦ Provide choices ♦ Use reflective listening

Stages of Change	Strategies	Interventions
Contemplation ♦ Discovery Track ♦ Consciousness Raising, Emotional Arousal, Self-Evaluation	♦ Consider & discuss with consumer extrinsic (probation, parole, court) & intrinsic (self-motivation) motivators ♦ Assist consumer in acknowledging intrinsic motivators ♦ Assist consumer in developing self-efficacy and a therapeutic alliance ♦ Reframe client's negative statement about perceived coercion ♦ Utilize decisional balancing interventions- discuss pros & cons of problem behavior and changing (What will it mean for the consumer to change their behavior?) ♦ Summarize consumer's concerns ♦ Normalize, explore, and process consumer's ambivalence & resistance ♦ Introduce feedback from assessments ♦ Examine consumer's understanding of change and expectations of treatment ♦ Re-explore consumer's values in relation to change ♦ Emphasize consumer's personal choices and responsibilities for change (self-determination) ♦ Provide continuity of care ♦ Express unconditional commitment to consumer ♦ Provide welcoming environment at all times ♦ Accentuate the positive aspects of change ♦ Anticipate barriers to achieving goal/change	♦ Develop and utilize extrinsic and intrinsic incentives for change ♦ Provide factual information/feedback and make it personally relevant ♦ Continue supporting consumer's attendance of educational group ♦ Continue discussing/educating consumer about the effects of drug use ♦ Involve family/significant others to develop discrepancy and support ♦ Gather information about past change attempts to assist in consumer's awareness of success versus relapse/failed attempt

Stages of Change	Strategies	Interventions
Preparation/Action ♦ Mix of Discovery & Recovery Tracks ♦ Emotional Arousal, Self-Evaluation, Commitment, Reward	♦ Clarify client's goals and strategies for change ♦ Negotiate treatment plan and/or behavior contract ♦ Consider barriers to change ♦ Explore treatment expectancies and client role ♦ Encourage consumer to publicly announce change plans to significant others ♦ Provide continuity of care ♦ Express unconditional commitment ♦ Provide welcoming environment at all times ♦ Identify high-risk situations ♦ Develop appropriate coping strategies ♦ Assist client in finding new reinforcers of positive change ♦ Assume role of dual recovery companion (Minkoff) ♦ Anticipate problems & pitfalls	♦ Enlist social support (mentoring groups, AA/NA/DTR, religious groups, recreational centers) or ♦ Practice/role play mock AA/NA meetings, change & barriers ♦ Write the treatment plan using the consumer's own words ♦ Refer to, or provide appropriate individualized treatment ♦ With client, employ a weekly schedule listing their current activities by the hour, and plan activities where gaps arise ♦ Encourage exercise regimen ♦ Reaffirm successful decisions ♦ Focus on successful activities
Maintenance ♦ Recovery ♦ Commitment, Changes Sustained, Relapse Prevention	♦ Prevent relapse by practicing and utilizing positive coping and problem-solving skills ♦ Process emotional triggers of relapse and develop a plan ♦ Provide continuity of care ♦ Express unconditional commitment ♦ Provide welcoming environment at all times	♦ Encourage attendance in aftercare program ♦ Provide continued emotional support ♦ Support consumer in continuing to strengthen social supports
Relapse/Recycling ♦ Relapse ♦ Based on Assessed Stage of Change to Which Client Has Regressed/ Recycled	♦ Assist client in constructive processing of relapse ♦ Assist client in learning from relapse before committing new plan of action ♦ Provide continuity of care ♦ Express unconditional commitment ♦ Provide welcoming environment at all times	♦ Refer client to undergo comprehensive, multidimensional assessment to explore all reasons for relapse ♦ Revise, re-evaluate goals and commitment ♦ Provide services based on stage of change client has regressed to

EMPACT
Suicide Prevention Center

TERMINATION LETTER REQUEST

Client Name:_____

Guardian Name:_____

Client Address:_____

City:_____State:_____Zip:_____

FORM LETTER REQUESTED:

#1 ☐ Disc. Phone only	#2 ☐ Missed Appt.	#3 ☐ Terminated Serv.	#4 ☐ Reduced-Meds
#5 ☐ No Contact	#6 ☐ Missed-Spanish	#7 ☐ No Contact-Spanish	

FORMS NEEDED

Value Options Appeals Form yes ☐ no ☐

(Therapist: Please fill out and sign appeals form and attach it to letter to be written.)

RETURN TO THE THERAPIST

Eastside ☐ Westside ☐

CHECK APPLICABLE ONE

Child ☐ Adult ☐

Therapist Name & Credentials:_____

TREATMENT/DISCHARGE SUMMARY

Client_____ SpectraMed ID # _____

Report Date_____ Intake Date_____ Date of Last Service_____

Discharge Diagnosis:
Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____

Summary of services provided:

Summary of accomplishments related to treatment plan (include client perception):

Summary of strengths and abilities identified:

Discharge medications:

Reason for closure:

Status at closure, referrals made, aftercare or follow-up needed:

Recommendations for further treatment:

_____ _____
Therapist Signature Date

EVALUATOR'S GUIDE FOR THE URICA INTERVIEW

Evaluator:
Please do not use this instrument to assess consumers who are hallucinating, delusional, intoxicated, have gross impairment in reality testing, or have other cognitive impairments that would prevent them from being able to respond to the statements. We are expecting that you will use your best judgment when considering this tool to measure the consumer's stage of change.

Discussion between Evaluator and Consumer:
The URICA (University of Rhode Island Change Assessment) is a tool that will help us figure out particular behaviors that have been keeping you from reaching your goals. The purpose of these questions is to figure out the most helpful way for us to work out a successful individualized change plan. Although some of these questions are asked over and over again and may seem unnecessary, please answer all 32 questions to the best of your ability. We will talk about the results and figure out our options afterwards.

Evaluator:
Please discuss with the consumer the following questions when determining the consumer's target/particular problem behavior.

- What are your goals?
- What are the barriers/road blocks to achieving your goals?
- What specific behaviors get in the way of achieving your goals?

After you assist the consumer in defining the target/specific behavior that needs to change in order for them to achieve their goal, write that down in the blank space on the form. Then, ask the consumer to answer according to how they feel about that behavior.

Furthermore, please direct the consumer to answer that they agree or disagree and then follow up by asking if they agree or disagree strongly.
For example:
Question #1 As far as I'm concerned, I don't have any problems that need changing.

- Evaluator asks the consumer, "Do you agree or disagree with this statement?"
- The consumer answers that she agrees with this statement.
- The evaluator then asks, "Do you agree with that statement strongly or just agree?"

Definitions of the Stages of Change (DiClemente):
Pre-contemplation: Consumer isn't even thinking about changing the identified/target behavior. They may not see the behavior as a problem.
Contemplation: Consumer is ambivalent about changing. Consumer waivers between considering change and rejecting change. Consumer is willing to consider the problem, and the possibility of change offers hope for change.
(The stages of Preparation/Determination have been omitted by the author of the URICA.)
Action: Consumer engages in particular actions intended to bring about change.
Maintenance: The consumer has made a strong commitment to the new behavior, which has been firmly established, and the threat of relapsing becomes less frequent and intense.
Rev 10/15/01

EVALUATOR'S GUIDE

EACH STATEMENT BELOW DESCRIBES HOW A PERSON MIGHT FEEL WHEN APPROACHING PROBLEMS IN THEIR LIVES. PLEASE INDICATE THE EXTENT TO WHICH YOU TEND TO AGREE OR DISAGREE WITH EACH STATEMENT. IN EACH CASE, MAKE YOUR CHOICE IN TERMS OF HOW YOU FEEL RIGHT NOW, NOT WHAT YOU HAVE FELT IN THE PAST OR HOW YOU WOULD LIKE TO FEEL. FOR ALL STATEMENTS THAT REFER TO YOUR "PROBLEM," ANSWER IN TERMS OF PROBLEMS RELATED TO_____.

INSERT PROBLEM BEHAVIOR

THERE ARE FIVE POSSIBLE RESPONSES TO EACH OF THE ITEMS IN THE QUESTIONNAIRE:

1=Strongly Disagree
2=Disagree
3=Undecided
4=Agree
5=Strongly Agree

Evaluator: Emphasize the underlined words/phrases when asking the consumer to respond to the statement.

CIRCLE THE NUMBER THAT BEST DESCRIBES HOW MUCH YOU AGREE OR DISAGREE WITH EACH STATEMENT.

1)	As far as I'm concerned, I don't have any problems that need changing.	1	2	3	4	5
2)	I think I might be ready for some self-improvement.	1	2	3	4	5
3)	I am doing something about the problems that had been bothering me.	1	2	3	4	5
4)	It might be worthwhile to work on my problem.	1	2	3	4	5
5)	I'm not the problem one. It doesn't make much sense for me to consider changing.	1	2	3	4	5
6)	It worries me that I might slip back on a problem I have already changed so I am looking for help.	1	2	3	4	5

7) I am finally doing some work on my problem.	1	2	3	4	5
8) I've been thinking that I might want to change something about myself.	1	2	3	4	5
9) I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.	1	2	3	4	5
10) At times my problem is difficult, but I'm working on it.	1	2	3	4	5
11) Trying to change is pretty much a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
12) I'm hoping that I will be able to understand myself better.	1	2	3	4	5
13) I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
14) I am really working hard to change.	1	2	3	4	5
15) I have a problem and I really think I should work on it.	1	2	3	4	5
16) I'm not following through with what I had already changed as well as I had hoped, and I want to prevent a relapse of the problem.	1	2	3	4	5
17) Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
18) I thought once I had resolved the problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
19) I wish I had more ideas on how to solve my problem.	1	2	3	4	5

20) I have started working on my problem but I would like help.	1	2	3	4	5
21) Maybe someone or something will be able to help me.	1	2	3	4	5
22) I may need a boost right now to help me maintain the changes I've already made	1	2	3	4	5
23) I may be part of the problem, but I don't really think I am.	1	2	3	4	5
24) I hope that someone will have some good advice for me.	1	2	3	4	5
25) Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
26) All this talk about psychology is boring. Why can't people just forget about their problems?	1	2	3	4	5
27) I'm struggling to prevent myself from having a relapse of my problem.	1	2	3	4	5
28) It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved. (The problem I thought I had resolved might be returning.)	1	2	3	4	5
29) I have worries but so does the next guy. Why spend time thinking about them?	1	2	3	4	5
30) I am actively working on my problem.	1	2	3	4	5
31) I would rather cope with my faults than try to change them.	1	2	3	4	5
32) After all I had done to try and change my problem, every now and then it comes back to haunt (bother) me.	1	2	3	4	5

Definitions:

Relapse-

- **The continued use of old, ineffective solutions in response to a lapse (chemical use) is a relapse.**
- **To fall back into a previous condition, or into a worse state after improvement.**

Options-

- **Freedom to choose.**

Goal/objective-

- **Something one is trying to achieve or reach.**

Computation of a Single Continuum Readiness to Change Score Using the URICA

1. Obtain the average score per subscale using the following grid:

Precontemplation (PC)	Contemplation (C)	Action (A)	Maintenance (M)
1. _____	2. _____	3. _____	6. _____
5. _____	8. _____	7. _____	16. _____
11. _____	12. _____	10. _____	18. _____
13. _____	15. _____	14. _____	22. _____
23. _____	19. _____	17. _____	27. _____
26. _____	21. _____	25. _____	28. _____
29. _____	24. _____	30. _____	32. _____
TOTAL _____	TOTAL _____	TOTAL _____	TOTAL _____
÷ 7 =_____(avg)	÷7 = _____(avg)	÷7 =_____(avg)	÷7 = _____(avg)

2. Compute the Readiness for Change score via the following formula:
(Avg C + Avg A + Avg M) - Avg PC

3. Compare the Readiness for Change score to the following group means. Choose the stage whose group average is closest to the computed readiness score:

STAGE	**GROUP AVG**
Precontemplation	9.3
Contemplation	11.0
Participation (Action)	12.6
Maintenance	(Not available)

EXAMPLE

1. Obtain the average score per subscale using the following grid:

Precontemplation (PC)		Contemplation (C)		Action (A)		Maintenance (M)	
1.	2	2.	5	3.	5	6.	5
5.	1	8.	5	7.	5	16.	5
11.	1	12.	5	10.	4	18.	5
13.	1	15.	1	14.	4	22.	5
23.	1	19.	5	17.	4	27.	5
26.	1	21.	5	25.	5	28.	4
29.	1	24.	5	30.	5	32.	5
TOTAL	8	TOTAL	31	TOTAL	32	TOTAL	34
÷ 7 = 1.1 (avg)		÷ 7 = 4.4 (avg)		÷ 7 = 4.6 (avg)		÷ 7 = 4.9 (avg)	

2. Compute the Readiness for Change score via the following formula:
(Avg C + Avg A + Avg M) - Avg PC = (4.4 + 4.6 + 4.9) - 1.1 = 12.8

3. Compare the Readiness for Change score to the following group means. Choose the stage whose group average is closest to the computed readiness score:
12.8 is closest to the average for participation (action) group; thus, this consumer is probably very motivated for treatment at this time.

For additional information on the SATOE Model, contact:

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KEY TERMS

Action – The stage of change when people modify their behavior and surroundings in a way that can be seen.

Cognitive Distortions – A group of thought processes evidencing a maladaptive thinking pattern, i.e., "twisted thinking."

Contemplation – The stage of change when people acknowledge that they have a problem and begin to think seriously about changing it.

Family Systems Modalities – Systems approaches to family therapy, which place emphasis on the relationship among members, rather than on the individual dynamics of each member.

Genogram – A way of collecting and organizing important data over three generations which can be used as a tool for therapists and family members to understand critical turning points.

Joining – The process a therapist uses to make a workable connection and the family members to establish rapport and trust by communicating empathy, showing respect, and being patient and supportive.

Maintenance – The stage of change which is the ongoing process of committing the changed behavior into the lifestyle of those making the changes.

Precontemplation – The stage of change when people have no intention of changing and deny that there is a problem.

Preparation – The stage of change when people are planning to take action to modify behavior.

Termination – The stage of change when the desired change has been made and reinforced and is no longer problematic.

TSAT 12-WEEK CURRICULUM (FACILITATOR NOTES)

Group 1 (Exercises 1 and 2)

- Rules for group (if old group, review rules): Write them on the board or on a piece of construction paper to keep up in the room (after reviewing, pass out TSAT group rules handout with client signature line).
    a. Respect.
    b. Not interrupting.
    c. Housekeeping.
    d. Break.
    e. No smoking- if a teen smokes, the entire group will miss the next break.
    f. Drug testing behavior at TASC, missed = dirty.
    g. Transportation.
    h. Clients can swear as a way of expressing their thoughts, but not at each other.
    i. Clients have the right to be quiet if they do not wish to take part in a particular discussion. Other members do not have the right to force them to participate but do have the right to ask them questions and encourage them to participate.
    j. Clients should not accuse one another of stupidity when they describe their self-defeating behaviors.

- Goal setting: Have the clients write a list of changes (on the board) they want to make in their lives. (What does your ideal life look like?)

- Discussion: While the members talk about their goals, the leader listens for shared themes, such as regaining control of one's life, rebuilding a sense of self, restoring and renewing damaged relationships, and returning to reality. She or he then reflects this common goal to the group.

- Ask each client to think of one goal they have achieved in the last six months. Discuss steps the client needed to take to achieve the goal and how the client knew when the goal was attained. Process the thoughts that led the client to create the goal in the first

place – what were the influences on the client to set goals (e.g., client's values, family, probation officer, etc.)?

- Discussion of goal setting: Begin with whole group discussion on goals. Create list on board of reasons why people set goals (provide direction, measure progress, for motivation, etc.). Utilize a T-bar graph to compare the characteristics of healthy vs. unhealthy goals: healthy goals are attainable, realistic, clear, positive, etc. They allow you to succeed and recognize the small steps forward. Unhealthy goals are unrealistic (for example, you have a four-year probation and have a goal to be off in one year), set you up for conflict with family members and set you up for failure. Identify short, intermediate, and long-term goals. Define time ranges for each goal as well as characteristics. For example, short-term goals are usually easier to attain and help to build confidence to tackle bigger goals. Also process how one can set up short-term goals that eventually lead to a long-term goal (e.g., one may have the long-term goal of getting his/her college degree; a short-term goal may be to complete applications to eight different schools).

- Setting personal goals – alternate format: Have clients break into small groups (two to four clients per group) and have them share their goals.

- Have each client take home a copy of "Setting Personal Goals" and discuss ways they can remind themselves of the goals to work on daily (where to put them, when to read them, etc.).

  [Exercises 3 and 4 can be used as additional or alternate exercises.]

- Explain the stages of change to the group:

  Precontemplation: Active resistance to change.

  Contemplation: Clients can get stuck in this stage for years. Ambivalence.

  Preparation: Takes you from the decisions you make in the precontemplation stage to the specific steps you take to solve the problem in the action stage.

  Action: Taking action. Working the program.

  Maintenance: "You're always a puff away from a pack a day." Here the client must replace the problem behaviors with a new, healthier lifestyle.

  Recycling: Relapse.

  Termination.

- Draw the following on the board to better explain to the clients where they may be between the first three stages of change. Ask the clients:

  Question #1: Do you seriously intend to quit smoking/using in the next six months?

  Question #2: Do you seriously intend to quit smoking/using in the next thirty days?

  You can determine your stage by the combination of answers you gave to these two questions (see chart).

Question 1	No	Yes	Yes
Question 2	No	No	Yes
Your Stage	Precontemplation	Contemplation	Preparation

- When dealing with the process of change, timing is everything. Have the group explore what this means to them: Timing is everything. Explore areas in their lives where they have or have not made changes because they were or were not ready. Discuss what occurred in those situations and what happened when the timing was right (e.g., quitting a job, obtaining a job, breaking up with a significant other, dieting, quitting smoking or using drugs, spending more time with family members, etc.).

Group 1

(Alternate)

Introduce the Stages of Change model and talk about each stage.

- PRE-CONTEMPLATION - "It isn't that they can't see the solution. It is that they can't see the problem."—G. K. Chesterson. Everyone else can. Yet the pre-contemplator can WISH to change. (Remember that WISHING is different than INTENDING to change in the next six months.)
- CONTEMPLATION – These individuals are aware that a problem exists and are seriously thinking about overcoming it yet have not made a commitment to take action. They can be here for years without taking action—knowing where they want to go, yet not quite ready to go. They are weighing the pros and cons of the problem(s) and solutions(s).
- PREPARATION (DETERMINATION) - Combines intention and behavior criteria. These individuals intend to take action in the next six months that they have not in the last year. They report small behavioral changes yet have not reached criteria for effective action (i.e., abstinence).
- ACTION - These individuals modify their behavior, experiences, or environment in order to overcome their problem(s). Requires considerable commitment of time and energy. Don't make the common error of equating action with change and consequently overlook requisite work that prepares changers for action and important efforts necessary to maintain the changes following action. Action exhibits significant overt effort to change.
- MAINTENANCE – Involves work to prevent relapse and consolidate the gain attained during action. This is a continuation of change, but NOT termination of change.
- RELAPSE - Returning to old behavior and actions.

Break

(Continue with model of change)

- Allow each client to talk about what stage of change they feel they are in.
  (Have them talk about the pros and cons of making changes)
- Have them explain why they feel they are in that stage. Allow the group to confront the individual if they feel the individual is in denial. (Be sure to let the group do this while you listen. The individual will accept it better from a group member than from you).
- Write the stages of change on a board and write each client's name beneath his or her respective stage.

WEEKLY GOAL

Name: _____

Date: _____

This week my goal is to:

_____

_____

To reach it I plan to:

_____

_____

What might get in the way is:

_____

_____

How I can handle this obstacle is to:

_____

_____

Signed, Date

_____ _____

GOAL REVIEW

Name: _____

Date: _____

Was your goal accomplished? Yes No

If it was, what steps helped you to reach it?

* _____
* _____
* _____

If not, what do you think you need to do differently next time?

* _____
* _____
* _____

HEALTHY VS. UNHEALTHY GOALS

HEALTHY GOALS	UNHEALTHY GOALS

GOAL WORKSHEET

1. Personal Goals: (examples - Quit smoking, eat healthier, exercise)

2. Professional or Work Goals: (examples - Write a resume, fill out a job application, volunteer)

3. Educational Goals: (examples - Take a class you are interested in, read a book or newspaper during your spare time, go to the library once a week)

4. Relationship Goals: (examples - Develop friendships, make amends to someone, join an organization where you can meet new people)

5. Leisure Goals: (examples - Make time for yourself once a day to do something fun, learn a hobby or craft)

Other goals not stated:

GOALS

Name three or more long-term goals you have for yourself (think of 10 years from now).

1.

2.

3.

Name three or more medium-term goals you have for yourself, some of which may relate to your long-term goals (think of one to three years from now).

1.

2.

3.

Name three or more short-term goals, some of which may relate to your long-term or medium-term goals (think of one day to six months from now).

1.

2.

3.

Name one immediate goal you have for yourself for today and tomorrow.

Today:

1.

Tomorrow:

1.

SETTING PERSONAL GOALS

1. My three short-term goals are:
   A.
   B.
   C.

2. My three medium-term goals are:
   A.
   B.
   C.

3. My three long-term goals are:
   A.
   B.
   C.

Group 2

Family Night

- Introductions: The group leader introduces him/herself and asks each client, parent, and relative to introduce him or herself (nametags are optional). Pass around a sign-in sheet with demographic information to be updated.

- Write "Family Systems Theory" on the board and ask the family members if they know what it means. Explore families' interpretations with the group.

- Explain to the group that systems theory directs our attention away from the individual (and individual problem) and toward relationship issues between individuals. The interdependence of the observer and observed is an important aspect of a holistic perspective that takes into account the context of their interactions. Theoretically, participant A and participant B exist in the context in which each influences the other, and both are equally cause and effect of each other's behavior. Systems theory allows us to describe relationships and patterns or interactions.

- Further explain to the group that the reason this is being explained is because EMPACT-SPC works from a family systems theory. Tell the families that when we discuss what is going on with the client, the client represents the entire family, and each family member will be challenged to discuss what each person is doing or not doing that contributes to the family problems. Explain that there is no blaming each other; rather, we are encouraging each other to look at how each member's behaviors affect others' behaviors.

- Ask families to check in and review the status of their families. Challenge them to think from a family systems theory. Encourage them to focus on positive behaviors and changes (as small as they may be) and what the parents/guardians are doing to encourage the positive behaviors.

Break

- Have family members break up into family groups and ask them to write down on a piece of paper the following:
    1. What are your expectations for your child/parent or guardian?
    2. What are your expectations for yourself?
    3. What are your expectations for the therapist/TSAT program?

    Ask the family members to write down on a separate piece of paper:
    a. What can I do to assist my child/parent or guardian in meeting my expectations for them?
    b. What can I do to assist myself in meeting the expectations I have for myself?
    c. What can I do to assist my therapist/TSAT program in meeting the expectations I have for them?

- After 15 minutes, have the family members discuss the above exercise amongst their own families. Have the group come together and share what they discussed. Encourage families to share when they experienced the same ideas or discuss when they disagreed. Tie family comments together and encourage them to view the questions and answers from a family systems perspective. Tie in substance abuse and recovery.

- Ask family members to explore what they are going to try to do differently for the next month: Hearing what your parent/child said that he/she needs from you, what are you going to do differently to try to employ that in your future interactions? Then ask the recipient what they are going to do to make that easier for the other person.

- Closing: Encourage families to come to future groups and to call the therapists and the TSAT coordinator with any concerns/comments.

Group 3

Consciousness-Raising

(Pre-Contemplation Stage Intervention)

The goal here is to increase information about the self and the clients' problems. "To make the unconscious conscious"—Freud.

- Explain how any increased knowledge about yourself or the nature of your problem, regardless of the source, raises your consciousness. Ask the group if they presently think they have a substance abuse problem and, if so, what made them come to that realization. Ask the group who in their lives has told them they have a problem and how many times they denied it before they were willing to accept it. Ask the group to raise their hands if they do not think that they have a substance abuse problem. Focus on observations, confrontations they have had with others (family, friends, therapist, P.O., bystanders, etc.). Ask for interpretations about their substance abuse: what does it mean to them, how do they view themselves, and how do others view them? Ask them to describe a day in their lives and how substance abuse plays a role. For clients who are presently clean, ask about their lives now versus when they were chronically using.

Break

- Have the group members write their own obituaries in their journals. Have them write what their obituary would look like if they were to die today. Have them write their name, age, who they are survived by, what they have accomplished in their life, and what they want to be remembered by. Have them write the way they died. Have them share this with the entire group. Encourage them to share their thoughts on their personal obituaries and the obituaries of others.

- Next, have the clients write in their journal what they would like their ideal obituary to be. Have them write their name, age, who they were survived by, and what they have accomplished in their life. Have them write the way they died. Have each client share

this with the entire group. Encourage them to share their thoughts on their personal obituaries and the obituaries of others. Ask the clients to explore what they need to do in their lives to change what their life looks like now to how they want it to look in the future.

Break

- Role play: State to the group: "Describe a situation in which someone in your family told you that you had a substance abuse problem." Have the client choose one or more people in the group to play the part of a family member and have the client play the role of himself/herself. Then have them switch and have the client be the family member telling the other group member (who is modeling the client) that she/he has a substance abuse problem. Each person in the group should do the role play one time. Discuss changes in attitudes when the roles were switched and how it felt for each client to be on each side of the role play.

Group 4

Social Liberation

(Pre-Contemplation Stage Intervention)

The goal of this group is to increase social alternatives for problematic behaviors.

- Explain to the group this process involves any new alternatives that the external environment can give you to begin or continue your change efforts. Social liberation not only makes actions more possible, but it can also increase self-esteem as practitioners come to believe in their own ability to change.

- Explore some examples of social liberation: non-smoking areas, taking animation off the packaging on cigarettes, a drinking age, the need for prescriptive medications to only be given out by doctors, low-fat menus, sugar-free candies for diabetics, motivational training seminars, financial advisors for people with debt problems, 12-Step programs, mental health organizations, women's rights groups, gay and lesbian groups, etc.

- Explain to the group that depending on the stage of change that one is in, some people will react to social liberations in different ways. Any individual can act as an advocate for his or her own rights, striving to alter the social environment in ways that can help others change themselves. Ask the group who disagrees with non-smoking restaurants or stores that card for alcohol. Ask the group to explore some areas in which they think social liberation is necessary. What groups or policies does the group believe would benefit society?

Break

- Explore how social liberation can increase self-esteem and make more actions toward change possible. Clients come to believe in their own power and ability to change. Have clients talk about a topic of importance to them and take a side. Have them pair off and debate the topic for 10 minutes. They can choose their own topic, use one from

the list below, or make one up. Some examples of topics can include (write this list on the board):

1. Eighteen years old as the legal drinking age.
2. Sixteen years old as the legal driving age.
3. Marijuana is illegal.
4. Drugs are illegal.
5. TSAT is court ordered as a term of my probation.
6. Counseling is helpful.
7. I have a substance abuse problem.
8. You cannot change the type of person you are .
9. You are an addict.

- Now have the same pair of clients switch roles and debate the other side for 10 minutes.

- Discuss what they noticed in the changes of their opinions, if any. Ask the client, "What was it like for you to be arguing for or against something that you did or did not believe in? How does this relate to your substance use (others' perceptions of you)?"

Group 5

Presenter

Presenters may include representatives from TASC, Inc., on what urinalysis results mean, Tobacco Prevention, Arizona State University Health Center on “safe sex,” Center Against Sexual Assault on “boundaries,” other community resources, and adults or adolescents in recovery themselves.

Group 6

Emotional Arousal

(Contemplation Stage Intervention)

The goal of this group is to experience and express feelings about one's problems and solutions. This area helps the clients to become aware of their defenses against change.

- Have the clients share stories from their lives of people that they knew who have died of cancer from cigarette smoking, drugs, drinking and driving, alcohol, or gang involvement.

- Have the clients write a letter to this person and tell them how they feel about the way that they died. If a client does not know anyone who has died or is facing a tragedy, have him or her think about what life would be like for him or her if they did lose someone very close to them.

Group 7

Self Re-Evaluation

(Contemplation Stage Intervention)

The goal of this group is to assess feelings and thoughts about self with respect to a problem. Self re-evaluation enables you to see when and how your problem behavior conflicts with your personal values. The result is that you come to not only believe but also truly feel that your life would be significantly better without the problem. Have the clients discuss what parts of their lives would be better if they were not using drugs (write the answers on the board).

- Have the clients write on a piece of paper their ideal person/hero. If they could be any person, who would it be and why? Then have them explore the reasons for this and what ways their lives are similar to this person and how they are different. Ask them what needs to happen in their personal lives so they are more like their hero.
- Remind the clients that before they make a choice, they can ask themselves "Would my ideal person do this (engage in the behaviors in which I am engaging)?"

Break

- Do exercises on values: The group leader is to engage the clients in a general discussion. Have the clients answer the following exercises:
    1. When did you form your set of values?
    2. Are your values like those of your family? If not, how are they different?
    3. What do your values say about you?
    4. How do your values guide how you live and the decisions you make?
    5. How does using drugs influence your value system?
    6. What can you do to focus more on some of your important values?
    7. Do you think some values are better than others? That some values are right and some are wrong?

- Ask the clients to describe how they see themselves as a drug user, pot smoker, alcoholic, person with a bad attitude, gangster, etc.

- Have the clients discuss what the cost will be of changing how they perceive themselves. What will be the cost of that change in time, energy, pleasure, stress, or image? What, overall, are the pros and cons of trying to overcome the problem?

- Have the clients discuss the topic of values (including defining the word).

- Have the clients complete the following sentences (see attached):

LIVING BY OUR VALUES

Because _____ is one of my values, I plan to _____.

Because _____ is one of my values, I plan to _____.

Because _____ is one of my values, I plan to _____.

Because _____ is one of my values, I plan to _____.

Because _____ is one of my values, I plan to _____.

Because _____ is one of my values, I plan to _____.

Because _____ is one of my values, I plan to _____.

Because _____ is one of my values, I plan to _____.

Group 8

Movie Day

- Watch a video on drugs and their effects or a movie that demonstrates how drugs affect the lives of the user and those around them. Process the movie and how it relates to personal experience.

Group 9

Signs of Substance Abuse

(Contemplation Stage Intervention)

This topic may take more than one group.

- Check in. Ask clients how they are doing and what their plan is to work on their sobriety. Explore who is hurt by the clients' drug use (family, friends, self, etc.)

- Identifying the stages of addiction: Hand out the "Identifying Stages of Addiction" questionnaire and have clients complete the exercise. After this is done, ask the group members if they learned something they did not know about themselves before. Read though specific questions and ask clients who identified with them and why. Remind the clients about the topic they explored during check-in—who is hurt by the clients' use.

Break

- Review the handout "Six Categories of Substances." Have the clients share personal experiences with each substance and explore how it affected their lives.

- Review the handout "Signs of Substance Abuse." Discuss the differences between substance abuse and drug dependence.

- *(Alternate activity)* Define substance abuse and substance dependence according to the DM IV. Read the scenarios on the handout "Evaluate the Following People for Substance Abuse…What Clues Do You See?" Have the group members break into small groups and discuss each scenario and answer the questions. Bring the groups back together and review them as a large group. Compare to group members' personal experiences.

IDENTIFYING STAGES OF ADDICTION

Instructions: Sometimes when people start to use alcohol/drugs they begin to have problems. These problems are often described as the symptoms of addiction or chemical dependency. Answer each question below as honestly as you can.

You may notice that some of the questions will make you feel uncomfortable. As a matter of fact, you may notice that you have an urge to lie about your answers. If this happens, it means that you have an urge to deny the problem related to your alcohol/drug use.

The goal of having you answer these questions is to give you the chance to think about some of the problems that you may be having. To make these questions helpful to you, you need to take the time to think about your answers. You also need to notice the feelings that each question stirs up. Some of these questions may raise concerns in your own mind or may make you start arguing with yourself. These are questions that you need to talk about with someone.

YES NO

1. Have you ever used alcohol/drugs without your parents?
2. Do you usually use alcohol/drugs more than twice a month?
3. On the days when you use alcohol/drugs, do you usually use three or more times?
4. On the days when you use alcohol/drugs, do you usually use heavily and want to get loaded?
5. If you couldn't use alcohol/drugs because of a medical problem, do you think that it would be difficult for you to stop?
6. If you use mind-altering drugs that have been prescribed for you by your doctor, do you sometimes use more than the amount prescribed, or use them at times you doctor didn't tell you to use them?
7. Do you sometimes use mind-altering drugs that have been prescribed for someone else? (This could happen when your parents, brothers, sisters, or friends share some of their prescribed medication.)
8. Do you ever use any other drugs that aren't prescribed for you by your doctor? (These might be medications like diet pills, sleeping aids, staying-awake pills, or herbal energy

supplements that make you feel high or give you a buzz. It might also include street drugs that you buy from friends or other people.)

9. Do you get high or drunk more than twice a year?
10. When you're using alcohol/drugs, do you ever put yourself in situations that raise your risk of getting hurt, having problems, or hurting others? (This includes things like driving while under the influence, having unprotected sex, getting into fights, skipping school, committing crimes, etc.)
11. Do you ever brag about your ability to drink heavily or use a lot of drugs?
12. Have you ever felt that you should cut down on your drinking or drug use?
13. Have your parents, teachers, or other adults ever been annoyed by or critical of your alcohol/drug use?
14. Have your friends ever been annoyed by you or criticized you because of your alcohol/drug use, or because of something that you have done while you were using?
15. Have you ever put yourself down or criticized yourself because of your alcohol/drug use, or because of something that you have done while you were using?
16. Have you ever lost a friend because of your alcohol/drug use?
17. Have you ever stopped seeing a friend you used to like because that friend wouldn't use alcohol/drugs with you?
18. Have you ever felt bad or guilty about your alcohol/drug use?
19. Have you ever done things while you were using alcohol/drugs that you regretted or that made you feel guilty or ashamed?
20. Have you ever used alcohol/drugs first thing in the morning to feel better, to get rid of a hangover, or to get ready to face the day?
21. Have you ever used alcohol/drugs to try to escape from or cope with a problem or situation that you didn't know any other way to deal with?
22. Have you ever thought that you might have a problem with alcohol/drugs?
23. Has anyone else (a parent, teacher, brother, sister, or friend) ever told you that you might have a problem with alcohol/drug use?
24. Do you ever use alcohol/drugs in larger quantities than you planned to?
25. Do you ever use alcohol/drugs more often than you planned to (for example, you plan not to use today but you do it anyway)?
26. Do you ever use alcohol/drugs for longer periods of time than you planned to?

27. Have you ever had a desire to cut down or control your use?
28. Have you ever actually cut down or controlled your use?
29. Are you spending more and more time planning to use or actually using?
30. Have you ever failed to finish your schoolwork because you were using alcohol/drugs or feeling hung over?
31. Have you ever failed to do the things you were supposed to do at home because you were using alcohol/drugs?
32. Have you ever let other people down who care about you because you were using alcohol/drugs or feeling hung over?
33. Have you given up any work, social, or recreational activities because of alcohol/drug use?
34. Have you gotten into trouble with the police as a result of what happened when you were using alcohol/drugs?
35. Have you ever had problems or conflicts at home because of your use of alcohol/drugs?
36. Have your parents ever punished you because of something that happened when you were using alcohol/drugs?
37. Have you ever been too sick to go to school as a result of using alcohol/drugs?
38. Have you ever missed school in order to hang out with your friends who use alcohol/drugs, or to do things that involve alcohol/drug use?
39. Have you ever had a problem or conflict at school because of your use of alcohol/drugs?
40. Have you ever gotten into trouble at school because of things that happened when you were using alcohol/drugs? (This includes being disciplined, getting detention, being sent to the person in charge of discipline, having your parents notified of problems, or being suspended).
41. Have you ever had problems with friends as a result of your alcohol/drug use?
42. Have you ever gotten physically sick as a result of your alcohol/drug use?
43. Have you ever kept on using alcohol/drugs even though you knew they were causing problems or making problems worse?
44. Has your tolerance gotten higher since you started using alcohol/drugs?
45. Have you ever kept on using alcohol/drugs even though you knew they were causing problems or making problems worse?

46. Do you have to use more alcohol/drugs in order to get the same effect you used to get when you used less?
47. Do you get physically uncomfortable or sick on the day after using alcohol/drugs?
48. Do you use alcohol/drugs to make a hangover go away?
49. Has a doctor or therapist ever told you that he/she thought you had a serious problem with alcohol/drugs?
50. Have you ever sold alcohol or drugs to other kids who had trouble getting them themselves?
51. Did you feel uncomfortable or have the urge to lie when answering any of the above questions?

SCORING

1. Count how many times you answered “Yes” to any question numbered 1-10.
2. Count how many times you answered “Yes” to any question numbered 11-50.
3. Check below the category that most accurately describes your risk of addiction based upon your answers.
   A. Low risk: If you answered “No” to all of the above questions, you are at low risk.
   B. High risk: If you answered “Yes” to three or more of the above questions numbered 1-10 and answered “No” to all of the remaining questions, you are at high risk.
   C. Early stage: if you answered “Yes” to three or more of the questions numbered 1-10 and answered “Yes” to 3-6 of the questions numbered 11-50, you are in the early stage of addiction.
   D. Middle stage: If you answered “Yes” to three or more of the questions numbered 1-10 and answered “Yes” to 7-10 of the questions numbered 11-50, you are in the middle stage of addiction.
   E. Late stage: If you answered “Yes” to three or more of the questions numbered 1-10 and answered “Yes” to 11 or more of the questions numbered 11-50, you are probably in the late stage of addiction.

SIX CATEGORIES OF SUBSTANCES

There are six categories of substances: opiates, depressants, stimulants, hallucinogens, cannabis, and inhalants.

1. OPIATES: Drugs that produce sleep or stupor and at the same time relieve pain.

Examples: Opium, heroin, morphine, methadone, Dilaudid, Demerol, Darvon, percodan, codeine, Tylenol with codeine, Robitussin A-C, empirin with codeine.

Sought effects: Euphoria, detachment, affect blocking, sexual enhancement, avoidance of deprivation/withdrawal effects.

Unsought effects: Severe withdrawal symptoms, tolerance, impotence, and high risk of overdose by respiratory failure.

Functions: May decrease need for affection and social contact, has an anti-psychotic effect, strongly promotes an emotionally detached and antisocial lifestyle.

2. DEPRESSANTS OR SEDATIVE-HYPNOTICS: Substances that decrease central nervous system activity and anxiety.

Examples: Alcohol, barbiturates-Nembutal, Seconal, Amytal, Tuinal, Doriden, Valium, Quaalude.

Sought effects: Relaxation of anxiety, pleasant sedation, euphoria, and sleep. Benzodiazepines (minor tranquilizers) have the principal effect of acting as depressants on the central nervous system, thereby relieving anxiety and tension and sometimes relaxing muscles.

Unsought effects: Severe withdrawal, dangerous lack of control, liver and kidney problems, passing out, coma, blackouts, and seizures.

Functions: Often used to escape or avoid unpleasant feelings or situations, or to reduce anxiety

to the point that other coping mechanisms can be effective.

3. STIMULANTS: Excite or stimulate some organs or a part of the body to a greater function or activity. Cause stimulation of the central nervous system, loss of appetite, and emotional problems.

Examples: Cocaine/crack, methamphetamines/crank, crystal, speed, ice, amphetamines (Dexedrine, Benzedrine, Ritalin), nicotine, caffeine, Primatene mist.

Sought effects: Added energy, increased arousal, activity, efficiency, and euphoria.

Unsought effects: Impulsiveness, violence, agitation, depression, paranoia, heart attack, malnutrition, high blood pressure.

Functions: Avoidance of unpleasant affects, false sense of self-esteem, self-stimulation, gain of social or sexual advantages, energy.

4. HALLUCINOGENS: Commonly referred to as "psychodelic drugs." The word hallucinogens stems from the Latin word hallucinari, "to wander mentally." Hallucinogens produce hallucinations or episodes of hearing, seeing, or feelings that are not real.

Examples: LSD/acid, microdot, mescaline/peyote, amphetamine variants - PCP, DMT, Ecstasy, psilocybin-mushrooms, Ketamine (special- K), Sherm.

Sought effects: Pleasant heightening and distortion of perception.

Unsought effects: Psychosis, depression, confusion, impulsivity, accidents, dangerous behavior, and violence.

Functions: Escape from reality, may support an asocial stance.

5. CANNABIS: Marijuana is a green, brown, or gray mixture of dried, shredded flowers and leaves of cannabis sativa or hemp plant. Psychologically, THC has some properties of

sedatives and at high doses may produce hallucinations.

Examples: Marijuana, hashish, hash oil, Marinol, THC.

Sought effects: Euphoria, sense of well-being, user feeling introspective and peaceful, imagination is usually stronger.

Unsought effects: Short-term memory loss, loss of depth perception, lack of motivation, rapid heartbeat, some loss of coordination, slower reaction time, difficulty concentrating, lack of physical maturity. Overdose effects: fatigue, paranoia, possible temporary psychosis, brain, lung, and throat cancer, and panic attacks.

Functions: Recreational use: for psychological coping to deal with anxiety, anger, depression, and boredom. Medical uses: THC that is manufactured into a pill has been used for the treatment of glaucoma, for reducing nausea in patients undergoing cancer chemotherapy, and for increasing appetite in AIDS patients.

6. **INHALANTS:** A general category used for a wide variety of substances taken into the body through the act of inhaling. The three major categories are aerosols, solvents, and gases.

Examples: Paint, paint thinner, gas, pledge, carburetor cleaner, whippets (nitrous oxide), poppers, glue, Wite-Out, and hairspray.

Sought effects: Strong relaxation, decreased anxiety, pleasant sensation, and numbness.

Unsought effects: Brain shrinkage, liver and kidney problems, instant death, coma, and blackouts.

Functions: Most not for human consumption, some may be used in a medical setting.

SIGNS OF SUBSTANCE ABUSE

Which apply to you? Check them off.

- Trying to stop using or decrease using the substance **but not being able to**.

- Protecting your access to the substance by being **secretive** about it, always having an amount of it you can get to.

- **Denying** to others and sometimes to yourself that there is a problem despite obvious signs or others stating it is a problem.

- Using the substance **to forget problems**, to get away from anger or stress.

- **Regretting** the substance use and feeling **ashamed about it** afterwards.

- Having uncontrollable **mood swings** including anger, fear, anxiety, and helplessness when using, coming down, or unable to use.

- **Rationalizing** that you can quit tomorrow, you could quit if you really wanted to, it really isn't much of a problem, everyone uses drugs, marijuana is not dangerous, you're not hurting anyone but yourself, etc.

- **Blaming** others for "making you" use substances.

- **Blowing off** other parts of life such as school, work, hobbies, and relationships in order to use.

- Planning life around the substance, being **preoccupied** about it, and being willing to do almost anything to get the substance.

- Continued use despite **bad consequences,** such as legal, health, financial, psychological, educational, and social problems.

- More **time** is spent thinking about, getting, using, and recovering from the substance.

- Larger amounts of the drug or more frequent use of it is needed to produce the same high (**tolerance).**

- When you go too long without the substance, you have bad **withdrawal** symptoms (headache, stomachache, irritable mood, pain, shaky, trouble thinking, can't sleep, too sleepy).

- **Control** is lost when you decide to use just a little—you use more drugs than you had planned on, or you use them for a longer period of time than you planned on.

- Using **alone** more and more.

- Friends who do not use drift away, and **new friends** tend to be drug users.

- Drugs may be used to **"punish"** other people, such as parents or probation officer.

- Episodes of **violence** against yourself, property, or others happen during drug use.

- More and more **lies** are needed to cover you when you are getting, using, or coming down off a substance.

- More and more **"war stories"** are told. Episodes of use are glorified, glamorized, or bragged about.

- **Paraphernalia** and drug-related posters, T-shirts, jewelry, etc., are collected.

- People are willing to put themselves in **dangerous situations** to get or use.

- **Substitution** of one drug for another in an attempt to quit the first.

SUBSTANCE ABUSE

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:
   a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated work absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
   b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating machinery when impaired by substance use).
   c. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
   d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

B. The symptoms have never met the criteria for substance dependence for this class of substance.

SUBSTANCE DEPENDENCE

A. Maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three or more of the following, occurring at any time in the same 12-month period:
    1. Tolerance, as defined by either of the following:
        a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
        b. Markedly diminished effect with continued use of the same amount of the substance.
    2. Withdrawal, as manifested by either of the following:
        a. The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for withdrawal from the specific substances).
        b. The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period of time than was intended.
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exasperated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

EVALUATE THE FOLLOWING PEOPLE FOR SUBSTANCE ABUSE… WHAT CLUES DO YOU SEE?

Jason

Jason is 16 years old. He started drinking last year with his good friend who is his next-door neighbor and goes to a different school. None of the rest of his friends has ever been drunk or has used drugs. No one in Jason's family appears to have a substance abuse history. His mom and aunts and uncles drink a little at family events and sometimes let him have a beer. When asked if he is interested in trying other drugs, Jason said he would like to smoke pot because he heard it's cool and it makes you really creative. He said he definitely did not want to try anything else. He drinks usually once on the weekends, sometimes both weekend nights. He and his neighbor, a guy his age, drink at keg parties at people's houses or at a nearby park. Jason has never been violent or emotional when drunk. He said that when he gets "buzzed" he relaxes and has a good time. He and his friends just hang out and socialize, or go walk around. He does feel guilty for lying to his mom about all of this. He is afraid if she finds out that she will be disappointed in him and very sad. One time he got so drunk he threw up and didn't drink again for a month. His grades are pretty good, B's with an A in his computer and music classes. He says some of his teachers are pretty cool. For future plans, he is considering maybe going to a community college, and he definitely wants to be in a band. Jason plays football in the fall and baseball in the spring. When asked what he likes to do for fun besides partying, he named working on his new computer, playing guitar, listening to music, and going to movies with his friends from school.

What clues do you see that Jason may have a problem?

What positive things do you see that may offset these?

Ricardo

Ricardo is 16 years old. When he was little he would sneak sips from adults' drinks, and he started to sneak wine coolers or beer once in a while when he was in late grade school. Since junior high he has been drinking alcohol and smoking marijuana every weekend with his friends. In the last two years he has been getting high after school once or twice a week, and he has dropped acid twice. Both times he dropped acid he did not like it, and he said he doesn't want to do it again. Last week he smoked a primo for the first time and now is interested in trying cocaine if he doesn't have to buy it. He does have a few friends who don't use drugs, but he said he hasn't seen them for a while. Ricardo's girlfriend doesn't do drugs at all. He said that he wouldn't date a girl that does. When he is with her he uses less and often not at all. Last month he was pulled over for driving drunk but was not charged. He said he rarely drives drunk, "only when he has to," because he doesn't want to go to jail. Driving stoned, however, isn't a big deal to him because he says he actually drives better that way. Ricardo's mother and stepfather do not have any substance abuse problems, but his older sister does. He thinks his biological dad might have been an alcoholic but he isn't totally sure. Ricardo feels that his drug use is not a problem and none of his parents' business. He isn't really close to either his mom or stepdad. He is very close to his grandparents. In school, his grades are okay except for failing one class. He was suspended four times last year for fighting and once this year for truancy. He didn't try out for the basketball team this year for the first time. He has no idea what he wants to do after he graduates from high school. He joked that he hopes he wins the lottery so he doesn't have to work.

What clues do you see that Ricardo may have a problem?

What positive things do you see that may offset these?

Melissa

Melissa is 16 years old. She started using drugs when she was 10. By the time she was 13 she was using crystal meth almost every day. She says she's "tried just about everything" but likes crystal the most because when she's high, "nothing bothers her." An uncle molested Melissa from the time she was 7 until she was 12; she refuses to talk to anyone about it. Melissa usually uses with her boyfriend, who is 23, and his friends. Otherwise, she'll just use by herself or with her younger sister. Her sister is 13 and Melissa won't let her use crystal meth because "it might mess her up," so she'll give her sister a joint to smoke. Both of Melissa's parents are addicts. Her mom goes to Narcotics Anonymous and has been clean for a year. Melissa won't go to a 12-Step meeting because she says it is "a cult." She hasn't seen her dad in a while but is pretty sure he still uses cocaine. Last month when she was high she fought so badly with her mom that the police had to come. She ran away, but after she and her boyfriend fought, she returned home. Melissa stated that she hates her whole family except for her sister and plans to run away for good when her boyfriend has the money. She hopes to help him come up with it by selling stuff that she steals from Wal-Mart. She has also heard that you can get a lot of money by threatening immigrants that you will turn them in if they don't give you a lot of money. Melissa dropped out of school last year. Her mom made her start a GED program—she has only gone once. She said she couldn't see what the point was as she probably would be dead before she was 21 anyway. Melissa lost a lot of weight from the crystal but says she feels healthy. Her mother said that a lot of her hair has fallen out and her skin looks bad, but Melissa denies this. She says she's really funny when she's tweaking, all of her boyfriend's friends think so.

What clues do you see that Melissa may have a problem?

What positive things do you see that may offset these?

HOW ABOUT YOU?

By now you are familiar with several signs of substance abuse and addiction and have evaluated several cases. Now, look at your own behavior, both now and in the past.

1. WHAT CLUES DO YOU SEE THAT *YOU* HAVE HAD A SUBSTANCE ABUSE PROBLEM?

2. WHAT POSITIVE THINGS DO YOU SEE IN *YOURSELF* THAT OFFSET THESE SIGNS?

Group 10

Commitment

(Preparation/Action Stage Intervention)

The goal here is to choose and commit to act, or to have belief in one's ability to change. It is an acknowledgement that you are the only one who is able to respond, speak, and act for yourself. The first step of commitment is private: telling yourself that you are choosing to change.

- Introduction to how thoughts and feelings are related to learning: The group facilitator should explain that events have happened during the course of our lives that have taught us to think as we do. We have a learned belief system and automatic thoughts, which we use without even consciously thinking about them. All we are aware of most of the time is how we feel and what we do when we feel that way.

- Ask the group: Who is in control of your emotions? What is the difference between a thought and a feeling? Then ask the group to come up with feeling words under each emotion. Put a list of words for emotions on the board and put feeling words under each emotion as the group members come up with them.

- Introduction to the thought feeling journal: Explain to the group that using this journal will help the members slow down their thinking and identify different parts of their thinking process. Create a sample thought/feeling journal on the board.

Break

- Hand out the exercise called "Making Choices": Explain to the group that we are each responsible for the choices that we make in our lives. Explore this with the group. Have group members raise their hands if they agree/disagree and explain their reasons for their opinion.

- Triggers: Explain that episodes of drug use are not random but part of a larger pattern for each individual. Components of the client's pattern of use function as operant and classical conditioning to further use (holidays, getting stressed, facing a court date likely to result in detention, having friends who use, smelling marijuana, etc.).

- Separate triggers into four categories: things, situations, people, and feelings. Have clients either brainstorm aloud to generate a large list on the board or fill out worksheets that are then read aloud and written for all clients to see on one large list. Propose to the clients that in order to successfully abstain from drug use, they must handle the triggers differently. Each item ideally is discussed in terms of how to handle it to minimize the threat of relapse, i.e., avoiding concerts, going to a party with a sober friend, talking through frustrations with a counselor or friend, or asking a parent to remove or lock up any alcohol from the home.

- Stumbling blocks: On the board, draw a box. Have the group members brainstorm things that interfere with their ability to make good decisions (friends, family members, parties, etc.). Then explore as a group how the group members can deal with these stumbling blocks. Hand out the exercise "Stumbling Blocks/Triggers." Have the clients complete it on their own and later explore it as a group.

MAKING CHOICES

Step One:
What is a problem you are currently facing?

Step Two:
What are your possible choices? (Ask the group what they think you can do about it.)

1.
2.
3.
4.
5.

Step Three:
Think about your choices.

Positive aspects (what positive consequences can come out of the five possible choices?)
1.
2.
3.
4.
5.

Negative aspects (what negative consequences can come out of the five possible choices?)
1.
2.
3.
4.
5.

Step Four:
Decide which choice is best for you.

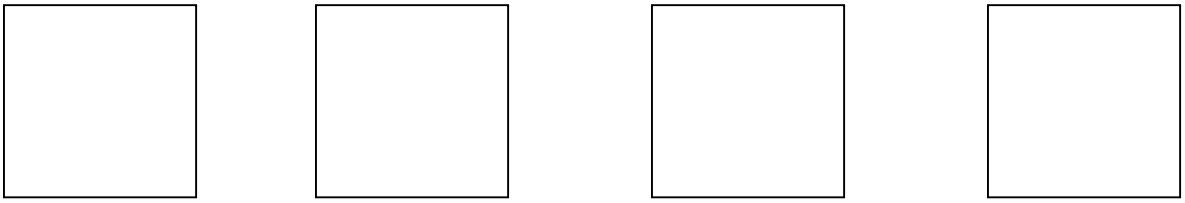
Step Five:
Follow through with that choice.

Step Six:
Afterwards, reflect on the choice you made. Looking back, was this really the best choice? Will I do anything differently next time I'm in this situation?

STUMBLING BLOCKS/TRIGGERS

For each block below, fill in something that interferes with your ability to make prosocial/good decisions. These stumbling blocks might include: a certain friend or group of friends, not getting enough sleep, not going to AA/NA meetings, a significant other, television, or family members.

What are your stumbling blocks/triggers and what are they telling you?



How can you deal with these stumbling blocks?

1.

2.

3.

4.

Group 11

Countering

(Preparation/Action Stage Intervention)

The goal here is to substitute alternatives for problem behaviors.

- Introduction to countering: The technical term for substituting unhealthy behaviors with healthy ones is countering. All of our behaviors are conditional, meaning we are more likely to overeat when dining out than eating at home, to abuse alcohol when angry or anxious than when relaxed or to smoke when bored than when active. In groups, we attempt to learn behavior we can substitute for the negative behavior.

- Have the clients complete the handout, "What Do You Do to Feel Healthy?" Discuss the outcome with the group. What other activities or behaviors can you do to feel healthy? What are the barriers to accomplishing these activities?

- Take the group on a field trip. Have the clients choose from a variety of community resources: park, gym, rock wall climbing, playing pool, video game center, swimming, miniature golf, movies, yoga, etc.

WHAT DO YOU DO TO FEEL HEALTHY?

_____ Get more (or less) sleep

_____ See a doctor when you need to

_____ Have your teeth and eyes checked yearly

_____ Drink more water, less soda or coffee

_____ Exercise more

_____ Spend more time outdoors

_____ Take vitamins

_____ Take prescription medication

_____ Eat better meals, improve nutrition

_____ Avoid or reduce sweets or fatty foods

_____ Keep a good mood, a clear mind

_____ Improve hygiene, care of body

_____ Keep room, house, apartment clean

_____ Eat special foods (what? _____)

_____ Avoid nicotine

_____ Avoid drugs (including alcohol)

_____ Avoid sunburn

_____ Avoid risky activities (like hitchhiking, playing in the canal, playing w/guns or fire, bumper dragging, etc.)

_____ Reduce worrying or stress

_____ Laugh a lot, have fun

_____ Wear your seat belt every time you ride

_____ What else? What do you do to feel healthy?

Group 12

Changing for Good

(Preparation/Action Stage Intervention)

Environmental Control: The goal here is to avoid stimuli that elicit problem behaviors.

- Explain to the group: In this instance, you do not seek to control internal reactions but to restructure your environment so that the probability of a problem-causing event is reduced. Environmental control can be as simple as removing narcotics or alcohol from your home or painting over tagging in a bedroom.

- Have group members discuss what they can do in their personal lives to remove stimuli/triggers from their home to promote environmental control.

- Have the group members make a collage or draw on a poster board signs that would remind them to stay clean and make good choices (e.g., a no-smoking sign on the refrigerator door).

Break

- Continue art assignment.

Group 13

Raising Awareness: The Good Things and Not-So-Good Things

(Pre-Contemplation Stage Intervention)

Awareness of the Good Things: The goal here is to explore the group members' awareness of the good and not-so-good things about substance abuse and to develop an understanding of the context of substance use of the group members and their ambivalence about change.

- Introduce the exercise by explaining the following: This exercise shows a window, with the headings "Good Things" and "Not-So-Good Things" on the top, and some short-term and long-term areas of your life on the left side. Let's take a few minutes now, starting with the good things, and write down (or talk about) at least one good thing in each area on the left. Let's start first with an example from the group. (Go to the board (if you use one) and ask for a volunteer to state a good thing to put under "social." If appropriate, write it down, then ask if everyone understands.) Only write in the "good things" boxes right now.

- If you use handouts, allow time for members to think through the topics. When everyone is nearly done, ask members to share their responses. List these on the board. Facilitate discussion of the "good things" topic. Encourage the group to share experiences with each other; the point here is to develop an understanding of the positive reasons for substance use and the context of people's use.

- Tell the group, "Now we are going to look at another side of the picture. On the right side of the window, list some of the not-so-good things about smoking, drinking, and using drugs for you personally. For example, you might list 'have been arrested for drunk driving' or 'have missed work' as not-so-good things about drinking. Can anyone give me another example of a not-so-good thing that they might list?" List appropriate responses on the board. Allow some discussion of the "not-so-good things" topic. Be careful to avoid labeling, and help members refrain from labeling each other's answers. If necessary, remind the group that the purpose today is to develop a clear

picture, using the window, of what substance use is like for each person. There are no right and wrong answers to the exercise. Encourage group discussion.

- If it has not come up naturally, ask a variant on the following questions:

  "Now that you are seeing both the good things and the not-so-good things about using, how are you reacting to this topic? How are you feeling in general about exploring these issues?" Also try similar exploratory questions that will help you judge whether any group members are becoming defensive. Explore the answers using reflective listening and summarizing skills. You may want to illustrate with a particularly open-minded group member, perhaps summarizing as follows:

  "So George, you enjoy drinking, especially when you're with your friends on the weekends while you work on your cars. Drinking seems to be a big part of hanging out with the guys, and you like the way everyone loosens up and jokes around while you're drinking. On the other hand, some not-so-good things are the way you feel late Sunday and Monday sometimes, the fights you get in with Darlene when you come home after drinking, and of course the DUI that brought you here. Is that about right?"

- Encourage group members to summarize their windows in a similar manner.

AWARENESS WINDOW

The windows below will help you explore what is "good" and "not-so-good" about drinking or using drugs in various areas of your life. In each box, list the things you have personally experienced in that category. For example, in the "good things" box, under "short-term, social" you might put "helps me to relax in a crowd," while in the "not-so-good things" box, you might put "has led to risky sex with someone I didn't really like to begin with."

	Good things	**Not-so-good things**
Short-term		
Social		
Emotional		
Financial		
Long-term		
Health		
Work/school		
Relationships		
Legal		

Group 14

Family Night

Defense Mechanisms and Family Communication

Introductions: Group leader introduces himself/herself and program assistants, then asks family members to introduce themselves and their relationship to the client. During check-in, families are encouraged to talk about how situations have been in their home since their son or daughter started using drugs or since they have begun the TSAT program.

- Have clients and family members define and discuss their defense mechanisms, then list them on the board. Allow them to elaborate on how their coping skills affect the rest of the family. What purpose do these defenses serve? What role do drugs play as a defense mechanism? It is important to conduct an extensive dialogue about defense mechanisms so everyone feels safe and uninhibited during the creative activity.

- Break into two groups. Group members may go to a separate room, if possible. Otherwise, use separate sides of the same room.

- Materials needed: 8 1/2" x 11" white paper, pencils, and colored markers.

- Instruct both groups to reflect on the defense mechanisms they spoke of earlier. Have each person draw what his or her personal wall of defense looks like. Individuals who feel inadequate about drawing may use words or symbols. Encourage honesty as well as creativity.

- Allow 20 to 30 minutes for this activity.

- Rejoin as one group. Allow each individual the opportunity to share his or her wall of defense with the rest of the group. When this portion of the activity is completed,

follow up with questions. *Example:* Are there any changes you need to make in your life or behavior? Do you see yourself differently after this exercise? If so, how? Can you recognize your hidden agenda?

Wrap-up

- Have family members and clients elaborate on how they feel after the exercise. What new information have they gained? How will this affect family communication? What have they learned about themselves, and how can this be applied to the family unit?

Group 15

Looking Forward

The goal of this group is to assist members to look forward and think about their possible futures, to develop a sense of hope for the future, and to develop discrepancy with current choices.

- Write the words "Looking Forward" on the blackboard or easel pad, if used. Paraphrase the following introduction to today's content: *Last session, we discussed the good things and not-so-good things about smoking, drinking, or using drugs. This week, we are going to focus on something a little different. Instead of thinking about where you are today, we are going to look ahead to the future.*

  First, let's start by going around the circle and putting us back into childhood. I'd like you to think for a minute about what you wanted to be when you grew up. How did you imagine your life would be? What were your dreams about your future? For example, you might say, "I'm Steve, and when I was a kid, I wanted to be a fireman when I grew up. I would have a house, a wife, and two kids who I would play baseball with. I would have an important job and save lives." That's just one example of a childhood dream. Who would like to start?

- Go around the circle, eliciting each member's childhood dream of the future. Try to get the following information from each member: imagined occupation, imagined lifestyle, and most important value in the imagined life.

- Pass out the exercise "Looking Forward" along with pencils for anyone who needs one. Tell the group: *Now that you have thought about some of your childhood dreams, let's do a little more dreaming. Even though we're adults, most of us still have dreams and*

hopes for the future. It may even be possible for you still to achieve some of those dreams you just talked about. I want you to look at the worksheet and fill it in completely.

- Ask the members to share their responses to the questions on the handout. Help the group members to feel the emotional impact of their dreams. As the group proceeds, watch carefully for members' defensiveness increasing. If this seems to be occurring, make some process comments or stop the group and ask about how they are reacting to the exercise. Allow the sharing to continue as long as members seem interested in their dreams for the future.

- Ask if there is anyone in the group who now feels ready to try a small change from their responses to the third question, one that they could try before the next session. If there is a volunteer, ask the person what small change he or she will try to make. Ask the person to ask the group for suggestions as to how to proceed, if necessary. If no one volunteers, simply comment on the exciting dreams each has shared and how wonderful it will be for the members to begin working on achieving some of them.

  (Remember that this is not a time to pressure for change. Rather, allow the weight of the exercise to settle on group members without rushing to solve problems.)

LOOKING FORWARD

Sometimes it is helpful to take time to look ahead in our lives. Having a picture of how we would like things to be can help us deal with the stress of everyday living, help us "hang on" in times of crisis or temptation, and help us structure our free time so that we move closer to our hopes and wishes.

1. What are some of your hopes for the future?

2. What are you doing now that is helping you to make these things come true?

3. What other things could you do (or do more of) to help your hopes come true?

Group 16

Values

Explain to the group that often the goals we set for ourselves are based on our values.

- Have the group discuss the following questions or write their responses on the handout "My Values Are…" Read the questions aloud.

    1. What are your values? (Independence, religion, spirituality, marriage, long-term relationship, creative expression, belonging [to someone or something], possessions, career/job, raising children, fame, sports, health, education, sobriety, friendships, helping others, excitement/thrills, leisure, politics, travel, personal growth, safety, money, education, family, animals, nature, peace/equality, arts, beauty, theatre/movies, caring for sick family members, contributing to society, intellectual growth.)

    2. When did you form your set of values?

    3. Are your values like those of your family? If not, how are they different?

    4. What do your values say about you?

    5. How do your values guide your life and the decisions you make?

    6. How does using drugs influence your value system? How does substance abuse/addiction affect each value?

    7. What can you do to focus more on some of your important values? Do you think some values are better than others are? Do you think that some values are right and some are wrong?

MY VALUES ARE…

1.

2.

3.

4.

5.

6.

7.

Group 17

Drug Education

The goal of this group is to educate clients on the dangerous effects of drugs. Educational materials are reviewed in group. Materials include, but are not limited to, newspaper articles, research articles, handouts, educational materials, and videos.

Group 18

Value Clarification

The goal of this group is to introduce values and how they affect our lives.

- Define the concept of values and the role that they play in our lives. (A value is typically something that is important to us and is positive and reaffirming. We use values to create rules we follow in our lives.)

- Process where values come from and learn how they develop (peers, family, media, etc.).

Break

- Ask the clients to complete the exercise "Values and Attitudes That Are Important to Me."

- Facilitate group discussion regarding the different values that emerged from the exercise.

- Have the group members break into groups of two and complete the exercise "Exploring Values" for 15 minutes. Then have them come back together and discuss what they learned about themselves and their partner. Explore how people have different values based on their different cultures.

VALUES AND ATTITUDES THAT ARE IMPORTANT TO ME

The following is a list of values and attitudes that may or may not be significant in your life.

First, consider each item individually. Then, consider all the items. Number these attitudes and values according to their importance in your own life. Number 1 is the most important, number 2 is the second most important, etc. Add anything you want.

___A. Justice	The quality of being impartial or fair.
___B. Altruism	Unselfish caring for other people.
___C. Recognition	Being made to feel significant and important, being given special notice or attention.
___D. Pleasure	A feeling of being pleased and joyful. Pleasure stresses satisfaction, a state of gratification.
___E. Wisdom	The ability to understand inner qualities and relationships; insight, good sense, judgment.
___F. Honesty	Fairness or straightforwardness of conduct; uprightness of character or action.
___G. Achievement	Accomplishment; a result brought about through effort or persistence. The word "achieve" is defined as "to bring to a successful conclusion."
___H. Sobriety	Freedom from mood-altering chemicals.

___I.	Family	Importance of those persons related to you. Parents, sisters, brothers, children and spouse.
___J.	Significant Other	Loving relationship with another person.
___K.	Autonomy	Being able to make one's own decisions.
___L.	Wealth	Abundance of valuable material possessions or resources; affluence.
___M.	Power	Possessions or control, authority, or influence over others.
___N.	Love	Affection based on admiration, warm attachment, and unselfish devotion that freely accepts another in loyalty and seeks his good.

EXPLORING VALUES WORKSHEET

Everyone has values or standards they believe in. However, sometimes we act in ways that do not match our values, because we forget about them, we get tired, or other things distract us. This exercise is intended to help us remember our values and share them with others.

1. What are some of your personal values? For example, some people believe in the Golden Rule, or "Do unto others as you would have them do unto you." Other people value telling the truth above all, or using their talents and energy to benefit others. Others see being a good friend or parent as an important value. *List some values that are meaningful for you, then circle the two that are most important to you at this time.*

2. What gets in the way of living by your values? What would it take for you to live in a way that is closer to your most important values?

Group 19

Supporting Self-Efficacy: Change Success Stories

(Contemplation Stage Intervention)

The goal of this group session is to enhance self-efficacy by reminding clients of past successes and to encourage members to be hopeful about the possibility of change.

- Start the topic by telling the group members that today's topic is "Successful Changes." Write that on the board, if you use one. Ask members what that means to them. Record appropriate responses. Distribute the worksheet "Remembering My Successes." Tell the group that each of us has some success stories, but sometimes we forget them, especially if we unhappy or frustrated about where we've gotten to in life. For example, members in the group may have experienced some of the following successful changes: attending the motivational groups, completing school, improving sports performance, developing a trade or skill (e.g., beautician, barber, construction worker), becoming a better parent or partner, or practicing safer sex techniques

- Say something along the following lines: "Many of these changes represent a time when you moved through the stages of change from not even thinking about changing, to thinking about it but having mixed feelings, to taking action, to maintaining the new habit or behavior. Let's take a few minutes now to complete the next exercise, "Remembering My Successes."

- Ask the group members to share one story of success each. Ask the clients individually after they share their success stories, "How does it feel to remember this now? " Encourage any self-motivational statements.

- Using the stories clients just shared, select one for debriefing by the group. Ask the group to discuss the stages of change the person cycled through. Question the client about his or her recollection of what helped and/or motivated him/her to change, using reflective listening skills. Make the discussion as concrete and simple as necessary to

help clients understand the abstract concepts. Summarize by pointing out that all of the clients have the skills they need to make changes. The evidence exists in the form of previous successful changes. If there are areas in their lives that they would like to change now, they probably have the power to start.

REMEMBERING MY SUCCESSES

It is easy to become discouraged when we forget the times when we were successful at making some change in our lives, or at achieving something we wanted to achieve. Everyone has made a successful change at some time in his or her life. Let's remember your successes.

1. List some positive changes you have made in your life.

2. Pick one of the changes above, perhaps the one that was hardest to achieve, and list the following:

When did you first start thinking about making a change?

What was going on in your life at the time?

Did you achieve the change all at once, or take small steps?

What were some of the steps?

How do you feel about the change today?

Group 20

Movie

Group 21

Planning for Change

The goal of this group is to review group members' progress through the stages of change during the group experience and to develop a concrete plan to change one thing in each member's life.

- Tell the group members that some of them may now be ready to consider implementing an action plan. Examples would include:
  - A smoker who decides to try the nicotine patch to stop smoking.
  - A drinker who decides that he will cut back to only two beers per night on the weekends.
  - A cocaine user who decides that even though it is hard, she will enter treatment to improve her life.
  - A person on probation who decides to stop taking chances on a dirty urine and stop smoking marijuana.

- Explain to the group members "even if you don't yet feel ready to solve your biggest concern, you might be ready to tackle a smaller problem. Today's exercise will give you practice solving a problem, even if you don't yet think you are in the action stage of change."

- Distribute the "Change Plan Worksheet." Allow time for completion, then ask group members to share their plans. Be careful to prevent group members from judging others' plans, and don't get drawn into praising only those whose plans are filled with action. Be sure to reinforce at least one positive aspect of each person's plan, even if it is to say something like "I can tell you put a lot of thought into selecting a smaller problem that would be easy to handle. Now you will have a method for solving even bigger concerns if you choose to." Remind clients that this activity can be done whenever they need to develop a plan to make a change, no matter how big or small. This exercise is a life skill that can be applied outside the group experience.

- Developing a new plan for change: Explain to the group members that as they begin to see themselves in positive ways, their goals for themselves may be changing. They may be starting to see that the old play places, playthings, and playmates are not working with their new lifestyle. They may feel that they have been forced to give these up because of probation. If that is the case, allow them to look at the positive results of their actions (i.e., by not continuing the same behavior, the same results will not occur).

- Allow clients time to talk about what they see changing in their lives as well as whether they see these changes as being positive. (How long have you been clean? What's different now vs. when you were using? How have your goals for yourself changed?)

CHANGE PLAN WORKSHEET

1. The changes I want to make (or continue making) are:

2. The reasons why I want to make these changes are:

3. The steps I plan to take in changing are:

4. The ways other people can help me are:

5. I will know that my plan is working if:

6. Some things that could interfere with my plan are:

7. What I will do if the plan isn't working:

Group 22

Exploring Importance, Confidence, and Desire for Change

(Preparation/Action Stage Intervention)

The goal of this group is to review group members' progress through the stages of change during the group experience and to explore the members' feelings about the importance of making changes, their confidence that they can succeed, and their desire or excitement about making changes.

Note: This "session" may require more than one meeting to complete, especially if you wish to follow up on implementing change plans. We include two versions of the handout, one version that focuses on a single change and another that focuses on multiple changes. You may find the first handout less intimidating when first introducing this task to clients. The second handout may be more beneficial for follow-up contacts or as homework once clients understand the task.

- Ask how they feel about being here today. Process reactions briefly. Congratulate the group members for sticking with it to the end of the group. Tell them that today, we will review what stage of change they are in now.

- Ask clients to silently, not aloud, identify the main problem that brought them in to the group. Ask them to think about the categories of change: precontemplation, contemplation, preparation, action, and maintenance (or use simpler terms for these stages). Have them silently identify what stage they were in on the first day of group. How does that compare to now? Have they moved along the stages of change or stayed in the same category? Ask if anyone is willing to share his or her silent comparison. After several group members have shared their progress (or lack of progress), ask members how they are feeling in general after this group. Are they really the same? Are they a little more motivated? Process answers for a few minutes.

- Ask for any comments or updates from last week's change planning session. Who has done some of the steps that they planned? Who has thought about another change that they might like to attempt or filled out a change planning form on another behavior?

- Distribute the "Importance, Confidence, and Desire to Change" worksheet. Review the instructions on the sheet. After members have completed the sheet, ask them to pick one change they identified, and review their responses with them. For each dimension (importance, confidence, desire), ask members, "What makes your response an N and not an 0?" (assuming that their response wasn't an 0). This elicits a self-motivational statement that can be reflected or summarized. Then ask, "What might make you mark two points higher on the scale?" (If the person has rated their importance 6, ask "What might make you mark 8?") This sensitizes you and the clients to events or concerns that can increase the clients' motivation to make a change.

- For confidence, also ask, "How can your family or friends help you increase your confidence or desire for making this change?" Suggest to the group that keeping these factors in mind while they implement their change plans can help to prevent setbacks.

- For "desire," make sure to normalize feelings of dread. It is common for people to have negative feelings about making a change, even if they believe the change is important to make and they have strong confidence that they can achieve the intended change.

- If this is the last session for a client, remind the group members that making lasting changes often takes time and involves some setbacks. Ask the group members to state what they will do if they find that they have had a setback that they are unable to take care of on their own (e.g., contact group leader or case manager). Take a few minutes to summarize your perceptions of the group, and reflect on positive aspects of the group that you have noticed (e.g., openness about vulnerable issues, determination of members to succeed, quality of participation). Ensure that the group ends on a positive note.

Note: This section was adapted from Rollnick, Mason, and Butler (1999).

IMPORTANCE, CONFIDENCE, AND DESIRE TO CHANGE

Most people are in this group because they are thinking about making a change or because other people think they should make a change. Often, that change is to quit their use of alcohol or drugs. However, that may not be the focus for you. If you are not focusing on quitting use of substances, please write in what change, if any, you are considering in your life.

Change:_____

_____

_____

_____

On the following 0 - 10 scale, please rate the importance <u>to you</u> of making a change in your life (or continuing to make a change that you have already begun). Please circle the number that most closely matches <u>the importance of this change to you</u>:

0 1 2 3 4 5 6 7 8 9 10

Not at all important *Most important thing in life*

Sometimes, even when goals or plans are important to us, we are still not sure if we can successfully achieve them. Please rate <u>your confidence</u> that you can successfully make (or maintain) the change you desire.

0 1 2 3 4 5 6 7 8 9 10

Not at all confident *Completely confident*

Sometimes, even though we know a change is important and we are confident we can make it, we really aren't looking forward to making the change. Please circle the number that most closely matches <u>how much you want to make this change</u>:

0 1 2 3 4 5 6 7 8 9 10

Dread making *Excited about making change*

Group 23

Guest Speaker Presentation

Many times, clients resist changing their substance abuse behavior for fear of developing a dreary lifestyle. A guest speaker is invited to the group once a month to speak about his/her former substance abuse experience and how his/her life has changed once he/she committed to a drug-free lifestyle.

Because of the legality requirements of the agency and the age of the clients, signed confidentiality consent forms are required. These forms are distributed to the client's home-based therapist so that he/she may directly contact the client's guardian and obtain needed signatures in person.

On the day of the presentation

- Clients are introduced to the guest speaker using only first names.

- The guest speaker begins with an introduction that includes a brief background of his/her drug life, the consequences he/she has endured because of his/her drug use, and the events that led to his/her change of lifestyle and sobriety. The guest speaker concludes by discussing how his/her life has been enhanced without the use of drugs.

- Clients are encouraged to ask questions during and after the guest speaker's presentation.

- Staff members take an active role by asking the guest speaker questions that incorporate the stages of change.

  Example: How long did you stay in denial? What was your opinion of drugs during that time? (pre-contemplation)

  When did you know you needed to make a change? What or whom influenced your decision to change your lifestyle? (contemplation)

Wrap-up

- Clients and staff thank the guest speaker for attending the group session.

Follow-up

- Because of time limitations, follow-up is usually conducted on the next group day (during the first 20 minutes).

- Group and staff process the presentation of the guest speaker by sharing their thoughts, feelings, and what they gained by listening to the speaker.

- Clients write thank-you notes to the guest speaker, which are mailed by staff the same day or given directly to the guest speaker.

Group 24

(Contemplation Stage Intervention)

- Explain to the group that there are 10 common thinking errors that people usually make when they are making changes. Discuss the errors and complete the exercises "Ten Common Thinking Errors" and then "Positive Statements Toward Self-Efficacy." Explore what it was like for the group members to think of the personal examples of negative comments they have heard (10 common thinking errors) and compare that to how they felt when they thought of positive statements.

Ten Common Thinking Errors

1. ALL OR NOTHING THINKING
    - Black or white thinking.
    - Either-or.
    - Perfectionist.
    - Often used with should statements.
    - Promotes procrastination.

      Example: "Either I get seven days vacation or I won't go at all" or "If I can't do it right I won't do it at all."

2. OVERGENERALIZATION
    - Goes from one person or event to encompass all. Example: "All men are scum" or "All blondes are dumb."
    - Is non-specific because it is so broad.

      Example: "I can't deal with my feelings." (Is that all your feelings or just one of them?) "Everyone knows I can't do it." (Who is everyone?)

3. MAGNIFYING/AWFULIZING
    - Thoughts that create mountains out of molehills.
    - Blows things out of proportion

      Example: “It is too hard to change” or “I will never be forgiven if I am late home.”
    - Sets you up for self-fulfilling prophecy.

      Example: “I can’t stand myself.” (If you don’t like you, how can you succeed?)

4. MIND-READING/ASSUMING
    - Assuming you know what others think.
    - Assuming others know what is on your mind.
    - Reading into or misinterpreting body language and/or tone of voice.

      Example: “Bill, why didn’t you stop at the store on you way home?” (You never asked, he was supposed to know you needed him to stop.) “Jane, you should have known that I needed you to come over today.” “Bill, you should know why I am upset with you.”

5. LABELING
    - The use of highly colorful, emotionally charged words. Focus on the words being used to describe the problem, rather than the problem.

      Example: “Bill, you are such a stupid slob!” or “I am such an idiot.”

6. EMOTIONAL REASONING
    - I feel it, therefore it must be true.
    - We operate as if feelings control our behavior.

      Example: “I feel so helpless, there is not any hope” or “I am too nervous to attend group.”

7. DENIAL OR MINIMIZING
    - Ostrich approach (if I can’t see it, than it is not happening).
    - Diminishes the importance of situations that are causing discomfort.
    - Prevents us from seeing an accurate view of the situation.

      Example: “I don’t have a problem, the system does”

- Prohibits healthy anger.

  Example: "It does not matter that I beat up that guy—it happens." If you have been missing work because of court hearings, you say, "If the system would leave me alone, then I wouldn't have to miss work."

8. "SHOULD" STATEMENTS
   - Unspoken rules and expectations we have of others and ourselves.
   - Should, shouldn't, must, have to, ought to.
   - Feelings of anger, frustration, resentment, disappointment, and guilt indicate should statements.
   - Why statements that cannot be answered indicate should statements.

     Example: "I should have stopped using years ago," "People should do as they are told," or "Why do I have to follow probation's orders?"

9. DISQUALIFYING (DISCOUNTING) POSITIVES
   - Not acknowledging positive assets.
   - Allows you to hold on to low self-esteem and low self-efficacy.
   - Difficulty accepting compliments.
   - Discounting available resources.
   - "Yes, but" statements.

     Example: "I can only do it right when someone tells me how." "I am so ugly." "I am a bad person."

10. BLAMING SELF OR OTHERS
    - Placing responsibility for your beliefs, feelings and actions on other people.
    - Placing responsibility for others' beliefs, feelings, and actions on you.

      Example: "I can't stay home, I'll hurt his feelings," "It is all your fault that I am this way," or "It is all my fault that you are so angry."

TEN COMMON THINKING ERRORS

DIRECTIONS: Write down personal examples of the 10 most common thinking errors.

1. ALL OR NOTHING (BLACK OR WHITE) THINKING

2. OVERGENERALIZATION

3. MAGNIFYING/AWFULIZING

4. MIND-READING/ASSUMING

5. LABELING

6. EMOTIONAL REASONING

7. DENIAL OR MINIMIZING

8. "SHOULD" STATEMENTS

9. DISQUALIFYING (DISCOUNTING) POSITIVES

10. BLAMING SELF OR OTHERS

POSITIVE STATEMENTS TOWARD SELF-EFFICACY

1. List some new messages that you would like to hear.

2. List some ways that you can describe yourself as an important person, using positive statements.

Group 25

(Contemplation Stage Intervention)

The goal of this group is to explore what the clients are doing in their lives to ensure a healthy lifestyle and how important it is for them to feel healthy. During this group we will raise the consciousness level of the clients regarding what the group members should be doing to live in a healthier way.

- Complete the activity "Feeling Healthy" with the group members. Have each client complete the handout on their own, then return to the group to discuss how they are physically feeling. Explore what was going on during the times they were feeling healthy versus the times they were not feeling healthy. Ask the group members who are feeling healthy if there was a time when they were not feeling healthy, and have them explore what that looked like for them. Additionally, have the group members who were not feeling healthy explore if there was a time when they were feeling healthy in the past and what that was like for them (have them describe their lifestyle).

Break

- Have group members discuss "What Do You Do to Feel Healthy" by checking off the space to the right of each activity. After this is done, explore how clients can get involved in these activities if they are not already involved. As a group, brainstorm other activities group members can do to get and stay healthy.

ON A SCALE OF 0 – 10…

- How important is it to you to feel physically healthy? _____

- How healthy do you feel today? _____

- How healthy have you felt in the last week? _____

- How physically healthy did you feel when you were using drugs the most? _____

For you, what are the three most important things to do or not do in order to feel healthy?

1.

2.

3.

Group 26

Family Night

The main goal of this group is for group members to work on normalizing family problems and to help each other to think of tools they can use in their homes to support the family. Educating group members on communication styles in their families and encouraging family members to talk to each other and share personal thoughts is the second goal.

- Introduce family members and their relationship to the client. Have each person share how things have been in their home since their son or daughter started using drugs or since they have begun the program. Encourage families to talk together, share personal experiences, and explore similar experiences, discussing what each parent/child did when in the same situation.

- Have group members explore feelings that they have felt based on incidents in their lives over the past six months or since their son or daughter started using drugs. Write them on the board.

- Have each parent pair off with their son or daughter and read the following instructions for the communication exercise:

1. Exercise must be written down exactly as stated (<u>no</u> deviations, unless discussed with counselor).
2. Allow at least two hours to complete this assignment.
3. Do not discuss the assignment with the other person before you carry it out.
4. Do not expect to solve any problems with this exercise. This is just an exercise in listening to the <u>feelings</u> of another person, and feelings are not right or wrong – they are only <u>there. No judgments.</u>
5. Exercise must be carried out without blame or demonstrations of anger. Simply state your <u>feelings.</u>
6. Use the list of feelings if they need help with feelings words.

- Pass out the exercise *Family Night Communication Exercise*. Read the instructions below step by step to the family members and have them complete the activity. When they are done, have them face each other and read the exercises to each other in front of the group.

1. Decide on at least **one thing** you **don't** like and at least **one thing** you **do** like about the other person. Also decide on at least three feelings about each like and each dislike. Give at least one example of each like and each dislike.
   Example must be specific so that the other person knows exactly what you mean.

2. Decide on the thing you most regret doing.

3. Decide on the thing you need most from the other person at this time.

4. Decide on at least three things you will do (not be) to keep communication open between the two of you in the future.

5. Write all of this down to read to the other person, following the exercise example.

6. Sign the paper, date it, and give it to the other person after completing the exercise.

*It is okay to use things from the past.

COMMUNICATION EXERCISE

John, I don't like it when you _____. For example,

_____. When this

happens, I feel _____, _____, and _____.

John, I do like it when you _____. For example,

_____. When this happens, I feel _____,

_____, and _____.

John, the thing I most regret doing is _____.

John, the thing I need most from you at this time is _____.

John, the things I will do to keep communication open between us are _____,

_____, and _____.

_____ _____

Your Signature Date

Group 27

(Contemplation Stage Intervention)

The goal of this group is to help each group member identify with who they are and the type of person they would like to be, and to give them direction into their present behaviors and future goals.

- Hand out the exercise "All About You" to the clients. Have them sit outside or separate from each other so they have a quite place to reflect on their personal lives and future goals.

- Have the group members return and discuss what they learned about themselves and their futures. (How many can accomplish their goals for where they want to be in 20 years if they are living the lifestyle they are leading now?)

Break

- Have the group members break into partners, and hand out the exercise "More About You…" Have them discuss the answers to the questions together. Ask them if they knew these things about themselves and if they would have assumed the same for their partner. Ask the clients to explore what it was like for them to do the activity and what they gained from exploring these questions.

- Pass out the activity "How 'Bout You!!!" Have the group members answers these questions aloud as a group. Focus on supporting the clients and encouraging other group members to be supportive. Then ask the clients if any of the responses made them want to use drugs. If so, help them with a safety plan, and have other group members share suggestions about what they can do to deal with the stress and sadness some of these questions may have caused/triggered.

ALL ABOUT YOU!!!

Give three words to describe yourself.

What are three ways in which others describe you?

Name your most important values.

What is something you'd like to accomplish in the next year?

What about the next five years?

The next 20 years? (See how many you can name!)

What is your most valuable possession?

MORE ABOUT YOU…

If you could pick three people that you would be stranded with on a deserted island, who would they be?

If you could have one talent that you do not have right now, what would it be?

If you won a million dollars and had to give or donate all of it, where would it go?

Name your two favorite movies.

If you could take an all-expense paid two-week vacation anywhere, where would it be?

Name two hobbies that you would like to get involved in at some point in life.

If you were a vehicle, what would you be?

HOW 'BOUT YOU!!!

What was the hardest time you have gone through, and why? How did you cope with it at the time? Looking back, what would you do differently?

What type of situation tends to stress you out the most? How do you tend to respond?

Which emotions are hardest for you to cope with? How do you handle them? What could you do differently to handle them better?

How do your parents/grandparents/guardians handle stress? Have you picked up any habits from them?

How much do you use drugs and alcohol (including cigarettes and caffeine) to "help" you cope? Has this changed since you began using?

What negative and positive effects have you gotten from how you handle problems? (Such as violations of probation, being trusted by family and friends, etc.)

Group 28
(Pre-Contemplation/Contemplation Stages Intervention)

The goal of this group is to help the group members understand what anger is and identify areas in their lives in which their anger has caused problems.

- Distribute handout, "Some Faces of Harmful Anger Expressions." Have each client read a type of behavior. Tell the group members to consider which behaviors they have been able to identify with in the past and who was involved.

- Have the group members discuss which family members express anger in the same way they do and how other members express their anger. Explore: What is it like for you to see your mom, dad, sister, brother, grandparent, friend, etc. have a reaction like that? How do you feel when that happens? What is it like for these people when you act out when you are angry? How does that make them feel?

Break

- Distribute the handout "What Makes You Angry?" Have the group members check off which items make them angry, and then discuss what other things make them angry.

- Distribute the handout "How Would You Describe Anger?" The group members should review this on their own and them come back together as a group. The facilitator will ask which descriptions they agree with and what they would like to add.

SOME FACES OF HARMFUL ANGER EXPRESSIONS

Physical Violence	Hitting, kicking, and slamming objects or people. Carried to extremes, this leads to assaults and other crimes of violence. These occur when anger is out of control.
Verbal Abuse	Ridicule, insults, name-calling, yelling, and shouting at loved ones, friends, or others. Also, phrases like "kill her/him!" "clobber them," or "destroy 'em!" may seem like okay expressions, but they incite anger and violence and can make them acceptable even in friendly competition.
Temper Tantrums	A common expression of anger that is selfish indulgence. It can lead to verbal or physical abuse of others.
Sarcasm and the Silent Treatment	Like ridicule and put-downs, these anger expressions can be just as hurtful as physical violence.
Blaming	Saying things like "You really aggravate me!" or "You make me so mad!" Here you're blaming someone else for your own anger.
A Sobering Note	Uncontrolled anger is not normal. The philosophy that advocates getting in touch with your anger and "letting it all hang out" can be potentially dangerous to yourself and others. Popularized anger and violence (e.g., in television, movies, books), which portrays anger and violence as normal, undermines both individuals and society.

WHAT MAKES YOU ANGRY?

Everyone experiences anger – some people more intensely than others do, some more frequently. Everyone I have asked has been able to come up with something that incites anger. Here are some of the most common answers that I've heard to the question**, "What makes you angry?"** Which ones are true for you? Are there some you'd like to add?

- ☐ Traffic jams
- ☐ Arrogance
- ☐ Rude people
- ☐ Prejudice
- ☐ Tailgaters
- ☐ Yelling
- ☐ Manipulation of my time
- ☐ Tardiness
- ☐ Child Abuse
- ☐ Waiting
- ☐ Lies
- ☐
- ☐

(Contemplation Stage Intervention)

HOW WOULD YOU DESCRIBE ANGER?

Everyone has ideas about anger and what it looks like. Recognition of anger occurs when its appearance matches one of these ideas. Listed below are words that people have told me describe anger. Which do you agree with? Are there any you'd like to add?

- ☐ Redness
- ☐ Loudness
- ☐ Hitting
- ☐ Sarcasm
- ☐ Tension
- ☐
- ☐
- ☐ Yelling
- ☐ Destruction
- ☐ Cursing
- ☐ Silence
- ☐ Verbal Abuse
- ☐
- ☐

Group 29

Review of "Ten Common Thinking Errors" (See Group 24)

1. All or nothing thinking
2. Overgeneralization
3. Magnifying/awfulizing
4. Mind-reading/assuming
5. Labeling
6. Emotional reasoning
7. Denial/minimizing
8. "Should" statements
9. Disqualifying (discounting) positives
10. Blaming self or others

The following statements can be copied and separated so each client can draw one and identify which common thinking error it represents.

SLIPS TO BE DRAWN AND DISCUSSED

I'm coming up dirty for coke—why not smoke weed or do a couple more lines? What's the difference now?

If my PO weren't so hard on me, I probably wouldn't have relapsed.

Everyone gets drunk once in a while.

I made such a fool of myself at that party, I couldn't hang out with any of those friends again.

If I can't get an A in that class, why bother to do the work?

Girls who wear short skirts can expect to get hit on or grabbed, you know?

If I miss that party, my whole year will be ruined.

School is boring, so what's the point?

When I pass out, my friends watch out for me. It's no big deal.

I felt really stressed out, so I needed to get high.

I should run at least two miles every day.

He only acts like he likes me because he wants to borrow my car.

I'm going to relapse anyway, so I may as well get high before I go to the concert.

Group stresses me out; of course I want to drink when I get home.

I shouldn't be so stressed out about this! (current crisis)

It was your idea to steal that cell phone—it's your fault I'm getting locked up!

If my mom didn't report that I took the car out, I wouldn't have gotten the violation of probation.

That guy should have expected his Mercedes to be stolen. If you drive a nice car like that, you gotta watch out.

If he's going to cheat on me, I may as well do the same.

My mom hit me when I was little—now she's getting back what she deserves.

Group 30

Movie Day (See Group 8)

A relevant movie is shown, then discussed and processed by the group.

Group 31

Consequences

Yes, drug use will bring about consequences. The more you use and the longer you use, the worse they will be. What effects have you already had?

WORK & SCHOOL CONSEQUENCES

___ Late to work
___ Bad performance/productivity at work
___ Skipped work
___ Got fired
___ Money problems from skipping work/being fired
___ Not getting hired because of felonies or reputation
___ Late to school
___ Skipped classes/days from school
___ Grades dropped
___ Bad reputation at school
___ Dropped out of after-school activities
___ Not allowed on sports team
___ Suspended from school
___ Expelled from school
___ Future plans like college, military dropped
___ Other school or work consequences

LEGAL CONSEQUENCES

___ Put on probation
___ Electronically monitored
___ Arrested for drug use or possession
___ Arrested for selling drugs
___ Arrested for DUI

___ Arrested for disorderly conduct, assault

___ Arrested for theft/burglary

___ Arrested for other drug-related crime

___ Must go to counseling classes

___ Have to pay fines

___ Have to test at TASC

___ Put in jail

___ Need to declare felonies on job application

___ Lost voting privilege

___ Lost right to legally own/carry a firearm

___ Lost right to work with children, sick, elderly

___ Lost right to serve in the military

___ Might be committed to Adobe/Black Canyon

___ Can't get your license until 18 or older

___ Court ordered to not associate with friends

___ Must spend weekends in jail

___ Missed important events because of being detained

___ Other legal consequences

SOCIAL AND FAMILY CONSEQUENCES

___ Family conflict and arguments

___ Thrown out of house

___ Lied to family

___ Stole from family

___ Bad reputation in family

___ Lost trust in family

___ Lost respect from family

___ Given less freedom from family

___ Loss of privileges from family

___ Family took away financial support

___ Family took away emotional support

___ Not there to be supportive, helpful to family because you were high/drunk or in jail

___ Lied to friends/boyfriends/girlfriends

___ Said or did embarrassing things when using

___ Stole from friends

___ Lost clean friends

___ Lost boyfriend/girlfriend

___ Not trusted by others

___ Not respected by others

___ Used other people for your own gain

___ Got a younger person started with drugs

___ Got involved with a gang, delinquent people

___ Other social or family consequences

PERSONAL CONSEQUENCES

___ Angry a lot

___ Sad a lot

___ Feeling confused

___ Worried, stressed a lot

___ Frequent mood changes

___ Irritable, short-tempered

___ Not caring about things that were important

___ Not liking your personality or behavior

___ Depression

___ Pulling away from family, friends (isolating)

___ Paranoid, mistrustful of everyone

___ Feeling like you may go crazy

___ Feeling overwhelmed

___ Wanting to kill yourself

___ Wanting to be violent

___ Being disgusted with yourself

___ Not caring about yourself anymore

___ Not caring about others

___ Not caring about others

___ Not caring about your future

___ Feeling that nothing is worth it anymore

___ Feeling that you don't have any "real friends"

___ Lost spirituality or religion

___ Guilt about what you have done

___ Shame about who you are

___ Acted against your values

___ Other personal/psychological consequences

MEDICAL CONSEQUENCES

___ Didn't take medication

___ Lost a lot of weight

___ Gained a lot of weight

___ Heart problems

___ Seizures

___ Hangovers

___ Blackouts

___ Eye problems

___ Lung problems

___ Throat problems

___ Sinus problems

___ Stomach problems

___ Dental (tooth) problems

___ Sick a lot, catch a lot of colds and viruses

___ Bad nutrition, not eating healthy

___ Hard time learning

___ Hard time paying attention

___ Bad memory

___ Low motivation

___ Trouble sleeping
___ Fatigue (very tired)
___ Depression
___ Panic attacks
___ Needed to be hospitalized from drug/alcohol use
___ High risk sexual behavior (that could lead to a sexually transmitted disease, HIV/AIDS, or an unwanted pregnancy)
___ Other high-risk dangerous behavior
___ Miscarriage
___ Premature or low birth rate baby
___ Injury from high-risk behavior
___ Hurting self from behavior when high/drunk
___ Gotten jumped, beat up, etc., from being around dealers, people who use, police officers, etc.
___ Other medical consequences

WHAT 3 CONSEQUENCES CONCERN YOU THE MOST???

1.

2.

3.

REMEMBER: CONSEQUENCES ONLY GET WORSE AS DRUG ABUSE CONTINUES.

Group 32

(Contemplation Stage Intervention)

WHAT KEEPS ME FROM HAVING FUN?

Look at this list of thoughts that can be fun-stoppers. Check off any that have run through your mind or apply to you. Be as honest as you can. Write down other reasons you use for not having fun.

_____ I don't have any time because I'm working.

_____ I have to take care of too many things at home.

_____ I'm too shy to meet people.

_____ I'm not a very enjoyable person.

_____ I don't think people will like me.

_____ I don't know how to dance, play sports, act, etc.

_____ I'm afraid of looking dumb if I try something new.

_____ I can never find the money to do something new.

_____ There is nothing to do where a lot of kids aren't getting high.

_____ It's too late for me to learn (to dance, play an instrument, play in sports, etc.)

_____ I have too much schoolwork to catch up on because I was doing so badly before I quit using.

_____ I tried _____once and it wasn't any fun. _____

Affirmations on Rediscovering Drug-Free Fun

*****I deserve to have fun

*There is joy in life without drugs.

*****I can find fun activities that don't involve drugs.

*****I can find friends who will help me have fun without drugs.

DRUG-FREE ALTERNATIVES

Encourage the group to try new things. List suggested activities and let group members decide how they can make it happen.

Acting
Aerobics
Amusement parks
Antiquing
Aquariums
Art exhibits
Archery
Astronomy
Auto daytrips
Auto racing
Ballet
Baseball
Basketball
Beaches
Bicycling
Bird watching
Board games
Boating
Bowling
Boxing
Camping
Canoeing
Card games
Chess
Classical music
Computers
Cooking
Dancing
Dining out
Fairs
Flea markets
Folk dancing
Football
Frisbee
Gardening
Golf
Hiking
Hi-tech audio
Horseback riding
Ice skating
Jazz
Jogging
Kite flying
Lectures
Long walks
Macramé
Martial arts
Model making
Motorcycling
Movies
Movie making
Museums
Needlepoint
Opera
Painting
Photography
Picnics
Ping-pong
Playing music
Poetry readings
Politics
Pool
Pottery
Racquetball
Rock climbing
Rock concerts
Roller skating
Scuba diving
Sculpting
Shopping
Sightseeing
Singing
Skiing
Skydiving
Softball
Soccer
Stamp collecting
Surfing
Swimming
Tennis
Theater
Video games
Woodworking
Working on cars
Working out
Zoos
Others:
_____
_____
_____

Group 33 (alternative if no community presenter available)

Chemical Versus Drug-Free High

(Contemplation Stage Intervention)

Review this information with the group members and have a general discussion. For the activity "Natural Highs," have clients circle what is applicable to them. Then, together, have the group make a list of natural highs similar to the ones on the second page of the handout.

What are the two main reasons that drugs are abused?

1. To feel good—achieve some pleasure.
2. To get relief from or to avoid pain—either physical or psychological.

Every society/culture uses some kind of drug to get high or change their moods.
Although many cultures do have a drug or drugs that are socially acceptable, some people do not use drugs. Even when a majority of people do use drugs, there are usually some other groups of people in that same society that do not use.

Who are these people?

Humans do not automatically seek out drug highs, nor do humans always require some drugs to cope.

The ability to enjoy life without drugs is a real ISSUE. Some people can and do enjoy life while drug-free. Some people have a lot of difficulty learning to enjoy life. In some cases, drugs can interfere with the pleasure centers in our brains.

Do you have difficulty enjoying life without chemicals?

MYTH: People should have the freedom to use whatever chemicals they choose.

Many people lose freedom by using drugs. Part of that is due to DEPENDENCY on the drug. If we are dependent on drugs, we stand to lose a lot of our freedoms.

Think about what it means to have to get increasing amounts of some chemicals daily. We can lose freedom because we've lost time for other things.

What things/people have you lost because of your chemical use?

WHAT ABOUT MORE "NATURAL" HIGHS—HOW ARE THEY DIFFERENT?

1. Chemical highs usually don't last long (ask addicts how long their highs last).
   For cocaine, it may be a matter of minutes. When sober, remembering the high does not bring back some of the feelings. Also, no coke addict who's still using ever learned how to be high without the coke. They have to quit first.

2. "Natural" highs can last a long time. If we create something and feel good about it, we may feel good each time we see it or think about it. Highs from falling in love, having a pet, or participating in an activity can also last a long time.

3. "Chemical" highs are not usually associated with a person in a meaningful way.
   We may laugh a lot, feel a rush, or feel there is some special intensity, but when the drug is out of our system we often feel empty again.

4. "Natural" highs with others are harder to achieve, but they are also harder to forget.

(Have group make a list of natural highs similar to this one)

NATURAL HIGHS

Falling in love. Laughing so hard your face hurts. Watching a child do something for the first time after you taught them. Getting mail. Working on a successful project with a good friend. Going out to eat with friends. Taking a bubble bath. Finding out that the sweater you want is on sale for half-price. Lying in bed and listening to the rain. Seeing someone you love do something outstanding. Being told you did an excellent job by your peers. Sledding down a hill during a big-flake snow. Having flowers sent to you. A clear day at the beach. Hitting the winning run in the bottom of the ninth. An unexpected present. Finishing a good book. Payday. A surprise visit from a friend. Meditation. A beautiful sunset. Solving a problem. A hot air balloon ride. Eating pizza. Your favorite meal. A job well done. A long-distance call from a friend. A hug. Walking on the beach. Decorating a Christmas tree. Clean hair. A letter from a friend. Dancing. Breakfast in bed. Hearing someone say, "I love you." Having a wish come true.

Group 34
(Contemplation Stage Intervention)

Explain resistance and how it can be both positive and negative. Have group members read each of the paragraphs aloud and discuss together what the paragraphs mean to them.

RESISTANCE

(clinical notes)

Explanation of resistance and how it can be both positive and negative.

It is useful to start talking about resistance as being important in our daily lives to help us stay on course. Generally, you may want to talk about how we need to keep our lives in balance as well as educate the group on the emotional effects to expect when they begin to make changes in their behavior (i.e., anxiety, feeling not in control, the need to return to previous behavior because it is comfortable). Talk about the change process starting with normalizing how uncomfortable it feels when you make a change. This is where you can begin to show that some of the ways of dealing turn out to be dysfunctional in the long run. These are the forms of resistance that we want to identify and change.

Resistance occurs when we try to protect ourselves from experiencing discomfort. Changes in our lives are often perceived as frightening because they are unfamiliar and uncomfortable. A common assumption is that because something is unfamiliar, it is therefore unsafe or too difficult to achieve. This assumption produces a natural response of "digging in our heels" and resisting in order to protect ourselves (demanding comfort).

The good news is that resistance can actually serve in a positive way. It is okay to use resistance. Choosing to respect your resistance and learning from it makes your process of change and growth much easier. Allow yourself to see the ways that you resist, making yourself aware without judging, blaming, or defending. Allow yourself to keep old choices available as long as you need them. Let resistance be a safety net to serve you until you have access to more productive choices.

Instead of assuming that change is unsafe, too difficult, or too painful, redefine what change means. Change can mean accepting a challenge and taking a risk in order to better our lives and make them more complete. Change in our lives is natural and something we can count on. Learning to accept this fact and work with it allows us to actively choose to go with change instead of fighting it.

Have the group members write a letter to themselves in which they acknowledge their own resistance and make a statement to themselves about how they can use this information to continue to work toward recovery.

RESISTANCE

Directions: Rank each of the following characteristics in terms of how often you use them—1 (never) to 4 (frequently).

_____1. HOPELESSNESS
When you are so depressed, you get so frozen in the pain of the present moment that you forget entirely that you ever felt better in the past. Therefore, any activity will seem pointless because you are absolutely certain that your lack of motivation and sense of oppression are unending and irreversible.

_____2. HELPLESSNESS
You can't possibly do anything that will make yourself feel better because you are convinced that your moods are caused by factors beyond your control.

_____3. OVERWHELMING YOURSELF
You may magnify a task to the degree that it seems impossible to tackle. You may assume you must do everything at once instead of breaking each job down into small, discrete, manageable units that you can complete one step at a time.

_____4. JUMPING TO CONCLUSIONS
You sense that it's not within your power to take effective action that will result in satisfaction because you are in the habit of saying, "I can't" or "I would because…"

_____5. SELF LABELING
The more you procrastinate, the more you condemn yourself as inferior. The problem is compounded when you label yourself "a procrastinator" or "a lazy person."

_____6. UNDERVALUING THE REWARDS
You feel that the reward simply wouldn't be worth it.

_____7. PERFECTIONISM
You will settle for nothing short of a magnificent performance in anything you do, so you frequently end up having to settle for just nothing.

_____8. FEAR OF FAILURE
You imagine that putting in the effort and not succeeding would be an overwhelming personal defeat, so you refuse to try at all.

_____9. FEAR OF SUCCESS

Success may seem even more risky than failure because you are certain it is based on chance. Therefore, you are convinced you couldn't keep it up, and you feel your accomplishments will falsely raise the expectations of others. You feel sure you will eventually fall off the cliff, so it seems safer not to try at all.

_____10. FEAR OF DISAPPROVAL OR CRITICISM

You imagine that if you try something new, any mistake or flub will be met with strong disapproval and criticism because the people you care about won't accept you if you are human and imperfect. If you don't make any effort, you can't goof.

_____11. COERCION AND RESENTMENT

You feel under intense pressure to perform, generated from within and without. You try to motivate yourself with moralistic "should haves" and "ought to's." Then you feel obligated.

_____12. LOW FRUSTRATION TOLERANCE

You assume that you should be able to solve your problems and reach your goals rapidly and easily, so you go into a frenzied state of panic and rage when life presents you with obstacles. You may retaliate against the unfairness of it all when things get tough, so you give up completely.

_____13. GUILT AND SELF-BLAME

If you are frozen in the conviction that you are bad or have let others down, you will naturally feel unmotivated to pursue your daily life.

Exercise

LETTER TO SELF

Group 35
(Contemplation Stage Intervention)

THOUGHT STOPPING

When you have decided to stop using drugs, a conflict is created. Part of you may still want to use, but you also know you have to stop. This causes a need to justify your drug use. Thoughts about drugs start an argument inside your head—your rational self versus your addicted brain. You feel as though you are trying to fight it and may come up with many reasons to stay clean. But your addict brain is really just looking for a loophole, a way to justify your relapse. The internal argument is part of the predictable sequence of events leading up to drug use. How often in the past has your addicted brain won this argument once it has started?

Cravings do not always strike full-blown like a punch to the stomach. More often, a thought of drug use will float through the consciousness with little or no gut craving attached. It takes some effort to transform a thought about using a drug into a craving. It takes a deliberate choice to allow the thought to be there and play with it—to allow it to grow, gain power, and bang on the wall of your addicted brain. Such a choice is a fine way to relapse. Working up a class "A" drug hunger is probably the most effective way to get you roaming toward a drug connection and then a relapse.

The key to success in dealing with this process is to not let it get started. Stopping the thought when it first surfaces prevents it from building in intensity into a mind and body consuming desire for the drug. It is important to stop it NOW.

ALLOWING THE THOUGHTS TO DEVELOP INTO CRAVINGS IS MAKING A CHOICE TO REMAIN ADDICTED.

TECHNIQUES FOR THOUGHT STOPPING

The process of using drugs is not automatic. It is a process that you can control. Triggers start the process and are then followed by drug-using thoughts. Cravings usually only last 60 to 90 seconds but are the last step before use. The process becomes more difficult to stop as it progresses.

A. Drug use continuum

Triggers----------Thoughts----------Cravings----------Use

B. Techniques

Visualization—Picture a switch or a lever in your mind. Imagine yourself actually moving it from ON to OFF to stop the thoughts of using drugs. Or have another image ready to think about in place of the drug thoughts. You may have to change your physical activity to make this switch.

Relaxation—Feelings of hollowness, heaviness, and emptiness are physical indications of cravings. These can often be relieved by breathing in deeply (filling your lungs with a deep breath of air) and exhaling very slowly. Do this three times. You should be able to feel the tightness leaving your body. Repeat this process whenever the uptight feeling returns.

Group 36

Relapse Warning Signs

(Maintenance/Relapse Stage Intervention)

(Clinical Notes) Read each and explain. Have clients check what they relate to happening and discuss.

The road to relapse has plenty of warning signs. If you can recognize these signs, you can turn back *before* you relapse. Here's a list of what happens to people when they are getting dangerously close to using alcohol and other drugs once again. Place a check mark by all the signs that apply to you.

- Stuffing feelings (not talking about your feelings)
- Blowing up (yelling, becoming frustrated over small problems)
- Negative attitude (being critical and judgmental)
- Bored (thinking there's nothing for you to do)
- Self-pity (feeling upset because you can't drink or get high)
- Denial of drug problem (thinking you can control it)
- Aggressive thoughts (thinking about hurting yourself or others)
- Thinking often about using alcohol and other drugs
- Isolation (avoiding family and supportive friends)
- Blaming (thinking everybody else is to blame for your problems)
- Dishonesty (telling lies to cover for yourself)
- School or work troubles (skipping class, flunking, missing work)
- Legal troubles (problems with police or probation officer)
- Conflicts with family members
- Rejecting advice (won't consider suggestions from others)
- Poor meeting attendance (skipping AA, NA, or support group)
- Hanging around places where you used to get high or drink
- Spending time with friends you used to drink or get high with

If I were close to relapsing, here's how people could tell.

1)

2)

3)

WHAT SHOULD YOU DO IF YOU RELAPSE?

Even though it might feel like it to group members (or you), drinking or getting high isn't the end of their world. But a great deal depends on what you do next. Like an ice skater that slips while performing, a recovering teenager can either get up and carry on, or he or she can stay down and turn a slip into a full relapse. It's a good idea for you to have an emergency plan to follow if you were to drink or get high. This isn't to say that you're going to use, but like having an emergency plan for a house fire, it's a good idea to be prepared just in case. Here are the steps group members should take if they use alcohol or other drugs.

1. Make a commitment.

Right away, you must make a commitment to yourself that, regardless of how you feel, you'll stay clean and sober for the next 24 hours. After slipping, you might feel like giving up completely, so this step is important.

2. Be honest.

It's vitally important that you tell people you have slipped. There might be someone you won't want to tell—maybe you have a parent who is drinking heavily and won't understand—but, at the very least, you should tell your 12-Step group, sponsor, friends, and counselor. You'll need the support these people can offer, and if you don't tell them about the slip, these people can't help. If you aren't honest at this point, the slip will most likely turn into a full relapse!

3. Learn from the mistake.

So, what exactly went wrong? They need to know. A slip is a warning light indicating a problem. You could ask your family, friends, fellow group members, and sponsor what these people think you should do differently.

4. Make the change.

Once you understand what went wrong, you can change. Going to more 12-Step meetings, talking about your feelings more often, staying out of your danger zone—whatever can be changed, you can do it! It's easy for you to feel discouraged after a slip, but many young people have relapsed and were able to pick themselves up and carry on. You can too!

Working a recovery plan is a choice you make every day. Check below the resources you will use to continue staying clean.

_____Spend time connecting with people who don't use.

_____Have a schedule. Structure my time.

_____Plan recreational activities (movies, athletic events, working out).

_____Eat healthy foods.

_____Get enough sleep.

_____Attend TSAT and participate.

_____Talk about thoughts of using with safe, supportive people.

_____Talk about feelings.

_____Drop UA's on time.

_____Stay away from places where there will be drugs or alcohol.

_____Talk with my counselor on a regular basis.

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