La Cañada:

Adolescent Substance Abuse Step-Down Treatment Model

Replication Manual

September 2001

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Preface

This document is a replication manual for the La Cañada Adolescent Substance Abuse Treatment Program, located in Tucson, Arizona. This manual is designed to give the reader (who has knowledge of substance abuse treatment) the foundation to replicate the La Cañada model for adolescent substance abuse treatment. Many of the replication issues (i.e., administrative, clinical, and evaluation) have been addressed. However, depending upon the readers' geographic location, funding issues, licensing issues, and staffing patterns, different replication issues may need to be addressed.

The manual was developed by three primary individuals: (1) Terry Kay (TK) Estes, (2) Steven Nath, and (3) Dr. Joseph Hasler. Thank you—TK and Steve—for "taking the blank piece of paper" and turning it into this manual. Thank you Dr. Joe for your consistent commitment to the project and, of course, all the red-pen marks. Additionally, many other people assisted with the preparation of this document, and acknowledgement of their work is so important. Other people include Mike Cameron, Katy Childress, Patricia Garcia, Tania Long, Zoe Powis, Sherri Ramirez, Mark Senior, Rebekah Taylor, and Steve Trujillo.

Questions or requests for further information should be directed to

Sally J. Stevens, Ph.D.
Principal Investigator
Research Professor
University of Arizona
3912 South Sixth Avenue
Tucson, AZ 85714
(520) 434-0334 – phone
(520) 434-0336 – fax
sstevens@dakotacom.net

I) Program Overview

In response to the need for adolescent substance abuse treatment services in southern Arizona, two non-profit social service agencies, Arizona's Children Association (AzCA) and CODAC Behavioral Health Services (CODAC), proposed to provide a residential step-down program for adolescent substance users. In 1996 the La Cañada Adolescent Treatment Program (La Cañada) was established with AzCA providing the residential treatment component and CODAC providing the clinical and aftercare components.

AzCA is the largest private, non-profit, non-sectarian organization in Arizona providing child welfare and behavioral health services to children and families. AzCA was founded in 1912 as an orphanage. Today AzCA is a statewide, full-service agency providing a comprehensive array of services to severely abused or troubled children and their families. The focus of AzCA is protecting children and preserving families.

CODAC Behavioral Health Services, Inc. was established in 1970 and is a community-based private 501(c)(3) non-profit agency that provides a full continuum of managed behavioral health care either directly or through subcontracts. CODAC has 30 years of experience in providing behavioral health and prevention services in southern Arizona. CODAC has extensive specialized services for juveniles, specifically for adjudicated youth.

The La Cañada program is funded by tobacco tax dollars from the State of Arizona. The program serves an ethnically diverse population of male and female adolescents age 12 to 17 years who meet the following four admission criteria: (1) a DSM Axis I diagnosis of substance abuse; (2) residency within one of Arizona's five southern counties; (3) meet medical necessity for residential care, defined as the inability to control use of substances in a lower intensity level of service, evidence of significant functional impairment as a result of substance use, and evidence of having used substance within the past 30 days prior to intake; and (4) are not receiving Title XIX services from the State of Arizona. Adolescents in need of detoxification services are referred to and must complete detoxification prior to entering La Cañada. There are only two exclusionary criteria: (1) if the client requires a lock down facility because of homicidal or suicidal ideations (based on a psychiatric evaluation) and (2) if the client's IQ is such that he or she would be unable to benefit from the program (based on school records and/or testing). The vast majority of adolescents enrolled in La Cañada are referred from the five juvenile county courts (87%). Clients are also referred to La Cañada by (1) other behavioral health care agencies (7%) and (2) families and self-referral (6%). The La Cañada program consists of three consecutive episodes of care. The first phase of treatment is a 30-day residential component (Phase I), the second phase of treatment is a 60-day intensive outpatient component (Phase II), and the third phase of treatment is a 60-day non-intensive outpatient component (Phase III). All youth enter the residential phase first and are "stepped-down" to the intensive aftercare and non-intensive aftercare phases.

During Phase I, male adolescents are housed in a three-bedroom, family-style group home. The female adolescents are housed at the AzCA main campus and transported to the group home daily. The majority of therapeutic programming occurs at the residential facility, with some activities occurring at the AzCA campus (such as a ropes course). CODAC personnel at the residential facility or at their central office provide the therapeutic treatment, case management, and aftercare services. Aftercare services for youth living outside of Pima County are provided by the Southeastern Arizona Behavioral Health Services (SEABHS), with individual/family counseling occurring in the SEABHS offices.

II) Philosophies Underlying the Step-Down Treatment Model

The La Cañada program provides an integrated treatment model that combines traditional psychiatric and milieu approaches with systems theory and intervention. It is believed that the problems of chemical dependency, substance abuse, and antisocial behaviors are often indicative of larger family dysfunction as well as being primary problems. Because of a strong philosophical belief that the family is the cornerstone of successful treatment, family therapy and involvement are essential to the program. During Phase I, a structured living environment is provided for all residents in which they may address and remedy problems and issues associated with daily living, personal care, social development, interpersonal behavior, and recreation. The therapeutic milieu is considered to be a critical factor in the treatment and rehabilitation of the adolescents placed in the La Cañada program. The milieu is a supportive environment that fosters growth, development, and the movement toward an adolescent's re-integration into the community. Community involvement, for which opportunities are provided for healthy alternatives to the use and abuse of substances, and treatment encourage a high level of involvement in the milieu. Clinical services include family, individual, case management, and group therapy. A treatment plan and the criteria for which successful completion of treatment are negotiated with the adolescents, their families, and the primary clinician during the residential phase. This treatment plan is carried out and reviewed during all phases of the La Cañada program. Succinctly, the La Cañada program focuses on increasing, or "stepping-up", an adolescent and their families' (1) self-sufficiency and resiliency skills, (2) pro-social skills and activities, and (3) healthy functioning and communication. In this way, La Cañada can decrease, or "step-down" (1) the symptoms and damage associated with substance use, (2) the families' dysfunctional or maladaptive patterns of functioning, and (3) the disconnection from community resources.

III) La Cañada—Administrative Issues

A) Description of Facilities

The La Cañada treatment program is located in a residential neighborhood in Tucson, Arizona. The residential treatment facility occupies a light-colored, ranch-style house (commonly referred to as "The House") that is surrounded on both sides by other neighborhood homes. The House has three medium-sized bedrooms, each housing two adolescent boys enrolled in the La Cañada program. Adolescent girls are housed at the AzCA main campus located approximately 17 miles from The House. The girls are transported to and from The House every day for treatment. There is a large kitchen, where meals are prepared. There is a dining room with dark wood paneling, where the meals are served. The large living room is furnished with couches and a television. Meetings and group counseling sessions take place there, as well as relaxation and TV viewing. The converted garage serves as a recreation room (complete with foosball table) and as the house manager's office. There is a fairly large fenced-in backyard, with a Jacuzzi, an in-ground swimming pool, and a small garden area, where residents may plant a variety of vegetables and other plants.

B) Staffing

1) Staff positions

- **Family therapist/program coordinator.** The family therapist position requires a master's degree and a minimum of 2 years in a behavioral health profession treating adolescents and their families. The position requires Arizona Board of Behavioral Health Examiners (BBHE) certification or the ability to become certified within 6 months of employment.

  As the lead clinician, the family therapist provides clinical assessment and treatment planning as well as the family therapy. The family therapist also serves as the program coordinator, which includes the oversight and coordination of clinical care, as well as hiring, training, and supervision of the clinical staff.

- **Case manager/substance abuse counselor.** The position requires a bachelor's degree in a field related to human services and a minimum of 1 year of experience providing case management or counseling to adolescent populations within the scope of this program. Two or more years of case managing or counseling for other populations may be substituted.

  The case manager provides intake and transition services as well as assists in the coordination of community resources and services for the adolescents and their families. The case manager also provides individual and group substance abuse counseling to adolescents in all three phases of the program.

- **Program assistant.** The position requires experience and competence in all clerical aspects of program functioning. Emphasis is placed on skill in communication, concern for the integrity and confidentiality of adolescents, and a keen awareness of organizational needs and priorities. Although there is no agency-wide expectation for hours spent in in-service training, standards of cultural competence apply to the program assistant as well as to all other staff members.

  The program assistant provides administrative, clerical, and management information system (MIS) support to the clinical component of the program.

- **Program supervisor.** The position requires a master's degree in social work from an accredited school of social work or Compton or an equivalent related degree; a minimum of 5 years post–M.S.W./M.S. experience, of which 2 years must have been in supervision or administrative positions; a demonstrated competency in program supervision; fiscal management; administration and management; and program development.

  The program supervisor provides fiscal, administrative, and developmental support as well as the general oversight and supervision of the residential component

- **Unit coordinator.** The position requires a bachelor's degree in behavioral health or related health field; a bachelor's degree in any field with 1 year of work experience in behavioral health service delivery; or a high school diploma or the equivalent, with a

combination of behavioral health education and relevant work experience totaling a minimum of 4 years.

The unit coordinator is responsible for the hiring, training, and supervision of the residential staff as well as the coordination of the residential care and services while collaborating with the clinical component.

- **Ropes course/recreation facilitator.** The position requires a bachelor's degree in a behavioral health or health-related field; a bachelor's degree in any field with 1 year of work experience in behavioral health service delivery; or a high school diploma or equivalent, with a combination of behavioral health education and relevant work experience totaling a minimum of 4 years. The position also requires completion of a nationally recognized ropes course.

  The ropes course facilitator provides rope course groups and recreational activities to supplement the treatment program.

- **Senior residential counselor.** The position requires a bachelor's degree in behavioral health or health-related field; a bachelor's degree in any field with 1 year of work experience in behavioral health service delivery; or a high school diploma or equivalent, with a combination of behavioral health education and relevant work experience totaling a minimum of 4 years.

  The senior residential counselor assists in the hiring, training, and scheduling of the residential staff as well as the oversight and guidance of the residential milieu programming.

- **Residential counselor (II).** The position requires a bachelor's degree in a behavioral health or health-related field; a bachelor's degree in any field, with 1 year of work experience in behavioral health service delivery; or a high school diploma or equivalent, with a combination of behavioral health education and relevant work experience totaling a minimum of 4 years.

  The residential counselor (II) is responsible for providing the care, supervision, and programming for adolescents in the residential treatment component as well as being a shift leader.

- **Residential counselor (I).** The position requires an associate degree from an accredited community college or a high school diploma or the equivalent. Residential counselor positions require current certification in first aid and CPR, as well as completion of a minimum of 21 hours training in therapeutic crisis intervention prior to direct care work. Residential counselors must have a valid Arizona driver's license and minimum automobile insurance, and demonstrate emotional stability, mature judgement, sincere interest in children, and the ability to provide nurturing. Overnight residential counselors must meet the same level of qualifications as listed above for residential counselor (I) or residential counselor (II).

  The residential counselor (I) is responsible for providing the care, supervision, and programming for adolescents in the residential treatment component.

2) Staff requirements

In the following summary of requirements, FTE is "full-time employee."

Clinical/Clerical	
Program Coordinator	0.25 FTE
Family Therapist	1.0 FTE
Case Manager	1.0 FTE
Substance Abuse Counselor	1.0 FTE
Supervising Psychologist	0.15 FTE
Program Assistant	0.5 FTE
Direct Care/Supervisory	
Program Supervisor	1.0 FTE
Unit Coordinator	1.0 FTE
Recreational Ropes/Activity Therapist	0.1 FTE
Senior Residential Counselor	1.0 FTE
Residential Counselor	1.0 FTE
Residential Counselor	1.0 FTE
Residential Counselor	1.0 FTE
Residential Counselor	1.0 FTE
Residential Counselor	1.0 FTE
Residential Counselor	1.0 FTE
Overnight Residential Counselor	1.0 FTE
Overnight Residential Counselor	0.75 FTE

3) Staff training

Forty-eight hours of in-service training is required in the first year of employment regardless of prior education, with 24 hours per year required thereafter in the field of employment for all positions, except the program assistant. This is a State of Arizona and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) requirement for behavioral health personnel. Further, staff members are expected to be knowledgeable in the following areas:

- Symptomatology and diagnostic differential
- Substance abuse/chemical dependency issues
- CPR/first aid
- Medications and self-administration of medications
- Resources for obtaining assistance
- Adolescent record keeping
- Therapeutic crisis intervention
- Adolescent intake/admission procedures
- Group facilitation
- Working with families
- Ethics/professional boundaries

- Activity management/therapeutic programming
- Adolescent rights
- Cultural competency
- HIV/sexually transmitted disease (STD)
- Bloodborne pathogens.

Ongoing training is provided to the residential and clinical staff on topics of interest or topics identified by supervisors for staff improvement areas. These topics include the following:

- Updates on drugs of abuse
- Management of various types of crises
- Issues affecting families of substance abusers
- Intervention into gang activity
- Interaction with peer agencies and other community
- Suicidology
- Teen sexuality.

Regularly scheduled in-service training for direct care workers include the following topics:

- Adolescent development
- Developing therapeutic relationships
- Communication
- Conflict resolution
- Developing and maintaining a therapeutic milieu
- Cultural competency.

In addition, CODAC and AzCA, along with another local community mental health facility in Tucson, compose the Southern Arizona Psychology Internship Consortium (SAPIC), which provides biweekly, in-service training on a wide range of topics related to the behavioral and mental health field. SAPIC training is available to CODAC and AzCA staff members.

IV) Description of Phase I

A) Phase I—Residential Treatment Services

Individual therapy	1 hour/week
Group therapy	5 hours/week
Psycho-educational group	3 hours/week
Case management	4 hours/month
Family therapy	1 hour/week
Therapeutic milieu	24 hours/7 days

The residential phase of treatment, Phase I, provides youth with a safe place to stabilize behaviorally and psychologically following the termination of their substance use. The

therapeutic milieu elements of Phase I include (1) a drug-free environment, (2) a structured daily schedule (routines, rules, responsibilities), (3) psycho-educational activities, (4) health-related seminars and activities, (5) level and point system, (6) daily therapy groups, (7) ropes and recreation therapy, and (8) standardized written and oral assignments. Individualized goals are developed every week into a written treatment plan, which is developed and reviewed by the therapeutic team and shared with the client. The adolescent develops a relapse prevention plan with the guidance from the staff prior to discharge.

1) Drug-free environment

Phase I allows the adolescents to take a "time out" from the pressures of their family, school, and community life, enabling the youth to self-examine in a highly structured, drug-free environment. This externally guarded sobriety offers the youth the opportunity to experience 30 days of clear thinking and increased physical, emotional, and social health, while addressing family issues in a safe and protected environment. It is hoped that this time will begin the process of developing pride and a sense of hope for the future, giving adolescents the motivation needed to continue their recovery in Phase II when they return home from the residential phase of treatment.

2) Structured daily living

a) Routines

Routines are defined as daily treatment activities that occur at the same time in the same manner. Routines serve in several ways. Most importantly, routines facilitate the stabilization of the adolescents. Many adolescents come to treatment from extremely chaotic environments and, as a result, feel no sense of control over their lives; many have adapted coping mechanisms that do not work within the normal structure of the community. Routines are the first step in restoring a sense of control and order to clients' lives. Adolescents wake up at a prescribed time and complete morning routines including personal hygiene, making sure their rooms are neat and clean, and getting to breakfast on time. After each meal, adolescents are required to complete chores that are rotated on a daily basis. The chores are important as they contribute significantly to the structure and allow adolescents to create a positive habit that can then be utilized when they return to the family system. It also allows them to succeed at a required task, which can boost their self-esteem and encourage the adolescent to try additional positive behaviors and actions.

Staff members have the primary responsibility for preparing breakfast with the assistance of an assigned adolescent. Following breakfast and clean-up of the kitchen, scheduled activities are started.

Meal times are very important to the structure of the house and provide further opportunity for the staff to model appropriate life skills. It is the staff's responsibility to prepare every meal according to the menu. Staff members encourage adolescents to aid in meal preparation whenever possible, as it provides an opportunity to talk and build rapport with the youth. Staff members must consider preparation, eating, and clean-up time to ensure these tasks occur within the prescribed time allotments. When the meal is ready, everyone, including the staff, sits down together to eat. The meal offers an important therapeutic time

with adolescents in teaching social skills, life skills, and maintaining rapport. After the meal, the staff and adolescents work together to straighten the house and perform the chores designated for the day.

At the beginning of each shift, the group is brought together, and the shift's activities and groups are briefly outlined in a "rap" group. In the rap group, adolescents and staff members share how they are feeling and talk about what is planned for that particular shift. By sharing this information, clients know what to expect for the day and get an idea of how everyone feels. This helps to alleviate anxiety and allows the adolescents to more effectively focus on treatment. By getting adolescents to settle into and accept routines in residential treatment, the transition into similar routines back home will be easier. All scheduled routines are posted on the walls so that the adolescents know what is expected.

Shift change refers to the time when new staff members are beginning a shift and other staff members are completing a shift. During this time, the incoming staff meets with the outgoing staff for about an hour, while the adolescents have quiet time in their rooms. The shift change routine serves two purposes. First, it gives staff members time to exchange information, complete paperwork, and plan the next shift. Second, adolescents are given the opportunity to reflect on the previous shift, do homework, read, write, or draw. These procedures are mandatory and occur at the beginning/end of every shift.

Evening routines begin when the female clients are transported back to the AzCA facility at 7:30 p.m. At that time, male clients at the residential facility stay in their rooms reading, writing, drawing, or talking quietly with peers while they are waiting to use the shower, unless the staff directs otherwise. Adolescents are allotted 10 minutes for each shower, and a shower schedule is posted. After client showers and get into bedclothes, they clean up after themselves and straighten their rooms. After the staff checks showers and rooms, the adolescents can come out and have a snack and watch TV. After snacks are completed, adolescents brush their teeth, get drinks of water, and use the bathroom. Adolescents then stay in their rooms for quiet time (reading, writing, or drawing) until the time for lights-out at 10:00 p.m. It is very important for the staff to remain consistent with the schedule and guidelines, as well as to provide cues and consequences to adolescents who do not follow the schedule. Female adolescents maintain a similar evening routine at the AzCA campus.

b) Rules

Rules or norms that apply outside of treatment are applicable in treatment as well. Program rules are designed to facilitate appropriate social interaction and help adolescents learn to monitor and adjust their own behavior. Many adolescents lack basic social skills that enable them to function effectively in the community. Rules, routines, and structure help the adolescents learn more acceptable and effective behavior and coping skills. Rules are a form of behavior management, but how they are framed to the adolescents will greatly influence how they incorporate those rules into their social interactions. When adolescents are told what to do, how to behave, and when to do something, they perceive themselves as having no control over the situation. Lack of control will manifest itself into the maladaptive behaviors and actions that originally brought them into treatment. When adolescents are asked to conform to a set of rules or norms, they have the ability to decide for themselves whether to conform or not. When adolescents can make their own decisions, they are more likely to conform and invest in their decision. By asking clients to do something, versus telling them,

they are given the opportunity to choose to experience proper social interaction. The opportunity to make choices is an extremely important factor in helping them regain a sense of control over their thoughts and actions.

c) Responsibilities

The adolescents have many responsibilities while in treatment. Some of these are easily recognizable, while others are implied. Performing household chores, doing their own laundry, keeping their rooms clean, and asking for permission are all straightforward responsibilities. Keeping an open mind and being a responsible member of the residential program are implied responsibilities. As adolescents move up the level system, they are encouraged to model leadership skills, and they are expected to maintain appropriate boundaries and behaviors while in the treatment milieu.

3) Psycho-educational activities

To enhance an adolescent's ability to make educated choices, specific educational topics are presented in a repeating 30-day cycle. All psycho-educational activities are designed to ensure age, gender, and cultural appropriateness. These topics include (1) introduction to the properties of alcohol, tobacco, and other drugs; (2) the use/abuse-dependence cycle; (3) medical/genetic effects of substances and addiction; (4) minimization/rationalization/denial; (5) use of self-help groups; (6) HIV/AIDS/STD risk reduction; (7) information sexuality; (8) family roles in recovery; (9) life skills; (10) self-soothing; (11) anxiety reduction; (12) assertiveness and confrontation techniques; and (13) self-esteem building. Perhaps, even more important than didactic training, adolescents are continually exposed to experiential learning as they observe staff members interacting with each other and with other adolescents.

4) Health-related seminars and activities

The milieu staff, in conjunction with clients, prepares healthy, well-balanced meals. While preparing the meals, the clients learn how to cook and the importance of nutrition, as well as having individual time with staff members. Every 4 weeks, the Pima County Health Department assists CODAC health educators in teaching about and offering screenings for HIV and STDs.

5) Level and point system

The level system is utilized to measure the clients' achievements in therapy process. Stated expectations for each treatment level and activity are communicated to the clients. The level system is designed to facilitate structure and to gradually increase the responsibilities of the adolescents. It serves as a tool to promote achievement and motivation through the assignment of responsibility, the monitoring of behavior, and the experience of consequences and privileges. As the adolescents move through the level system, they are given more freedom and privileges within the structure of the program. Conversely, they are also given more responsibility, and they are expected to take positions of leadership within the program to the best of their abilities.

In the evaluation stage, which begins at treatment entry, the primary counselors are assigned to the adolescents. The primary counselors initiate the majority of the adolescents' interventions and assignments. They also act as their advocates during staffings (weekly staff meetings in which a client's progress is discussed) and help the adolescents meet their basic needs. With the help of the primary counselors, the adolescents will develop three personal goals for treatment, each of which should be achievable and measurable. By having the adolescents participate in establishing their own goals for treatment, it is hoped that they will be more likely to invest in their commitment to those goals. The evaluation period allows further acclimation to the program and helps set the tone for the remainder of their treatment. Through sharing and structure, the adolescent begins to stabilize; this is key in making the residential treatment, as well as aftercare, a meaningful experience. The evaluation level generally lasts for approximately 2 to 3 days of treatment. A youth is able to "petition" to peers and staff members to move to another level once he or she has completed the assigned workbook projects. Petition groups are held twice a day. The youths present why they feel that they should be moved to the next level. The other clients and the staff provide each youth with both positive feedback and with suggested areas for improvement. The other clients and the staff then vote whether or not the petitioning client may move to the next level. If one participant objects to the petitioner moving to the next level, then he or she must re-petition the group in 48 hours. Levels 1, 2, and 3 follow the same structure, and generally, the youth advances to the next level after a week.

The main focus of a point system is to provide instant feedback to the individuals and the group, as a tool for change. The basic structure of the point system is to acknowledge client behavior and actions during routines, groups, recreation, meals, chores, and overall behavior. The points used are 0, 1, and 2. A score of 0 means that no effort was made by the client. A score of 1 means that some effort was made by the client, with room for improvement. A score of 2 means that a good effort was made by the client based on the group, the activity, the level of the client, and their abilities. It is important that the abilities and expectations of the individual client be taken into consideration when giving points. Points are based on five criteria:

- **Being on time.** Points are based on the clients' punctuality and their readiness when the group or activity starts.

- **Participation.** Did the client contribute thoughts and feeling to the group and stay focused? Did he or she discuss topics and issues openly? Or, did he or she cross talk and/or use body language or facial gestures to show lack of interest?

- **Behaviors.** What tone of voice did the client use? Was respect given to peers? Was the client appropriate or disruptive? Polite? Did the client use appropriate behavior?

- **Leadership.** Was there peer intervention? Did they address negative behaviors of the group? Did they encourage honesty and openness? Were they supportive of peers?

- **Feedback.** Was the feedback of the client appropriate? Did they accept feedback from the group? Did they relate personal experiences and feelings dealing with the topic or issue?

Clients are placed on the point system on their first full day in treatment. During entry level and level 1, clients are expected to maintain a minimum of 80 percent of the total points possible. On level 2, they need to have a minimum of 90 percent, and on level 3, they need a minimum of 95 percent. Finally, on level 4, they must maintain 100 percent. Clients are responsible for getting their point sheets signed by staff members on duty. A very effective way to promote awareness with the points and use them as a motivational tool is to have the clients give themselves points while discussing the point sheet with the facilitating staff. The points should be done at the close of each activity so that the feedback is immediate and the client then has the opportunity to change or try out a new behavior. This gives the client the opportunity to build trust and responsibility at the same time that the point sheet promotes dialogue and awareness regarding a client's actions and behaviors. The consequences of the point sheet can be positive or negative. It is important that the consequences are framed as a learning experience and not as a punishment. It can be easy for some staff members to abuse the points and turn the awareness tool into a punitive system.

It is important to observe overall behavior and have a good understanding of the client in order to effectively use the point system. Some clients talk more than others and are more open. The points must be given with the client's individual abilities in mind. Active listening may be all the participation that a client can offer at that particular time. Acknowledging that effort can be very powerful in bringing out more participation later. Conversely, taking points because a client did not talk as much as another may turn them off to the treatment experience altogether. Clients' length of time in treatment, their personality, their issues, and whether this is their first treatment episode must all be taken into consideration when giving points.

6) Daily/weekly therapy groups

The program supervisor, substance abuse counselor, psychologist, and residential counselors facilitate groups. Each week focuses on one of four themes: self-esteem, family and relationships, emotions and feelings, and life management skills. Peers offer support and advice as well as confrontation, leading to group trust and empathy. Additionally, each week, adolescents learn about a different class of drugs and their consequences.

7) Ropes and recreation

Bi-weekly, evening groups at the AzCA gym teach healthy recreation, as does the weekly ropes and challenge course led by a certified recreation therapist. Adolescents get to experience (rather than just talk about trust), team building and conquering fear in the context of a recreational activity. Residential counselors participate in these activities to act as a role model for facing challenges in a positive healthy way. The ropes activity also teaches adolescents that there are positive, exciting ways to have fun without substance use.

8) Standardized written and oral assignments

During the entry level of treatment, each client is given a workbook that includes written assignments such as (1) relapse triggers, (2) family dynamics, and (3) positive recreational activities. The client must complete the written assignments prior to petitioning the group to

move to the next level. The youth must also make oral presentations to peers and staff members with regard to workbook assignments and other therapeutic activities.

B) Phase I—Assessment

Various assessments are utilized in the process of determining appropriateness for treatment and adolescent orientation to the milieu. Adolescents undergo psycho-social, physical, and psychiatric assessments to determine needs, stability, and treatment focus. Assessments are useful for identifying barriers to treatment and to individualize the treatment plan.

During the pre-intake interview, the adolescents will go through a psycho-social assessment. The assessment obtains their history in areas such as school, family, previous substance use, prenatal and child development, exposure to domestic violence, abuse, substance use, previous traumas, coping skills, and other areas of concern. The intake evaluator uses this information to (1) develop strategies for treatment, (2) individualize the treatment plan, and (3) identify potential barriers to stabilization within the milieu.

Prior to intake, adolescents must undergo a physical examination to determine medical health status and stability for intake. This assessment is a JCAHO-mandated assessment and may vary from site to site. Adolescents also undergo a nursing assessment 24 hours after intake as governed by AzCA regulations. Despite variations in State, accreditation, and agency policies, medical assessments are useful tools for treatment planning. They assist in determining the appropriateness for treatment and the need for medical stabilization prior to intake. Medical assessments also detect areas of need and possible barriers to treatment. For example, discoveries in the medical assessment of conditions, such as an STD, may become areas of treatment focus.

Adolescents may also undergo a psychiatric assessment to determine other areas of need, which if undetected, could compromise treatment once in Phase II. Many areas of psychiatric concern may be identified in the psycho-social assessment. If needed, a psychiatric assessment is requested to identify additional areas of concern. Adolescents are not asked to undergo a financial assessment to determine the portion of treatment to be borne by the family, as all fees for services are funded by the tobacco tax grant. However, should funding not be available to pay for all services, a financial assessment of the family to determine ability to pay and availability of third-party reimbursement is recommended.

C) Acclimation to the Program

An important initial aspect of the treatment process is to help adolescents to feel at ease, to acclimate them to the program and their new surroundings. How they view the staff and the other adolescents, and how they respond to treatment overall can be greatly influenced during the first days of treatment. It is expected that adolescents will experience many feelings when they first enter treatment. These may include anxiety, anger, abandonment, and fear, as well as mild symptoms of withdrawal. The importance of providing a safe environment during this time will make the adjustment to treatment easier and more rewarding. In addition to feeling safe and accepted, the clients must have a clear understanding of the structure of the program in order to acclimate safely and calmly into the program.

When adolescents arrive with their parents or guardians, they are all given a brief overview of the program. A tour of the facilities and the intake paper work are completed at this

time. During the intake process, it is important that the adolescents and their parents or guardians feel at ease with their decision to enter treatment. The process of explaining the rules and expectations of the program, as well as explaining the expectations of the adolescent, helps to minimize misunderstandings and fears on the part of the family. It is important that the adolescents and the family members feel at ease with the treatment program and all expectations that apply to them. If this is accomplished, distractions to treatment are minimized, and adolescents can better focus on themselves. The treatment team has observed that the more comfortable the parents feel about the treatment program and facilities, the easier the adjustment to treatment is for the adolescent.

By giving a tour of the facilities, the parents' anxiety level and fears can be lessened, as this gives them an opportunity to actually see the staff and adolescents interacting in the treatment milieu. Following the tour, the parents fill out necessary intake documents and waivers. This is also a very important "ritual" of the intake process, as it concretely demonstrates the seriousness of the commitment for which the family is about to undertake. An inventory of the client's belongings should be done before the parents leave the facility. This allows the parents to take with them any items that are inappropriate for the treatment setting, and assists in generating a list of needed items for the parents to obtain. By doing the inventory last with the parents present, time is provided for everyone to think and absorb what is happening without the distraction of paperwork. This is a good time to open dialogue with the parents at the same time it allows the family to slow down and formulate questions.

On the day of intake, adolescents are not given any chores or responsibilities other than to observe. They are encouraged to participate and interact, as they feel comfortable. Once the family has left, the new adolescents are placed with the group and given a welcome by staff members and the current residents. The welcome group is a ritual for all new clients. During welcome group, the adolescents are given rules to remember; everyone is introduced and states why they are there. This group is effective for several reasons. The welcome group allows the new adolescents to acclimate even more as they realize that they are not that different from peers and staff members. It also allows the other adolescents to assess their own journey through the program and see how far they have come. Through observation, the staff can identify where lines of communication are drawn or opened between the new adolescents and their peers. The welcome group is the first point of reference for the new adolescents to understand where they fit in the group's socialization process. During evening routines, rooms are assigned to the newcomers on the basis of availability and the staff's observation and assessment.

D) Structural Components of Phase I

1) Interactive supervision

Interactive supervision is one of the most important aspects of the therapeutic milieu. While having rules, guidelines, and structure help in the treatment process, how the staff interacts with the client and each other seems to have a dramatic affect on the treatment experience. Interactive supervision is part of the day-to-day activity and includes interactions carried out between staff members and clients. Interactive supervision elements are framed around questions, including (1) How do staff members communicate to each other and with the clients? (2) How do staff members follow the rules of the house? (3) Do staff members set double standards? (4) Do staff members show respect for clients and each other?

Interactive supervision is the foundation for teaching, modeling, and presenting appropriate behaviors and social skills to the milieu. It guides the milieu and the clients in a subtle, yet powerful way.

"Actions speak louder than words"; this is especially true in the residential treatment of adolescents. What staff members say or how they ask a client to do something can be the difference between a client "buying into" treatment or just going through the motions. Many of the clients that enter treatment are very street-smart and come from chaotic environments in which they are hypervigilant of their surroundings. By observing the staff at meals, recreation, play, groups, and during routines, clients learn appropriate behavior. Clients are observing not only their peers' behavior, but the staff as well. In the milieu, every interaction can be a therapeutic interaction.

2) Behavior management

When clients enter residential treatment, they often are confronted with emotions and issues that are difficult for them to manage. These emotions and issues can become difficult for the clients when their usual coping mechanisms are not working or when, because of their substance use, they have forgotten how to manage their emotions and impulses. As a part of the stabilizing and intervention goals of Phase I, it is often necessary for the treatment staff to intervene and assist the clients in learning to manage or cope with these situations. The treatment team's philosophy of behavior management begins with the assumption that an adolescent's behavior reflects needs. The practice of behavior management is meant to build upon the adolescent's strengths to teach healthy and constructive ways to deal with difficult situations and emotions. This includes the La Cañada treatment standard that an adolescent's behavior is strongly linked to feelings of self-esteem. As adolescents begin to accept and adopt the values necessary to make them feel worthwhile, they will in turn accept and adopt those behaviors, allowing them to successfully adapt to their environments. Although this is usually inherent in an early developmental stage, disruptions in the developmental process often make it necessary to begin with helping the adolescent develop a positive self-concept before they can begin to internalize the social skills that will enable them to successfully function in the community. Self-esteem is built by providing adolescents with experiences wherein they are able to succeed so that they acquire a repertoire of successes that outweighs their failures.

The second assumption is that adolescents often react to stress, painful feelings, and change with maladaptive coping responses. These responses are often symptomatic and may or may not be what they appear (i.e., depression will manifest as a conduct disorder). To this end, the ultimate goal of behavior management is one of self-discipline and effective adaptive coping that will help the adolescent generalize appropriate responses for the rules and values of the community. The purpose is to enable the adolescent to develop a sense of responsibility for his/her behavior.

a) Behavior management techniques

The treatment team recognizes that the most therapeutic and effective way to manage or change an adolescent's behavior is by managing or changing one's response to the adolescent. This can be accomplished on a one-to-one level or on a milieu level, depending on the specific behavior. The techniques listed below are designed to manage the surface behaviors exhibited

by adolescents. These are various intervention techniques utilized by the treatment team spontaneously upon occurrence of maladaptive behaviors. The treatment team will often educate and train the parents or guardians of a client on these behavior management techniques, often incorporating the parent or guardian into the treatment milieu. In this way the structure and consistency of the milieu can more easily be transferred to the client's home environment.

- **Active listening.** Sometimes instead of attempting to understand an adolescent's feelings, we may make statements that discourage the adolescent from expressing his or her feelings. Active listening is meant to allow and encourage the communication of needs and to validate feelings; it conveys interest, understanding, and acceptance. It is best used as an early intervention technique to encourage adolescents to "talk out" rather than "act out."

- **Antiseptic bounce.** This may be used when an adolescent's behavior has reached a point where it is best to ask him/her to leave the immediate environment for a few minutes. This technique is used merely to give the adolescent an opportunity to regroup and regain control and is not to be confused with time out. An adolescent may be asked to get a drink of water or to wash up for dinner, or may be directed to take a walk with the staff.

- **Conflict resolution.** Conflict resolution is a method of intervening when there is a conflict between two or more adolescents by acting as "mediator" or "facilitator" rather than as an authority figure. Conflict resolution involves helping adolescents to mutually resolve disputes through the promotion of a collaborative approach. The conflict resolution model involves the incorporation of the following steps in the facilitation of the dialogue between the adolescents involved:

  — Establish ground rules
  — Focus on feelings
  — Define the conflict
  — Explore alternatives
  — Select a solution
  — Evaluation.

- **Consistency.** All adolescents benefit from structure and a known daily routine. When adolescents know what is expected and are able to plan for activities, feelings of anxiety are laid to rest.

- **Direct appeal.** To utilize this technique with adolescents, a trusting relationship must have already been achieved between the adolescent and the staff, and the adolescent's personal value system must be apparent to the staff. The staff uses this technique to appeal to the personal relationship, to the undesired consequences inherent in the adolescent's actions, to the value sensitivity for the child or the group, or to the adolescent's pride in personal improvement. This technique is effective when the adolescent is able to gauge the effect of his/her own behavior on others.

- **Directive statement.** As an adolescent's behavior escalates and his or her ability to make rational decisions decreases, it is necessary to provide direct guidance. Directive statements range from making requests, to stating rules, to issuing commands.

- **Humor.** Often a joke or funny comment can be used to defuse a tense environment or an adolescent in the beginning stages of escalating. It is extremely important to not confuse humor with sarcasm or "funny" insults, as these are frequently misconstrued as veiled anger or threats. The use of humor often is more effective than other approaches and carries less production of secondary consequences.

- **Hurdle help.** When we know that an adolescent is not able to begin or complete a task that appears to be overwhelming or requires some assistance, we can help to get the adolescent over the first hurdle and on to success by providing the assistance necessary to begin or complete the task. Often adolescents use misbehavior to avoid tasks when they are unable to understand what is being asked or required of them. Their frustration and anxiety can be alleviated by offers to help or work with them on the task.

- **Hypodermic affection.** Like praise, affection helps to increase an adolescent's self-esteem. When a child's misbehavior stems from insecurity, fear, or anger at life circumstances, an additional shot of affection and caring may help that adolescent cope with the problem at hand instead of being overwhelmed.

- **Life Space Interview.** The Life Space Interview (LSI) is a therapeutic, verbal strategy for intervening with an adolescent that helps the adolescent assume responsibility for actions, learn successful problem-solving skills, and develop a plan for handling the next problem effectively and appropriately. The LSI should be used throughout the day within the living environment, and it follows these steps:

  — Isolate the adolescent
  — Explore the adolescent's point of view
  — Share the staff's point of view
  — Connect the behavior to feelings or past events
  — Develop alternatives
  — Develop a plan
  — Enter the adolescent back into the routine.

- **Logical consequences.** Logical consequences are responses to misbehavior that are both logical in terms of the misbehavior and psychologically correct in terms of the needs of the individual adolescent. These consequences often take the form of restrictions connected to teaching an adolescent what will result from continued misbehavior in the same circumstance. Logical consequences should not be delivered or administered in a punitive or derisive manner.

- **Natural consequences.** Natural occurring consequences result from an adolescent's misbehavior without adult intervention. Care should be taken that these consequences are not dangerous to the adolescent or are viewed as a reward.

- **Physical restraint.** A physical restraint is the use of trained staff members to safely and therapeutically hold a child in order to contain acute physical behavior, as in behavior that clearly indicates the intent to cause physical harm to self or others. Physical intervention should not be used until all other early intervention techniques have failed to de-escalate an adolescent.

- **Planned ignoring.** Ignoring harmless, attention-seeking behavior withholds the reinforcement an adolescent gets from adult attention. Assuming that the behavior will not spread to others, the behavior may be extinguished when it is no longer effective. Planned ignoring should be accompanied by praise for appropriate behavior.

- **Prompting.** Prompting involves signaling to an adolescent to either begin a desired behavior or to stop an undesired behavior either verbally or non-verbally. Prompting can be a simple, non-critical direction given when an adolescent needs help in progressing or transitioning to the next step.

- **Proximity control/touch control.** These non-verbal techniques incorporate a range of adult responses to help an adolescent regain focus or stay in control. Often the mere fact an adult is close by will be calming for an adolescent. Touch should be used with caution and only in those circumstances where it will not be misconstrued by the adolescent.

- **Redirection.** Redirecting an adolescent or group by changing the activity may be enough of a change for an adolescent to calm down and return to a normal functioning level. This method of distracting or diverting an adolescent's energy or attention to a substitute activity can de-escalate the situation and help the adolescent maintain control.

- **Regrouping.** Sometimes the source of increased problem behavior comes from the interplay between the members of a group constellation. Changing the group membership often helps to de-escalate an adolescent and offers the adolescent a new psychological setting for dismissing the problem behavior.

- **Removing objects.** Some objects are either physically stimulating or physically threatening to an adolescent. Tempting objects that could be harmful to an adolescent should be removed from the adolescent's environment and secured in an inaccessible place.

- **Restructuring.** Restructuring the physical environment or routine schedule may divert an adolescent from misbehaving out of boredom.

- **Signal interference.** Sometimes an adolescent's attention to a potentially disruptive influence can be interrupted with cues (usually non-verbal) such as raised eyebrows, finger snapping, eye contact, or clearing the throat. This technique is most effective prior to an adolescent engaging in misbehavior.

- **Structuring the environment.** Where we choose to talk to an adolescent, whether we sit or stand, and who we sit next to are all part of structuring. This can be used to set a warm, friendly tone, or it can set a cold, business-like, authoritarian tone.

- **Time out.** Requiring adolescents to go to a quiet, neutral setting when upset and over-stimulated can help them clam down and regroup (refer to "Use of Time Out," below).

- **Verbal reminders.** Verbal cues can be used to let adolescents know what behavior is unacceptable and why. Adolescents may not know that what they are doing is unacceptable when they are doing it, nor do they always understand why the behavior is unacceptable. Using verbal cues helps to teach adolescents to recognize certain behaviors and allows them the opportunity to modify their own behavior.

b) Use of time out

Time out, used as a behavioral management intervention, is the temporary separation of a client from a stimulating situation. It is a strategy that entails removing the client to an area in which he or she can regain control or calm down when emotionally distressed. Time out involves separation from the peer group and takes the form of instructing the client to stay in his or her room or in a neutral setting apart from others. There is no minimum amount of time that a client should remain in time out, but care should be taken that only such time as it takes for a client to resolve his or her distress should be maintained in time out.

Time outs should only be prescribed when less intrusive behavior management techniques have failed to de-escalate a client or prompt an adaptive change in behavior. A client can then be asked/instructed to take time out in a neutral setting such as in the client's room, on the steps outside the facility, or in the nearest chair sitting away from the group or situation. Clients should process their behavior leading up to the time out with the staff prior to integration with the peer group in order to prevent further distress and to allow the client to develop alternative coping strategies.

The treatment program does not permit the use of seclusion or placement of a client in a room where the door is closed or locked, or exit from the room is prohibited in any way. Time out rooms shall not have doors, and clients should not be restricted from exiting the room by any other means, provided that they are not exhibiting acute physical behavior.

It should be noted that there is no standard way that time outs are used, and over-controlling through the use of time outs should be avoided. There should be flexibility in the way that time outs are used, and they should not be overused for every instance of misbehavior. However, staff members should refrain from dialoguing with the client or engaging in any reinforcing behavior during a time out. Time outs are not a substitute for natural and logical consequences except when the behavior of a client is distressing or disruptive to others. Staff members should explain to clients that their behavior is either not acceptable around others or

that they will not be socially successful given their exhibited behavior when a time out is assigned or suggested by that staff member. Time outs are not generally successful as consequences for misbehavior, and using timeouts in such a manner detracts from their effectiveness as a de-escalation tool. Time outs should not be used with depressed or withdrawn clients, particularly those who may engage in self-harming behaviors when apart form others.

c) Discipline

Discipline is a positive and essential educational process designed to help adolescents live usefully and cooperatively with others. The ultimate goal of discipline is self-discipline. In other words, it is to help an adolescent learn to successfully control and direct his or her impulses and responses to function within the acceptable boundaries of the community. Effectively applied discipline helps an adolescent to develop a sense of responsibility for his or her own conduct and to accept and handle normal and difficult situations. Good discipline takes into account what the adolescent is capable of doing, what the adolescent needs, and what will help the adolescent grow and develop.

The authority of the treatment staff is required to guide and reassure adolescents as well as to maintain order and safety. It is essential that discipline, or consequences, be both logical in terms of the offending behavior and psychologically correct in terms of the needs of the individual adolescent. Naturally occurring consequences are also preferable unless those consequences may be dangerous or viewed as a reward. A team approach is most effective when creating consistent responses for misbehavior.

The manner in which consequences are delivered or administered is vital. Staff members should never display a punitive or derisive manner toward the adolescent. Discipline should also maintain the adolescent's self-esteem. Some forms of discipline are more conducive to learning than others, and care should be taken to ensure that adolescents are supported and encouraged through the disciplinary process.

Certain principles and procedures should be kept in mind applying discipline with adolescents.

- It is essential that policies and procedures of the program, the group, and the individual be clear for all the adolescents and the staff working with them. It is important that adolescents understand what is expected from them at the outset.

- Corporal punishment is not permitted under any circumstances. Any other behavior that degrades the integrity of the adolescent or infringes upon the physical well-being of the adolescent is unacceptable.

- Deprivation of food, mail, or family contact as a form of discipline is not permitted.

- The withholding or withdrawing of allowances from an adolescent's account for disciplinary measures should not be practiced. Adolescents should, however, pay restitution for any property that they may damage or destroy, as a logical consequence. If an adolescent does not have funds to pay restitution where restitution is a logical consequence, work opportunities with compensation may be made available to enable the adolescent the opportunity to pay restitution. Work is not to be

used as a negative consequence for adolescents in residential treatment, but adolescents on restrictions can be assigned work when regular activities are unavailable to them as a means by which the adolescent can resolve the issues around destructive behaviors that may have impacted others. These assignments should not be in the context of disciplinary action.

- Discipline of an adolescent should not be carried out by other adolescents as it is the responsibility of the adult.

- Consequences should be related to the maladaptive or inappropriate behaviors exhibited by the adolescent and should be in proportion to the level of disruption caused by the behavior. The consequence for minor behavior should not be the same as for a major behavior. In addition, consequences should be administered promptly, and the corrective action should be completed quickly. Most consequences should be within the context of the shift, or within 24 hours if a more serious maladaptive or inappropriate behavior is being addressed.

- Once consequences have been completed, the corrective action should be left in the past. Staff members should use the opportunity to discuss the situation related to the imposing of consequences to help the adolescent increase his or her sense of responsibility for behavior, to clarify expectations, and to explore alternatives and more successful ways of coping with feelings, stresses, and situations.

3) Important dynamics of the residential milieu

Because of the nature of the therapeutic milieu, there are certain dynamics that can have a large impact on the functioning of the milieu. It is important for staff members to be aware of these dynamics so they can respond accordingly.

One is a clear parallel between the processes of the staff and the client group. For example, if one group begins exhibiting problems with communication or decision-making, the other group will respond with similar dynamics. Consequently, it is very important for staff members to be aware of their own functioning on a daily basis and how it may affect the functioning of the client group. Basically, staff members should consider the conscious use of themselves in every interaction. This is the core of interactive supervision.

The second dynamic is how the clients re-create their family dynamics within the milieu. It is very common for clients to respond to staff members and peers the same way they would respond to their family members. Often they will take it a step further and try to get staff members or peers to respond in the same way that their family members would respond. For example, a client who may have a relationship with their parent that includes yelling may choose a staff member that reminds them of that parent and try to illicit the same response patterns. Consequently, it is very important for staff members to be conscious of the response patterns that they have with the clients so they can change their response to the client if necessary.

The third dynamic, or set of dynamics, has to do with the components and ways that a group forms and functions. Because of the length of stay (30 days) and the rotation of clients in and out of the residential phase, the staff needs to be aware that the clients are always in the

process of forming a peer group or terminating a peer group. Depending on the timing of intakes and departures, the group may experience a short period of cohesion as one group (7 to 10 days). Consequently, the staff needs to respond on a group level to facilitate cohesion or termination as well as to exploit a stable period to increase the effectiveness of the treatment experience.

E) Residential Treatment Programming and Focus

In the residential phase of the program, several specific treatment foci are executed to ensure a comprehensive treatment experience. There are two areas of focus for every week of the program. The first area focuses on a specific substance. The treatment team assists adolescents, both individually and in group settings, with educational activities that teach them about the drug's properties and consequences related to use. While adolescents may not have used each substance, education is provided to discourage any future experimentation.

The second area of weekly focus is concerned with aspects of adolescents' lives that have been affected by their substance use, such as self-esteem, family and other relationships, emotions, feelings, and life management skills. During the week, a daily focus is derived that guides the scheduling and structure of daily activities. For example, a weekly focus of self-esteem may have a daily focus of trust, identity, or self-awareness. The daily focus is incorporated into the daily activities, groups, and the weekly focus. Each activity that the adolescents participate in is processed with staff members to ensure the adolescents' understanding, with an opportunity given to ask questions, and allow adolescents the opportunity to acknowledge the skills involved in the activity's success.

1) Week 1 overview

During week 1, the focus is on cocaine/crystal methamphetamine. Education is provided in areas such as history of use and physical, psychological, and social effects. The second focus is the building of self-esteem through daily activities such as trust-building exercises, team building and group challenges, identity exploration, affirmation groups, the gaining and giving of respect, and defining goals and dreams. Trust-building exercises consist of activities such as an anonymous secrets group, mask making, and specific trust-based groups. Adolescents gain team-building skills through a day of indoor/outdoor challenge activities, gym/recreation time, and specific group challenges. Adolescents gain self-awareness and explore their identities through activities such as therapeutic groups, body mapping, mask painting, group games, the ropes course, and constructing a family portrait. Adolescents give and receive positive messages through mask sharing, groups that focus on how adolescents obtain messages, and movie night. Respect is taught through a respect group, board games, recreation, and family visits. These activities are processed in the group to help clients learn about and gain respect for others. Goals and dreams are explored through nature hikes, walks or activities, autobiographic presentations, and goals groups.

Throughout the week, growth activities and self-help (GASH) groups, substance abuse groups, and therapeutic groups facilitated by substance abuse counselors, psychologists, and other team members support the focus of the day and week. Adolescents participate in Narcotics Anonymous, Alcoholics Anonymous, and various groups to aid in the weekly and daily focus. At the end of the week, all activities are reviewed along with

what clients feel they have learned and accomplished. Adolescents are encouraged to ask questions, validate feelings, and give feedback to others. At this point, adolescents shift their attention to the focus of the next week and begin to work on the incorporation of the new focus into their treatment goals.

2) Week 2 overview

During week 2, adolescents learn the physical, psychological, and social effects of alcohol, with the other area of focus being family and relationships. Adolescents explore communication through charades/role-play, the telephone game, the mad-libbing game, and debating. Problem-solving is explored through role-play, indoor/outdoor challenge, a mystery game, and various problem-solving activities. Prejudice and discrimination are explored through a segregation of privileges group activity throughout the day (with later processing), as well as discussions of experiences and individual prejudices. Adolescents explore sexual awareness through an HIV/STD prevention group, a sex feud game (concerning sexual facts), and group discussions and questions. The exploration of morals and values is accomplished through groups, a lifeboat ethics exercise, and creation of a family crest. Family history is explored through drawing, discussion of the family house, family visits, and the weekly wrap-up and discussion of events.

3) Week 3 overview

The focus of week 3 includes education on the history of use of hallucinogens, including their physical, psychological, and social effects. Management skills are the second area of emphasis. Hygiene and manners are discussed and learned through educational groups and a game called “hygiene jeopardy.” Jobs and careers are researched through quizzes, resources, applications, interview groups, discussions of work ethics, and possible GASH activities. Adolescents learn about money and budgeting through a daylong budgeting group activity, as well as education about checking and savings accounts. Shopping and process groups also assist in this area. Home skills are learned through groups, discussion, and participation in meal preparation, as well as through other types of specific instruction. The importance of education is explored through discussions of how one learns, the acquisition of study skills, and library field trips. Adolescents learn about planning and organization through several groups, including the planning of the day’s activities when appropriate. Hobbies and interests are explored through discussions and GASH activities. As with every week, the week ends with a wrap-up and discussion.

4) Week 4 overview

Week 4 focuses on the history and physical, psychological, and social effects of marijuana use. The secondary focus involves having the adolescents explore and identify emotions through group discussions and activities. They are encouraged to express emotions through discussion of previous experiences and conflicts. The skills of anger management, dealing with grief and loss, and love and commitment are explored through several groups and activities. Adolescents may help one another through relaying previous experiences and

ideas. Conflict resolution techniques are learned through exploration of house and family conflicts and participation in self-fulfillment exercises.

The focus on specific substances is based on the drugs common to the geographic area and may change depending on the drugs in the community. The areas of weekly and daily focus are fairly universal and are more likely to remain consistent from community to community. Additional group activities and discussions such as gym/recreation, movies, or other specific focus groups can be added as appropriate.

F) Clinical Treatment Focus

The weekly therapeutic intervention includes 1 hour of individual therapy, 1 hour of family therapy, 4 hours of case management, 4 hours of GASH, and 5 hours of group. A psychiatric evaluation, if indicated, occurs in Phase I. Since each member of the clinical team participates in negotiation of the treatment plan, a holistic approach to treatment is created.

1) Individual therapy

The goal of individual therapy is to uncover previously unexplored issues that have contributed to the adolescent's dysfunction. Individual therapy offers the clients a private place to disclose issues and feelings that they might not feel comfortable sharing with the group. Individual therapy is also a logical place to encourage a commitment to recovery, explore the consequences of substance use/abuse, and acknowledge the impact that substance abuse has had in the clients' lives.

2) Family therapy

While providing a "locus of stability" for youth, Phase I is a crucial time of preparation to cope with the damage that substance abuse has inflicted upon the adolescent's family. Upon admission to La Cañada, the family therapist meets with parents or guardians to assess the need for family education and treatment rehabilitation. In many cases, the family system has enabled the youth's substance abuse and disruptive behaviors. Consequently, this system must be confronted and restructured before the clients can be expected to make major life changes when they return home. It is the family therapist's job to assess what work needs to be done with the family both before and after the youth's residential stay has ended.

The family therapist, in conjunction with the treatment team, negotiates a behavioral goal agreement between the youth and the family. The agreement forms the basis of recovery for both the client and the family, and it will set the stage for ongoing family recovery once the youth returns home.

3) Case management

The case manager also plays a crucial role in the adolescent's treatment during Phase I. Prior to intake, the case manger assesses the appropriateness of the adolescent for the program. The pre-intake interview also introduces the parents to the treatment process and enables the case manager to orient the family to the program while collecting a psychosocial history. Once an adolescent has entered Phase I, the case manager aids in negotiation of the treatment plan,

coordinates psychiatric evaluations, and contacts probation officers regarding the adolescent's progress. The case manager also maintains the paperwork required by agency and accrediting organizations.

4) Growth activities and self-help (GASH)

Phase I is seen as an important time for the youth and the treatment team to start planning GASH, which begins during Phase I and intensifies in Phases II and III. GASH is the personal plan the recovering youth uses to re-enter into the community. It is aimed at replacing harmful former behaviors with constructive, meaningful, and enjoyable relationships and activities with peers and community. Through the networking efforts of agency staff members, a broad range of community organizations has agreed to participate in the program, thus providing a wide array of support and activities the youth can explore after graduation from Phase I. The network includes health, recreation, community service, and employment agencies. Weekly outings to visit these agencies occur during Phase I according to the individual needs of the adolescents.

G) Group Sessions

1) Overview

The Phase I curriculum has seven core groups. The groups coincide with the 4-week curriculum utilized by the residential team. The Family Roles, the Identification of Feelings, and the Identity groups are consistent parts of the 4-week cycle curriculum. The Identity groups have two options: one group focuses on self-concept (CD cover) and the other group focuses on self-worth (Advertisements). The clinician may use the Identity groups interchangeably. The clinician will want to use the self-worth–focused group with a population that has noticeably low self-worth. The self-concept group is more effective with a population that has little identity outside of drug usage.

The remaining groups are chosen depending on the client population and their needs. The Johari Window/Secrets group is routinely done when the treatment team believes the group to be holding secrets that negatively impact on the group dynamics. The DSM-IV group is done with groups who are new to treatment or appear untrusting of treatment. The DSM-IV group provides new clients with an introduction to the diagnostic procedures for substance abuse treatment. The DSM-IV group provides an objective view of how diagnoses are made, thus relieving clients' anxiety about having labels attached to them arbitrarily. The process group aids with groups who have poor internal communication or open conflicts.

The clinician is integral to the implementation of the groups. The clinician has the responsibility of ensuring the safety and the structure of the group. The clinician has intimate contact with the client and is therefore able to have a profound impact on the client's treatment. Consequently, the clinician's abilities and personality need to be compatible with the population. The ideal clinician will have at least 2 years of experience in facilitating group therapy with adolescents. The clinician will need to be neutral and non-judgmental of the clients while giving feedback. The clinician has to understand the addiction process and be aware of the power of denial. The clinician must understand how drug use retards the clients' emotional growth. The ideal clinician will have sufficient self-worth to accept feedback and possibly

criticism from the clients without retaliating. Finally, the clinician needs to be adaptive to the changing dynamics of the group.

2) Description

a) Family roles

- **Purpose.** To introduce the clients to family dynamics.

- **Desired outcome.** Clients will improve their ability to recognize and interrupt dysfunctional family patterns.

- **Implementation.** The group is broken into three parts. The first part consists of the clinician explaining the six family roles (dependent, co-dependent, hero, scapegoat, lost child, and mascot) to the clients. The clinician must emphasize that each of the family roles serves a purpose of keeping the family together. The family roles are not mutually exclusive—meaning a person may take on more than one role within the family. A person tends not to change the family role(s) once he or she starts playing the chosen role. When explaining the six family roles, it is important for the clinician to elicit the participation of the clients. The clients may ask the clinicians for clarification of confusing terminology. The clinician may need to give examples of how each of the roles impacts the other family members. The clinician will refer to the handout because it serves as the visual learning aid for the clients (see Appendix 2t).

  — **Dependent person.** The dependent person, for example, might be the 26-year-old who lives at home, has no job, is not looking for a job, and does not attend school. The dependent person appears lazy and unable to do much of anything. The dependent person may seem demanding at times; this person wants help on his or her own terms. Dependent persons charm people into doing things for them. The clinician refers to the thoughts and feelings of the dependent person. The dependent person fears that the family will fall apart if they don't rally around one cause. The dependent person creates that cause by being needy, and therefore the family has to rally around and take care of the dependent person. In addition, the dependent person hopes to draw the family's attention away from its dysfunctional patterns. The dependent person may feel guilty at times for taking advantage of his or her family. The dependent person may feel worthless, because he or she is not accomplishing goals in life.

  — **Co-dependent.** The co-dependent is the main enabler of the family's dysfunction by covering up the dysfunction. The co-dependent is the person who always helps even when he or she shouldn't or doesn't want to. The co-dependent person constantly attempts to make things better. The co-dependent person blames himself or herself for the family's dysfunction, because he or she can't fix the family. The co-dependent person may seem overly emotional. The co-dependent person's feeling state is determined by external conditions in the

family. Consequently, this person will exhibit fluctuation of feelings due a lack of internal control. The co-dependent person is very helpful, even to the point of taking on the workload of others in the family. The co-dependent is dependable, often sacrificing his or her own needs to meet the needs of other family members. The co-dependent person has become a master of making excuses for others in the family (an example is the spouse who dismisses repeated acts of violence as "accidents"). The co-dependent person may have latent hostility toward the family because he or she carries everyone's load and gets no thanks. The co-dependent person has no internal sense of self-worth, assessing worth on how well the family is doing. The co-dependent person thinks that he or she is able to save the family and can control the family's dysfunction. The co-dependent person will fail almost every time because his or her actions in fact only increase the dysfunction of the family.

— **Hero.** The hero role is the person who looks perfect to family outsiders. The hero is the one whom the dysfunctional family points to as proof of its healthy functioning. The hero is proof that an outstanding person such as himself or herself could only come from an outstanding family. The hero is an academic achiever, successfully employed, an impeccable community member, intelligent, articulate, etc. The hero's internal state may be very different from his or her external state. The hero may often have self-doubt, stemming from the knowledge of hidden faults. Persons in the hero role feel guilty because they are aware that they are not any better than their own families. They are quite aware that the outside view of themselves is a façade. Their behavior within their families is often as dysfunctional as any of the families' members. The hero may feel alone, in that he or she could be isolated from the family. The hero can be overwhelmed by the responsibility of looking good all the time.

— **Scapegoat.** The scapegoat carries all the blame for the dysfunction in the family. Scapegoats have two ways of bearing all the blame. They may have all the blame placed on them (some common phrases directed at scapegoats are "we wouldn't have any problems if it weren't for you" and "I wouldn't be mad and have drink if you would act right"), or they might choose to take on the role themselves. The scapegoat figures that acting up causes the family less problems. The family focuses on the failures of the scapegoat, and less on the true dysfunction of the family system. The scapegoat believes "I'll just keep acting bad so everyone will hate me and not each other." Naturally, the scapegoat has a lot of anger and resentment towards his or her family for having to carry all the blame for the family's dysfunction. The scapegoat often expresses this anger in violent acts such as fighting. The scapegoat appears defiant, unwilling to adhere to any sort of structure whether in or out of the home. The scapegoat is a visible failure, never doing anything right. The scapegoat's sadness will frequently be hidden under a cloak of anger. The scapegoat will choose to be loyal to peers rather than to his her family. The scapegoat is the perfect candidate for gang involvement because he or she will receive acceptance and praise from a gang. In addition, the gang will provide the

scapegoat ready means to vent anger through violent acts. Because of the chronic negative messages from his or her family, the scapegoat will have low self-worth.

— **Lost Child.** The lost child is invisible, or attempts to be invisible. The lost child will leave footprints that prove his or her existence, but will rarely be seen. The lost child is the person who has little or no interaction with the other family members. The lost child believes that by being invisible there will be one less person for the family to worry about. The lost child may also believe it is healthier to avoid the dysfunctional family altogether. The lost child is quiet, not prone to converse with others. Persons in the role of the lost child maintain their invisibility by making sure to not draw attention to themselves. As a result, the lost child is often lonely, having few friends and poor social skills. The lost child will perceive himself or herself as being misunderstood.

— **Mascot.** The mascot is the clown of the family. The mascot will make light of serious situations. The mascot is hyper, never seeming settled in his or her emotions. The mascot relates to others in a shallow manner, having no depth of shown emotional integration. The mascot's behaviors are childish; he or she lacks control of language and behavior. The mascot hopes to lessen the family's dysfunction by creating humorous distractions. More importantly, persons in the role of the mascot distract themselves from their own difficult feelings of living in a dysfunctional family. Their persistent avoidance of difficult feelings will leave them confused about how to experience emotions.

The second part of the group consists of the clients identifying which role(s) they and family members play. The clients identify the roles by writing on the handout given at the beginning of the group. The clinician needs to encourage the clients to ask questions during this phase. The clinician will observe how the clients go about completing the activity, keeping track of clients who are working slowly or too fast.

The third part of the group consists of the clients sharing their family roles with the rest of the group. The clinician encourages the clients to share what they feel comfortable disclosing. The clinician will process any hesitation of the client in the moment. The clinician encourages the group to give each other feedback. The clinician also gives feedback to each client and to the group as a whole.

b) Identity/self-concept

- **Purpose.** To identify and process own self-concept, as related to drugs and external influences. To address how a shift in identity is required to achieve sobriety.

- **Desired outcome.** The clients will gain insight into how much of their identity and self-concept involves drug use.

- **Implementation.** The clinician explains the instructions for completing the compact disc (CD) cover. Instructions are as follows: The clients will create a CD cover that best

represents who they are. The CD cover has no limits, and no topics are off limits. The client's full creativity must not be limited by guidelines or labeled as inappropriate according to some clinician's moral code. The client's uncensored response is essential to this group. The crux of the group is to get at how clients identify themselves, in order to fully explore themselves outside a framework of limitations.

Clients will then write 10 song titles that represent how they feel and think about themselves. Song titles may be from real song titles or made up by the client (see Appendix 2v). No further instructions are given. Client self-exploration is key; therefore, direction should not be provided, as this may sway the client. The clinician is available simply to answer questions regarding content (because client exploration is key, too many directions may sway outcomes).

Clients will have approximately 15 to 20 minutes to complete the CD cover. The clinician will encourage the group members to help each other by answering questions. Clients asking questions of each other promotes a sense of empowerment in the group. The clinician needs to be aware of clients having difficulty starting the activity. Clients having difficulty starting may have not fully understood the instructions or may be overly concerned about the image he or she wishes to present. The clinician processes with the client about difficulties getting started. The clinician observes clients who seem to work very fast. The client may be working to get the activity completed without much thought. The clinician can pose a question like "you seem to really be into this activity, you are getting done so fast". The question opens a non-threatening dialogue about the client's attentiveness to the activity.

Ultimately clients will share their CD covers with the group. Clients will be encouraged to share what they feel comfortable disclosing. The clinician will encourage group members to give feedback to each other.

The clinician processes how much of the client's identity is composed of drug use or illegal behaviors. The clinician will process the client's identity without drugs. The clinician will process with clients who are hesitant to share during the group helps to identify the barriers to the client's sharing.

The clinician will give a general impression of how the group went and will allow time for the clients to give their impressions of the group process.

c) Identity/self-worth

- **Purpose.** Clients will identify their own positive qualities.

- **Desired outcome.** Clients will be able to recognize their own strengths and the strengths of others. The clients will be able to make more positive life choices because of improved self-worth. The clients will have improved interpersonal relations because of an enhanced ability to see the positive qualities of others.

- **Implementation.** The clinician gives directions to the group. The directions are for group members to create advertisements depicting themselves as a good friend, good son or daughter, good student, or a combination of the three (see Appendix 2u). The clinician gives examples of advertisements taken from magazines. The clinician reinforces the fact that the advertisements are about positive qualities and asks the

clients to similarly convey their positive qualities to others. The clinician gives no further instructions.

The clinician allows 15 to 20 minutes to complete the advertisements. Clients sometimes have difficulty identifying their own positive qualities. To further improve the client's ability to recognize positive qualities, the clinician encourages group members to help each other identify positive qualities during this stage of group. The clinician answers any procedural questions.

The clients present their advertisements to the group. The clinician encourages group members to give feedback to each other. The clinician processes how drug use often negatively impacts the client's ability to recognize and act out of a place centering upon his or her own positive qualities. The clinician provides a general overview of the group and elicits responses from the group.

d) Identification of feelings

- **Purpose.** Clients will identify their feelings.

- **Desired outcome.** Clients will be more familiar with their own feelings. Clients will gain awareness of past unresolved feelings. Clients will gain insight into the patterns of and cycles of their feelings.

- **Implementation.** The clinician hands out an "Identification of Feelings" sheet to each group member. The clinician explains and gives examples of each of the feelings on the sheet. The clinician starts at the top of the sheet and works his or her way down.

  The clinician defines ***happy*** as a joyful memory, a time when things went really well for the client. Examples of happy can be a visit to Disneyland or having a family get-together. ***Sad*** is defined as a time when things went very bad, not joyful. The death of a close friend or family member is an example of a sad memory. ***Scared*** is an immediate experience of fear, such as moving out of the way of a speeding car or being shot. ***Lonely*** is the experience of being alone, not necessarily physically alone. A person can feel alone even though he or she is surrounded by a group of people. ***Hurt*** is an experience of emotional pain. Adolescents may feel hurt when parents yell or when parents don't visit them in detention. ***Frustrated*** is the feeling of experiencing many different feelings occurring at the same time. An example of being frustrated is when a person attempts to think of something and can't. ***Fearful*** is the concern about something that will happen in the future. Clients can relate to examples of awaiting a court date or a urinalysis result. ***Loved*** is the experience of being cared about by another person (for example, a parent that never gives up on a client or someone that is supportive of the client). ***Angry*** is an experience of being full of rage. An example of being angry can be a client attacking another person. ***Anxious*** is the experience of anticipating something happening in the future, wanting something to happen. Clients often relate anxiousness with completing the Phase I residential component. ***Guilty*** is the experience of being sorry about something that was done. For example, a client may feel guilty about stealing, yelling at parents, or ever having started to use drugs.

The clients have approximately 20 to 30 minutes to complete the feeling sheet. The clinician answers questions for clients during this stage of group. The clinician makes a mental note of the order in which clients complete their feelings sheets. The clinician observes clients who seem to have difficulty recalling a set of feelings (for example "happy, loved"). The clinician wants to observe themes to process during the discussion portion of the group.

Next, clients present their feeling sheet to the group. They are encouraged to share within their comfort level. The clinician will process any hesitancy on the part of the client. The clinician provides feedback to the client and helps to process any difficult feelings of the client. The clinician needs to pay attention to the client's pattern of experience, observing repeated themes and experiences. The client's themes give information regarding the way the client interprets experience. The client, for example, could relate feelings of sadness, being scared, loneliness, fearfulness, anger, and anxiousness to memories that correlate to some abandonment. Additionally, report themes give information about how the client copes with life events (for example, does the client display little trauma resolution when discussing feelings). The group is encouraged to provide feedback to the client presenting. The clinician will provide feedback to the group and ask for feedback from the clients regarding the group.

e) Johari Window/secrets

- **Purpose.** For clients to share secrets in a safe environment

- **Desired outcome.** Clients will gain an understanding of the purpose of group therapy. Clients will learn how to share openly with others and thereby improving their interpersonal skills. Clients will improve their ability to trust others. Clients will decrease their levels of shame about their secrets. Clients will improve the ability to empathize with others.

- **Implementation.** The clinician informs the group that there will be two activities for the group. The first activity will be a discussion of the Johari Window. The second activity will be a group on secrets. The clinician presents the information regarding the Johari Window to the clients. The clinician draws the Johari Window on a board (see Appendices 2c and 2d).

  The clinician starts at the ***"open"*** pane. The clinician explains the parameters of the "open" pane. The "open" pane consists of things a person knows and things others know (for example, the color of the person's hair or car the person drives). The items in the "open" pane tend to be easy for the person to share with others, or the obvious. The clinician explains that the desired outcome is for the person to increase the "open" pane. As a result, she should be more able to share openly with others and more able to hear what others say. The ultimate goal is to help the client to develop more meaningful, intimate, and lasting relationships by opening communication. The person increases the "open" pane by decreasing the "secret," "blind," and "subconscious" panes to check that the information is understood. The clinician asks for examples from the group.

  The clinician explains the ***"secret"*** pane. The "secret" pane consists of items the person knows and others don't know. The items in the "secret" pane tend to be difficult

to share (such as past traumas or illegal activities). The person diminishes the "secret" pane by disclosing his or her secrets. With group members, the clinician explores the reasons they keep secrets. The clinician then explores, through dialog with the group, what set of conditions need to unfold in order for the clients to disclose their secrets. The clinician and the group agree to adhere to a set of conditions around safety needed for disclosure of secrets. Adherence to these conditions will be utilized as an anchor for the secret disclosure portion of the group.

The clinician explains the ***"blind"*** pane. The "blind" pane consists of items the person does not know and others do know. The person is unaware of the "blind" pane and can only become aware through acceptance of feedback from others. The person's acceptance of feedback will facilitate the diminishing of the "blind" pane. It is important for the clinician to emphasize the importance of feedback in a group setting, resulting in clients' understanding of the purpose and the power of group therapy. The person is able to achieve greater insight through feedback and has multiple opportunities to receive feedback from his or her peers.

The clinician briefly explains the ***"subconscious"*** pane. The "subconscious" pane consists of items the person does not know and others do not know. The "subconscious" pane is not the focus of the group because of the impracticality of discussing it within this group structure. The exploration of the "subconscious" pane would require interventions on a deeper level than can be performed in the timeframe of the group. Furthermore, the full exploration of the "subconscious" pane would detract from group focus by confusing clients. The clinician will explain that the "subconscious" pane in its entirety is better explored separately.

The clinician gives the safety guidelines of the secrets group. The guidelines of the secrets group mirror the conditions agreed upon earlier during the Johari Window presentation. The clinician explores each group member's commitment to continue with the secrets group. The clinician allows the opportunity to process the hesitance of any clients.

The clinician gives the instructions for the group. Each group member, including the clinician, writes a secret on an indistinguishable piece of paper. The clinician's participation adds to the group experience because both clinician and client make themselves vulnerable. The paper is then folded and placed into a receptacle. Secrets are read aloud by the clinician. The group then discusses the secret. Clients are reminded to not divulge which secrets are theirs (clients could discern which secret belongs to whom through deduction).

The clinician processes the experience of disclosing and hearing secrets. The clinician checks the general mood of the group. The clinician makes note of clients who appear to need additional closure after the group ends.

- **Optional.** The clinician and the group go to an area outside and burn the secrets. The burning of the secrets symbolize the transformation and release of the secrets. The clinician gives a general impression of the group and elicits impressions.

f) Process group

- **Purpose.** To allow clients to process group-related issues.

- **Desired outcome.** Clients will find resolutions or gain insight into group dynamics as they relate to dysfunction.

- **Implementation.** The clinician will allow the group to choose the topic to be processed (such as conflicts within the group, conflicts with staff members, or issues around past trauma exacerbated by the group experience). The clinician will serve as a moderator, providing feedback and ensuring that group rules, agreed upon by the group members, are obeyed. In order to build self-efficacy the clinician will encourage the clients to dialogue among themselves. The clients will give feedback on the effectiveness of the group. In turn, the clinician will share her give a general impressions of the group.

g) Focus group—DSM-IV

- **Purpose.** To introduce clients to clinical assessments.

- **Desired outcome.** Clients will gain an understanding of substance abuse diagnoses. Clients will get an objective description of their drug use behaviors. Clients will self-diagnose their substance use.

- **Implementation.** The clinician gives each of the clients a copy of the DSM-IV criteria for dependence and abuse (see Appendices 2g and 2h). The clinician will have a separate copy of the DSM-IV criteria that has paraphrases and examples (see Appendices 2i and 2j). The clinician explores the criteria for dependence and abuse. The clinician will have a member of the group read aloud each criterion and provide a simplified paraphrase of what the criteria say. The clinician writes the paraphrase on a board. The clinician may help the client to read and/or paraphrase the criteria. The clinician may need to give examples to the group to further aid understanding. The clinician will have the clients identify whether they meet the criteria for substance dependence or substance abuse. The clinician gives a general overview of the group and asks for feedback regarding the group.

H) Individual Counseling Sessions

This section focuses on individual sessions for Phase I. It will describe the parameters, the importance, the basic structure of individual sessions, the substance abuse counselor's involvement in the formation of the treatment plan, how the substance abuse counselor passes information on to the residential and the clinical teams, and frequently encountered problems of the substance abuse counselor.

1) Parameters

During Phase I, the substance abuse counselor provides weekly individual sessions to the clients, for a total of four sessions. The area of emphasis for individual sessions is substance abuse, although alternative issues are also discussed. Individual sessions run for a scheduled 50 minutes.

2) Importance

The individual sessions produce self-empowerment, investment in, and ownership of treatment. The clients have 50 minutes a week in which they are the sole focus. Clients often report that they like the individual attention of the sessions; they often ask if they have a session the minute the substance abuse counselor walks in the door of the residential house, for example. The client's enthusiasm for individual sessions is testimony to the client accepting the individual sessions as his or her own. Individual sessions provide a safe outlet for the discussion of issues that the client doesn't want to share with the group (such as trauma issues). The substance abuse counselor establishes a therapeutic relationship with the client through individual sessions. The therapeutic relationship can be both an instrument of change and a setting in which to process issues; for example, a female client who has been the victim of sexual abuse can work through her trauma with a male substance abuse counselor. The client will gain the ability to understand what a healthy relationship with an adult male might be like. The client learns how to effectively communicate with an adult (the clinician). Further, the client learns how to engage in a trusting dialogue.

The substance abuse counselor may more easily confront clients during the individual sessions. Clients appear more receptive to confrontation and feedback during individual sessions. Clients have less need for "posturing" to impress their peers as in a group setting. Clients are more genuine in their responses to confrontation and feedback without a group being present because they are less bound to their past roles.

The clinician is able to work on a deeper level in individual sessions than in a group setting. The clinician has time to focus on the client more during individual sessions (as opposed to group sessions when the focus is shared between five to nine clients). The clinician can implement different interventions during the course of the individual session. Additionally, the clinician has the full attention of the client during individual sessions without distractions from peers. This facilitates a deeper level of therapeutic work.

3) Structure

The substance abuse counselor utilizes a uniform set of guidelines for the first session. The clinician discusses confidentiality with the client at the initial session and processes the entry-level timeline, body map, and genegram. The timeline, body map, and genegram provide a comprehensive overview of the client's experience from the client's perspective. These entry-level assignments have the advantage of being more complete than the initial psychosocial assessment because the clients and/or parents are sometimes deceptive during the intake procedure. The substance abuse counselor has the client establish both short- and long-term goals. The substance abuse counselor gains an understanding of how the client expresses himself of herself through observation of his or her patterns of communication.

4) Descriptions

a) Timeline

The substance abuse counselor and the client discuss the ***timeline*** to find correlation between four aspects of the client's life: drugs, school, relationships, and traumas (see

Appendices 2k, 2l, and 2m). Because it is broken down by age, the timeline provides a visual description of the client's life that can be easily assimilated. Clients gain insight into their drug use as being more than "I use just for fun," because the timeline provides a cause-and-effect depiction of the client's life. For example, a client can see how drug use starting at age 12 correlates to a decrease in school performance at the same age. Further, clients often find connections between trauma, the events, and drug use (for example, a client may have been the victim of abuse and shortly thereafter began drug use). The timeline brings out this correlation by the trauma event and the client's drug use.

b) Body map

The ***body map*** aids clients in identifying where in their body feelings and drug use are experienced in their bodies (see Appendices 2q and 2r). The body map helps the client gain insight into how drug usage impacts his or her feeling state. (For example, a client reports experiencing anger in his hands and likewise reports "experiencing" marijuana in his hands. The client may then process how the marijuana serves to calm his anger.) The body map also provides a tool for the clinician to more easily utilize body awareness techniques such as Gestalt or Neuro-Linguistic Programming (NLP) in later sessions.

c) Genegram

The ***genegram*** allows the client to explore family history and its effects on the client (see Appendices 2n, 2o, and 2p). A client may, for example, report a family history of substance abuse and violence when he or she is a substance abuser and also violent. The client then processes how the historical prevalence of substance abuse and violence impacts his or her life. The genegram opens discussion on the biological component of substance abuse and on co-occurring emotional conditions such as depression or mental illness. The genegram provides alternative interventions and possible areas for further assessment by the family therapist (parenting skills and learned behaviors, for example). Adopted clients will use the current family with whom they reside.

d) Other sessions

The structure of subsequent sessions is not rigid, yet some basic guidelines apply. The substance abuse counselor will first need to check-in with the client in order to assess his or her mental and emotional state. The clinician will determine if the client's emotional and mental state have negatively impacted the realization of the predetermined goals from the previous session. The counselor will need to identify, address, and resolve barriers to achieving goals. Knowing that, overcoming a barrier often becomes a goal in itself. Barriers must be overcome before counselors proceed with a planned session. In line with this, counselors benefit clients by pointing out treatment events (for example, anger at a staff person or peer) in relation to a client's typical past responses to conflict.

A substance abuse counselor should review the past session and formulate a focus for the present session. The counselor and the client then work through the focus topic toward goal achievement. A skilled substance abuse counselor needs to be equipped with several

interventions and therapeutic techniques during this segment of the individual session if he or she is to facilitate goal achievement.

The substance abuse counselor provides closure to the session. The counselor ensures that the client is emotionally capable to end the session. He or she should review the issues learned, discussed, and processed during the session. This review allows the client to recognize the therapeutic work that was done during the session. This review also gives the client the sense that something is happening during the session beyond the perception that two people have merely been engaged in conversation. The substance abuse counselor should then ask the client for his or her impressions of the session.

The substance abuse counselor and the client then set an agenda for the next session. The counselor informs the client then of possible interventions and therapeutic techniques to be used in the upcoming session and asks the client to have input on which techniques or interventions he or she considers to be most effective. The counselor may then assign the client tasks, or homework, to be completed by the next session.

5) Treatment planning

The substance abuse counselor has a part in treatment planning during Phase I. The counselor aids in treatment planning at the weekly multidisciplinary staffings where he or she discusses the client goals of treatment. The substance abuse counselor also formulates objectives and discusses them in this setting.

6) Passing information

Information passed at weekly staff meetings comprises the client's progress toward goals, some barriers to achievement of the goals, concerns regarding the client, and useful interventions.

The clinician passes information to the residential and clinical teams through various methods after first informing the client of what will be passed on to other treatment team members. (The clinician's actions should always build trust and respect with the client.) Clients often thank the clinician for informing them of passing information. Further, informing the client will allow for a dialogue regarding the team approach to treatment.

The clinician may have direct dialogue with the residential staff and clinical staff to pass information. The clinician utilizes direct dialogue when the information to be passed is of an urgent nature. Direct dialogue sometimes is in the form of voice mail messages if the treatment team member is not available.

If the information is not of an urgent nature, the clinician may also leave written information for treatment team members. The clinician usually writes information to the residential team in the residential team's communication log.

I) Phase I—Clinical Troubleshooting

The substance abuse counselor encounters circumstances that may impact treatment. The counselor often has to reschedule clients because of activities that the residential staff members are conducting with the group. Calling ahead to the residential staff to confirm the scheduled individual session can alleviate some of this.

The substance abuse counselor is limited to providing Phase I groups and individual sessions during the early part of the day because aftercare clients are usually only available for services during the afternoon hours. Therefore, the substance abuse counselor has to maintain a busy and compact schedule in order to provide individual counseling to Phase I clients.

The substance abuse counselor needs to be mindful of two agencies with sometimes differing procedures and schedules. The residential team has a set of guidelines from which it can seldom deviate. The clinical team, however, is more flexible. The substance abuse counselor must be mindful of adaptive interventions as they impact guidelines of the residential team. (For example, the substance abuse counselor might instruct a client to complete an intervention on boundaries and self-worth that requires the client to say "no" to all requests. The substance abuse counselor will need to moderate the intervention so the client can abide by the residential guidelines.)

J) Individualizing Treatment

Treatment is individualized for the client by reviewing and taking into account the youths' (1) age, (2) ethnicity/culture, (3) developmental stage, (4) gender, and (5) drugs of choice. Weekly staffings occur to re-evaluate the treatment goals.

1) Age

The client's age is always taken into consideration when formulating treatment plans. Adolescents are encouraged to look for employment, obtain appropriate social skills, and enroll in educational programs relevant to age and current living situations. Those approaching 18 years of age are encouraged to find jobs and explore independent living situations when the discharge plans involve moving away from the family unit. Younger clients are encouraged to develop more adaptive coping skills in order to become a more effective member of the family.

2) Culture/ethnicity

The cultural and ethnicity needs of youth and families are addressed through several means. Bi-lingual, multi-cultural staff members are provided by both agencies to render a sensitive and culturally diverse environment. Adolescents' native ceremonies, traditions, rituals, and spiritual and religious activities are celebrated through education, cultural groups, clubs, and recreation. The residential facility provides and recognizes culturally relevant foods, dress, and grooming habits when possible. Culture is expressed and celebrated with adolescents and staff members to furnish a culturally diverse environment. Each client's culture is assessed for inclusion in the treatment plan, and no adolescent is asked to formulate treatment objectives that are in disagreement with cultural norms and practices.

3) Developmental stage

Undoubtedly, adolescents of various developmental stages are enrolled in the program at any given time. Differing treatment assignments, therapeutic approaches, and treatment plans may be formulated for adolescents with similar issues as appropriate to the developmental level.

Adolescents of lower developmental levels may not be able to see the long-term effects of drug use or behaviors. These adolescents may require more immediate and concrete responses in addressing issues related to substance use.

4) Gender

Treatment is individualized by gender in several ways. The provision of gender-segregated groups, when applicable, creates an environment of stability, security, and safety for sharing. Adolescents are given the opportunity to share with both male and female staff members, as adolescents may only feel comfortable sharing certain issues with a specific gender. For example, females suffering the effects of sexual abuse by males may be assigned to a female primary counselors in Phase I. Adolescents may also be assigned to primary counselors of the opposite gender to confront gender issues.

5) Drugs of choice

Adolescents with varying drugs of choice will be given different objectives in treatment. As various drugs are taken for different reasons with different effects, treatment approaches should be addressed through different treatment models. For example, those adolescents using IV drugs could have treatment plans that encourage utilizing methadone, STD/HIV education and testing, and needle exchange facilities (if legally viable). Adolescents using alcohol as their drug of choice may be asked to talk to MADD, contact AA, or investigate the medical effects of alcohol use. The different drugs used, along with other aspects related to their use, will be addressed when developing the treatment plan.

6) Reviewing progress in treatment

Individual treatment progress is reviewed weekly during the clinical team case review. A summary of the review is documented in the treatment plan review notes, including justification for the level of care provided, as well as possible barriers to the successful completion of treatment. When the level of care for the adolescent changes, either because of consistent progress or changes in needs, the lead clinician will modify the treatment plan to address such changes. Adequate and sufficient services or step-down options may be explored through coordination with the placing agency representative or case manager. It is considered optimal to have the placing agency representative available at the time of the clinical team review so that alternatives or adjustments may be discussed directly with the representative without delay. Residential adolescents may additionally be reviewed through the utilization review process as mandated by agency policy to approve certain types of service changes. Agency representatives are invited to these team reviews to expedite and coordinate the referral process.

K) Treatment Goals

The treatment team recognizes that clients enter treatment for a reason, and the relationship that forms between clients and the treatment team is a purposeful one. Two important conditions regarding this relationship are knowing what pathway the relationship will

take and when the relationship will be terminated. Both the client and the treatment team must establish indicators that will tell them that they are on the right track or have been successful. Without any indicators, it is difficult for the client or the treatment team to know if progress has been made or treatment goals have been met. Often, treatment will meander or continue longer than necessary owing to the client and the treatment team not finding the appropriate clinical pathway or not realizing that treatment goals have been met.

The treatment team finds that the need to develop a treatment pathway, with indicators for success, is a particularly important requirement for working with adolescents. Our clients often feel like failures in their lives, receiving daily reminders of not being successful at home, in school, at a job, or in their relationships. We believe it is very important for these clients to experience success and the feeling of moving forward. Without a clear treatment pathway and specific goals, with indicators of progress, it is difficult for our clients to evaluate their success.

Because of the predetermined number of sessions and length of treatment for the La Cañada program, the treatment team finds it more useful to incorporate specific qualities into treatment goals that help clarify the treatment pathway and indicators of progress.

- **Importance to the client.** A treatment goal must be important and personally beneficial to the client. The treatment team believe that it is more respectful and productive to work with the client's goal than to insist that the client have the "appropriate" goal for treatment, such as the therapist's or the program's goal.

- **Thinking small.** The treatment team believes that when treatment goals are set small and are achievable, it increases a client's motivation for treatment. At the same time, it provides the client with a sense of accomplishment and success.

- **Specific and behavioral.** The treatment team feels that it is more simple to evaluate progress when treatment goals are defined in specific and quantifiable terms. When goals are vague or general, it makes progress more difficult to evaluate; it also allows treatment to become unfocused and drawn-out.

- **Something instead of nothing.** The treatment team believes that when goals are stated in positive and proactive terms, their accomplishment is easier to identify. Clients, especially adolescents, are less likely to accomplish a goal that contains words like "will not," "can't," or "never." Something positive instead of something negative is more effective.

- **Realistic and achievable in context of client's life.** The treatment team believes that treatment goals need to be realistic and achievable within the context of the client's life. It is disrespectful and discouraging to assume that all clients can achieve the same goals to the same degree. Because of all the bio-psycho-social variables involved, clients' motivation and abilities are going to vary drastically.

- **Perception of hard work.** The treatment team believes that it is very important to frame goals with a perception of hard work involved. If a client ends up not accomplishing a particular goal, then it can be framed as just needing more work instead of framing it as a failure. Also, if a client ends up reaching a difficult goal

within the stated timeline (or sooner), then the client should be praised for achieving the goal.

L) Candlelight Ceremony

The candlelight ceremony is a long-standing tradition at La Cañada. The ceremony is a significant rite of passage for leaving the residential portion of treatment and beginning the transition to outpatient aftercare and home. The ceremony was started years ago when clients and staff members sat around a campfire to discuss their treatment experience. The staff took this opportunity to process the clients' feelings and then encourage them to say goodbye to the experience and say hello to a renewed sense of self. This process group impacted the clients and the staff so positively that it became a tradition when a client or staff member left. Today, when a client successfully leaves Phase I of treatment, staff members, peers, and family members share thoughts and emotions as a means of saying goodbye and good luck. The adolescents leaving the group reciprocate with thoughts and insights on treatment, relationships, and feelings about their future, as well as advice to those remaining.

Although the ceremony is for the clients completing Phase I, they are not forced to participate. Clients may choose not to participate in their candlelight ceremony. If so, they are given the option of observing the ceremony or removing themselves completely from the ceremony area. The reasons for having the ceremony without the graduating client are that it gives the rest of the group closure and allows them to express themselves regarding that closure. It shows that structure will always be maintained and that individual needs can be met without disrupting the routines or plans.

The client usually chooses the setting in which the ceremony is conducted. Many clients prefer a more casual ceremony, while some prefer to formalize the ritual by seating the group a specific way or playing music. It is important to allow clients to create the environment for their ceremony as much as possible. Usually a horseshoe or semi-circle is formed around the departing client. In front of the client is a small table or stand on which a larger guardian candle is placed in the center and ringed with smaller candles or tea lights. The number of people at the ceremony and how many candles the client lights for those not attending determines the number of candles needed. Each person goes up, lights a candle, and shares a thought or thoughts with or about the client and the times they spent together. After all the participants are done, the client then starts with the first person and shares her thoughts with regard to the person.

Clients are given the guardian candle as a gift and a symbol of their accomplishment. This is helpful as a token or reminder for maintaining hope and motivation towards sobriety and ongoing treatment. The ceremony is an important ritual for transition to the aftercare portion of treatment and home. It is very important for the family to hear and see the positive feedback given to the client. This has a tendency to build hope and motivation within the family system. It also allows the family the opportunity to share the treatment experience with the client. It is even more powerful when the family participates in the sharing of feelings and insights along with the group. When the family participates, it provides a stronger sense of completion for the client, the family, and the group. Following the candlelight ceremony, a final residential family session can be conducted before the youth transitions to aftercare and home.

Another important aspect of the candlelight ceremony is its effect on the milieu. If staff members are observant during the ceremony, they may pick up clues about how to help the milieu be more productive. They may also pick up clues to further empower the remaining

clients. Clients tend to confide in one another, and the departing clients will give advice on issues not known or discussed by staff members with the remaining clients. Out of this may come excellent goals and/or disclosure of a client's true goal. Peer-to-peer advice can be very powerful in the therapeutic milieu. During the candlelight ceremony, clients often tell staff members what they did and did not like about them, and this information can be very beneficial in evaluating staff approaches and initiation of the milieu. While the candlelight ceremony does represent closure, it also represents growth for clients, their peers, family members, and staff members. The candlelight ceremony is a perfect example of interactive supervision. During this activity, clients and staff members work together to create the therapeutic milieu, each participant learning and passing that learning to someone else. This is one example of how the therapeutic milieu works.

V) Description of Phase II

Phase II—Intensive Aftercare

Family/Individual Therapy	1.5 hours/week
Community Activities	5 hours/week
Family Case Management	4 hours/week
Family Activities	3 hours/week

The intensive aftercare phase of treatment is designed to assist the adolescent in becoming a functional member of the community. The adolescent utilizes family, individual, and group sessions to assist with renewing relationships, maintaining sobriety, and making restoration for earlier behaviors. Adolescents are expected to maintain a strong commitment to treatment throughout aftercare. Individualized treatment continues in two main areas: individual and family therapy. The client is given the opportunity to participate in weekly groups, weekly family therapy, and individual therapy twice a month.

A) Family Therapy

1) Family treatment goals

The family treatment goals have been negotiated during Phase I among the parent/guardian, siblings, treatment team, and the youth. During Phase II, goals become important as the youth has been returned home. Anticipated problems and practical solutions are talked about openly in family therapy. The family unit, prior to treatment, may have previously relied on innuendo, threats, and triangulation in its communication. However, during Phase I, the family members have developed and agreed upon new communication strategies and new rules. The family therapist will introduce the weekly "family council meeting," a time-limited (usually 1 hour), agenda-driven tool for restoring both order and understanding to family communications. Specific, concrete guidelines for communication and goals for achievement have been drawn up with the help of the family therapist. During Phase II, the family therapist helps all family members learn to recognize old communication patterns and utilize new guidelines. Therapists and counselors help youth and families plan weekly activities. These activities can be (1) fun (picnics, sporting events), (2) educational (library, movies), or (3) therapeutic (AA, Al-Anon).

2) Interventions

a) Rules and consequences

Rules and consequences are discussed and written down during family therapy sessions to ensure that all family members are clear about expectations. During one of the first family sessions, the family therapist and the family make a list of the rules that the client will be expected to follow at home. Most clients already have rules in place at home, but are not subject to consequences when rules are broken. Many parents admit to being so frustrated with their drug-abusing adolescent that they are no longer willing to be involved in arguments; therefore, they often give their child more freedom than has been earned. Teaching these skills are important, so that the parents understand and practice setting limits and maintaining structure at home for their child. Education, in terms of appropriate consequences, is also important. Consequences, both positive and negative, need to be age appropriate and meaningful to the youth. The importance of recognizing and rewarding good behavior is stressed in an effort to teach parents to focus on the positive behaviors of their children instead of the negative ones.

b) Family council meeting

The family council meeting is introduced to the family early in Phase II. The adolescent learned during Phase I to open up and share feelings and struggles. The family council meeting is designed to continue that skill within the family. The family is encouraged to structure its own meeting, by agreeing upon (1) a set time each week, (2) the meeting place, (3) how long the meeting should last, and (4) what topics will be discussed. Families may also use this time to schedule special outings or activities, to discuss problems and solutions within the home, and/or to create lists of discussion topics for the next family session. Adolescents who have just completed residential treatment are encouraged to be leaders in the process of starting the family council meetings. These clients can share their expertise regarding the group process and specific group rules (such as no side talking and using appropriate language) to make the meetings run more efficiently and to improve communication and relationships within the family. These meetings allow parents to keep in touch with their children and be aware of their activities and choices of friends. The family council meeting further allows family members the opportunity to discuss what kinds of support they need from each other.

c) Fair-fighting techniques

This intervention encompasses many strategies. The most common need for this technique is in households where both parents and adolescents have anger management issues. When arguments turn into fights and potential domestic violence disputes, family members need to learn and agree to “fair-fighting” techniques. The most common intervention is physical separation. This technique requires the ability to ask the other person for a “time out” when things get too heated. The person asking for the time out asks for a specific time limit and then both agree to revisit the problem to resolve the issue after both parties have calmed down. It is also stressed that this technique may need to be utilized many times in the course of one argument. In many cases, families have used this technique in the past but did not follow through to resolve the problem. Prior to utilizing this technique, all

family members must possess the communication skills to participate in this intervention. Also, all family members must agree to the time limit, respect the time out space of others, and agree to where the time out space can take place (such as a bedroom, the backyard, or other place where the person will not be disturbed). This should not be utilized as a chance for the adolescent or parent to leave and go to an undisclosed place without permission. During the time out period, the client and family members are encouraged to use techniques such as listing the issues to be discussed or writing a letter to the person they argued with. These techniques are utilized to release anger brought on by the argument and to help family members focus on the problems and potential solutions.

d) Chore lists

This technique is similar to the list of rules and consequences mentioned previously, and it pertains to the whole family. A chore list is created to divide all the chores of the household. In many cases, clients create the chore list, since they have experience from residential treatment. The chore list is used for many reasons. It is a tool to show parents that the child is committed to being a part of the family, and it aids in building trust when tasks are assigned and completed. The list is also utilized to provide immediate gratification and build self-esteem when chores are completed. Parents are encouraged to provide positive reinforcement when chores are completed; focus should be on the positive.

B) Community Activities

1) GASH

Also during Phase II, the youth are introduced to community groups, self-help associations, and esteem-building activities that have been chosen while preparing their Growth Activities and Self-Help plan. Time investments for these activities have been established in Phase I and are carried out accordingly, unless it becomes clear to the youth and counselor that a change of time concentration would better suit the individual and family involved. This intervention is individualized to each client. During Phase II, each individual decides which GASH activities they want to be involved in. Some select new interests and some return to interests they had prior to their drug use. The treatment team helps the youth pinpoint some activities they would like to learn more about and provides referral sources in the community.

2) Case management

In order to follow the adolescent's progress, case management continues during Phase II. The case manager has weekly communication with probation officers and other agency staff members who may be involved with the youth (Child Protective Services, schools). Monthly staff meetings are facilitated with the treatment team to discuss individual progress or to design interventions in other areas for the youth and family. The case manager ensures that the adolescent is receiving proper services through the coordinating agencies and may assist with treatment planning.

C) Group Therapy

Group therapy sessions are conducted during Phase II to continue work on the goals determined during Phase I. Adolescents continue to explore issues surrounding previous substance use, current relapses, and other personal setbacks. They learn new skills for making amends to their friends and family.

The aftercare groups consist of 16 weeks of rotating curriculum, which includes discussion topics such as (1) relapse, (2) coping skills, (3) positive self-talk, (4) support system identification and utilization, and (5) drug-free activities. All clients are expected to lead at least one group on the topic of their choice during the 4 months of aftercare. This strategy is used to improve self-esteem and communication skills, to foster creativity and leadership skills, and to create a forum for demonstrating what has been learned during Phase I of the La Cañada program.

The Phase II and III clients are mixed among the groups, because schedules vary and it is important to maintain about eight or nine clients per group. Each group is 50 minutes in duration. On the basis of clinical assessment, clients are selected into the group most suited to the individual client.

The groups have similar initial sequences and closing sequences. A "check-in" is conducted to assess the various levels of functioning among the adolescents and to determine the general group dynamics. New clients are asked to introduce themselves to the group. The topic of the day is presented and the group begins. The clinician always provides his or her impression of the group in the form of constructive positive or negative feedback. Below are some examples of group topics.

1) Stages of drug use

- **Purpose.** To introduce clients to the stages of drug use

- **Desired outcomes.** Clients will gain insight into their addictive process. Clients will make a correlation between cognition and behavior.

- **Implementation.** The stages of drug use are written on a board. A brief explanation is provided. The clinician asks the group participants for additional examples of the stages of drug use. The process is continued until all stages of drug use are discussed. Emphasis is made with regard to how the previous stages influence the subsequent stages. How cognition in one stage may impact behavior in the next stage is also discussed.

2) Marijuana and the law

- **Purpose.** To inform clients about federal mandatory sentencing for marijuana possession.

- **Desired outcome.** Clients will decrease marijuana use out of awareness of the seriousness of legal consequences.

- **Implementation.** A video on the subject of federal mandatory sentencing for marijuana possession is played. The clinician gauges the reactions of group members, and group discussion is facilitated about the video. The legal perception of marijuana as a serious drug is emphasized.

3) Key issues in recovery

- **Purpose.** To aid clients to identify social, vocational, educational, and spiritual components of recovery.

- **Desired outcome.** Clients will incorporate social, vocational, educational, and spiritual components into their recovery program.

- **Implementation.** The clinician writes "social," "vocational," "educational," and "spiritual" on the board. Discussion occurs with regard to how each component is important to recovery, and examples of some types of positive activities in each component are provided. The group brainstorms additional examples of what makes each component successful. The clinician writes the ideas of the clients on the board. Exploration into how the adolescents can implement these examples into their daily lives is facilitated.

4) Relapse warning signs

- **Purpose.** To help clients identify cognitive and behavioral precursors to their own relapse.

- **Desired outcome.** Clients will reduce, if not eliminate, relapse.

- **Implementation.** An example is given of cognitive and behavioral relapse warning signs. The clinician has the group explore cognitive and behavioral warning signs through open dialogue. Major themes are reviewed and discussed. The next week's topic regarding managing relapse warning signs is presented, thereby preparing the group to think of how they would counteract their relapse warning signs.

5) Management of relapse warning signs

- **Purpose.** To have clients identify skills required to manage their own relapse warning signs.

- **Desired outcome.** Clients will utilize effective methods to avoid relapse.

- **Implementation.** The clinician provides some examples of healthy ways to manage relapse warning signs. The group is opened up for dialogue regarding management of relapse warning signs. Having clients discuss their personal management skills is helpful through feedback to others in the group.

6) Internal versus external relapse triggers

- **Purpose.** To have clients explore how their environment may impact relapse.
- **Desired outcome.** Clients will avoid environmental factors that contribute to relapse.
- **Implementation.** The clinician reviews the two previous groups, and internal factors to relapse are discussed. A few examples of external factors to relapse are given. Group dialogue regarding external factors to relapse is facilitated. The clinician encourages the group to discuss and to find solutions among themselves, reinforcing positive sanctions.

7) Identification of support network

- **Purpose.** To have clients identify people supportive of their recovery. To have clients assess their support network.
- **Desired outcome.** Clients will establish a support network.
- **Implementation.** The clinician discusses how an effective support system may positively affect sobriety. Each client is asked who are the people that compose her support network. Specifics as to how these people support the client's sobriety are discussed. The clinician prepares the group for the next group topic, utilization of a support network. The clinician asks the clients to keep a mental note of how they utilize the people in their support network.

8) Utilization of support network

- **Purpose.** To have clients identify and assess how they utilize their support network.
- **Desired outcome.** Clients will more effectively utilize their support network.
- **Implementation.** Each client discusses how he or she has utilized the support network during the past week. The clinician provides feedback but also encourages group members to provide feedback to each other.

9) Non–drug use activities

- **Purpose.** To have clients identify some leisure and/or recreational activities that do not involve drug use.
- **Desired outcome.** Clients will engage in a daily drug-free leisure and/or recreational activity.
- **Implementation.** A discussion starts the group with regard to leisure and recreational activities. The group discusses which leisure and/or recreational activities do not involve drug or alcohol usage. The counselor has group members explore how often

they engage in drug-free recreational activities, and group members identify and agree to participate in one drug-free activity of their choice during the week.

10) Progress in recovery

- **Purpose.** To have clients self-evaluate progress and obtain feedback from peers.

- **Desired outcomes.** Clients will gain insight into their own recovery. Clients will incorporate new methods to improve their recovery.

- **Implementation.** The group begins by discussing the progress of the clients in the aftercare component of treatment. The facilitator encourages group members to give constructive feedback to each other. The facilitator provides further feedback to help clients achieve realistic self-evaluations.

11) Vocational aptitude and preference

- **Purpose.** To have the clients identify their vocational strengths and preferences.

- **Desired outcome.** The clients will find suitable vocations.

- **Implementation.** The staff member writes a few vocational categories on the board. These categories include (1) “work with people,” (2) “work with animals,” (3) “work indoors,” (4) “work outdoors,” (5) “work with numbers,” (6) “work with travel opportunities,” (7) “work that is routine,” and (8) “work that varies.” Each group member identifies a vocational preference. Group members identify three strengths or reasons they would excel in the type of work they identified as a preference. All of the responses are recorded on the board. The counselor and group members provide feedback on each participant’s strengths with regard to their stated work preference. The counselor provides encouragement to the clients in seeking employment that matches their strengths and preferences.

12) Process group

- **Purpose.** To allow the client to discuss relevant issues.

- **Desired outcome.** The clients will resolve current issues.

- **Implementation.** An open forum is provided for the clients to discuss their current issues. The group works toward providing advice in an effort to help the client resolve issue(s). The facilitator encourages the group to provide the client with feedback. Review of what has been discussed is facilitated, and the client shares feelings concerning the issues resolution. An individual session may be scheduled if the counselor deems it necessary.

D) Individual Sessions

The individual sessions during Phase II are scheduled for every other week. The individual sessions during Phase III are scheduled for once a month. The clinical team determines whether clients would benefit from additional individual sessions, providing the individual counselor with some flexibility with regard to scheduling additional sessions. The sessions usually occur at the CODAC offices, but staff members are flexible with the location of the sessions. The counselor may need to conduct sessions at the client's home, school, placement facility, or detention center. The Phase II and III individual sessions are scheduled to last for 50 minutes.

The Phase II and III individual sessions are an arena in which to continue the therapeutic relationship that was established in Phase I. The counselor becomes an integral part of the client's support network during Phases II and III. Acute therapeutic interventions are provided to the client during these sessions.

During the individual sessions, the clinician checks in with the client, that is, reviews the client's life events since completing Phase I and returning to the community. The client explores his or her short- and long-term goals and then joins in the discussion of the treatment plan. After review, input, and agreement of the treatment plan, the youth demonstrates commitment to the plan by signing it.

Subsequent individual sessions follow similar formats including (1) checking in with the client to determine the client's ability (emotionally, mentally) to proceed with the session, (2) resolving any barriers that may impede the therapeutic process, (3) reviewing of the previous session(s), and (4) deciding on a specific focus for the current session (family, peers, school, recreation). At the end of the session, a review of what has been accomplished and discussed occurs, and preparations are made for the next session. The counselor provides information to the client concerning possible further interventions that may be used during the upcoming sessions.

E) Treatment Planning

The counselor is responsible for completing a treatment plan prior to the adolescent's discharge from Phase I. The entire clinical team provides input on the treatment plan. The goals outlined for Phase II and III treatment plans focus more upon relapse prevention and family reconciliation. Both Phase II and III treatment plans span 60 days. The treatment plan is reviewed during the monthly case review staffings.

F) Troubleshooting Issues

1) Groups

In an attempt to avoid group problems, the clinician is thoughtful in the selection of group members. To find the best match, the counselor takes into account the various personalities of the clients, as well as the overall group dynamics. Among other considerations, a balance must be struck between vocal and not as vocal clients.

a) Absence/tardiness

Clients who do not show up for groups have been the most common problem. La Cañada staff members maintain an attendance roster for the day's group. This group roster is forwarded to the liaison in the Juvenile Probation office, who distributes the roster to the appropriate probation officers. The probation officers address the lack of attendance with the youth generally by giving some type of legal consequence. Letters are also written to parents to inform them about their child's lack of attendance.

Clients who arrive late for group are the second most common problem. Clients arriving more than 10 minutes after the group start time are considered late. The clinician provides the client with a verbal warning when they are late for group and documents on the roster that the client was late. Clients arriving more than 20 minutes late can be admitted, so long as they are not disruptive, but do not get credit for attending the group. The most frequent reason the clients report being late is due to transportation issues. The vast majority of clients do not have or are ineligible to obtain a driver's license.

b) Tobacco, alcohol, and other drugs

Smoking cigarettes before and after group has caused some disruptions to the aftercare groups. The clinician reminds clients frequently that smoking is not tolerated and that consequence may be forthcoming if smoking occurs during the groups.

Clients may appear to be under the influence of some mood- or mind-altering substance during aftercare groups. Staff members may want to confront the client prior to starting the group. Generally, the best environment for the counselor to confront the client is outside of group. This eliminates any desire to "save face" in front of his or her peers. Additionally, confrontation outside of group allows the opportunity for the client to decide whether he or she will disclose this drug use with peers or whether he or she will sit out of group, reflecting upon this use.

c) Violence

Violence is an extremely rare problem. Staff members can avoid violence during groups by making accurate initial assessments of the group and intervening when necessary. Also, careful observation should be made to determine any changes in the group's typical dynamic (for example, groups may be more loud or quiet than usual).

2) Individual

a) Absence/tardiness

Individual sessions typically have fewer problems, the most common being a client's failure to show up for a scheduled session. The clinician writes a letter of nonparticipation to the parent(s) and probation officer each time the client fails to show up for a scheduled individual session.

Clients arriving late for their individual session are the next most common problem. While the counselor will often see clients who arrive late (up to 30 minutes past their scheduled

time), it is important and therapeutic to address the issue with the client. Adolescents who arrive more than 30 minutes late are offered a re-scheduled session at the earliest possible date and are not given credit for attending the session. They are considered to be absent, and a letter of nonparticipation is written.

b) Tobacco, alcohol, and other drugs

Clients who are using tobacco, alcohol, and other drugs prior to an individual session have generally not been a problem. This is because youth who are actively using mood- or mind-altering substances generally do not show for their individual sessions. In the case that a youth does show up intoxicated, the staff member addresses issues surrounding the relapse, including triggers and prevention. The La Cañada staff may also obtain a urine sample from the youth if a staff member suspects drug use.

VI) Description of Phase III

Phase III—Non-Intensive Aftercare

Individual/Family Treatment	1 hour/month
Family Case Management	4 hours/week
Family Activities	2 hours/month
Community Activities	10 hours/week

Phase III is designed to be the time when all of the work invested in the first two phases pays off. Ideally, the youth has now begun to show improved choice making, and the home setting has stabilized and become an environment for growth and safety. At this point, both the adolescent and family should be ready to explore the surrounding community in a more fulfilling way.

Less therapeutic time is given to individual and family problems during this phase, as the treatment team has turned over decision-making and problem-solving efforts to the family. The case manager and family therapist stay in contact with the client and the family to help with appropriate use of GASH time, to monitor the abstinence pledge (through urinalysis), and to identify other resources in the community to fulfill ongoing needs presented by the individual and family.

For the adolescents, the principle source of growth at this point is the attention given to their renewed self-image as community members. A minimum of 10 hours per week is spent in well-balanced, challenging community activities. For those interested, the opportunity to mentor new clients in La Cañada or to volunteer to facilitate discussion groups at the residence can fulfill community activity requirements.

VII) Evaluation

A) Participant Profiles

The majority of La Cañada clients are male (72.5%), age 15 to 16 years old (59.8%), and Hispanic (46.1%). Prior to enrollment, the majority of the youth (86.3%) were living in a house or an apartment. The majority of the youth (76.5%) reported that prior to enrollment

into the La Cañada program, they were not going to school or working. Given this percentage, it is not surprising that average last grade completed in school was 8.6. Fifty-one percent of the youth reported that the substance that they needed treatment for was marijuana. The next largest percentage of substance needed treatment for was alcohol (15.8%). Interestingly, 10.9% of the youth self-reported at intake that they did not need treatment for any substance. Almost all of the youth (97.1%) reported that the first time they got drunk or used any drugs was before the age of 15. The average number of times in their life that they had been arrested was 9.4. However, the data indicated a large (9.8) standard deviation.

B) Process Evaluation

The evaluation staff collected process data through a variety of instruments and methods, including (1) completion of the Progress Checklist by the counselor and the clients, (2) ongoing observation and informal interviewing, and (3) the "monthly process evaluation component." The monthly process evaluation component includes the administration of the Monthly Evaluation Questionnaire. This "Likert"-type process questionnaire lists the ongoing activities and special activities offered during the previous month. La Cañada staff members and clients are asked to rate each activity from "not helpful" to "very helpful" in terms of client recovery process.

The same (or similar) Monthly Process Evaluation Questionnaire is administered each month. It includes ongoing activities such as groups, therapy sessions, and GASH. Activities that are earned each month, such as family visits and special recreation outings, are also included.

Facilitation of the staff and client focus groups is designed to supplement the quantitative data collection through the administration of the Monthly Process Evaluation Questionnaire. These focus groups are used to gain understanding of the staff perceptions and the participants' personal interpretation of their recovery process and the impact of the program's activities.

After analysis of the percentage ratings for each treatment component, a difference in ratings of 20% between the staff and clients was deemed significant. It was noted that for the months of July 1999, January 2000, and March 2000, both groups were equal in ratings between what the staff and clients rated as helpful similarities and differences. Conversely, during the month of October, the difference of rates ranged between 13% and 67% (many ratings being past the cut-off rate of 20%).

One of the factors that seem to contribute to the variation in what the staff and clients deem as "quite helpful" or "very helpful" is turnover of staff members and clients. For instance, at the time of the October 1999 process evaluation, 10 adolescents participated because one of the clients was awaiting his discharge from residential treatment (Phase I). Of the staff and clients combined, the majority of the percentage ratings fell beyond 20%. This group rated AA meetings (15%), relationship with the staff (17%), family visits (0%), and movie night (0%) as being "quite helpful" or "very helpful." The reasons for the differences in ratings could be due to clients not agreeing on what they received from treatment. For example, one client stated with anger that ***"half of us are here because we're court-ordered to be here. It's not even our choice."*** Another participant replied, "***I learned I don't have to use drugs to have fun, that doing something like the ropes activity is a natural high."*** During this evaluation, a staff

member stated, ***"clients may want to use drugs more while in treatment because they're drilled with the subject of drugs all day."*** Another staff member added, ***"it's hard to answer if treatment makes clients feel like using less, about the same, or more, because we're talking about all different clients here."***

At any given month, the number of staff members can be significantly less than the number of clients receiving treatment. For example, during the month of March, five residential staff members were employed at the La Cañada facility, while seven clients were enrolled. These seven clients seemed to be proactive in making use of their individual treatment, as can be evidenced by their ratings on the Monthly Process Evaluation Questionnaire with regard to individual therapy, self-help groups, and AA meetings.

It was noted that participants during the months of July 1999 and January 2000 rated their relationship with staff members and peers at 100%. Both process evaluation and focus group results demonstrate a high level of trust between staff members and clients (ratings between 0% and 20%). It appears that there is a high level of trust associated with groups and activities, such as therapy process groups, petition and presentation groups, AA meetings, ropes, and candlelight ceremonies.

C) Preliminary Outcomes—Ethnic and Gender

Between January 1998 and December 2000, 169 youth who were enrolled in the La Cañada program consented (as well as their parents/guardians) to participate in the evaluation component. Currently, of the 169 participants in the study, 149 have a baseline and 6-month post-baseline assessment entered, re-entered, and verified in the database.

Background descriptions of the 149 study participants include: (1) 32% (n=47) were female, (2) 43% (n=64) were Latino, (3) the mean age was 15.77 years old, (4) 62% (n=93) come from single parent households, (5) the mean grade completed in school was 8.58, (6) 78% (n=116) came to La Cañada upon the basis of a referral from the criminal justice system, (7) the mean age in which they first got drunk or used drugs was 10.86 years old, and (8) the mean number of previous treatment experiences was 1.68 times.

The 6-month post-baseline outcomes for La Cañada youth indicate significant reductions in substance use, criminal activity, and mental health issues for all subgroups [girls, boys, Latino(a), non-Latino(a)]. Comparisons of baseline and 6-month post-baseline outcomes for girls and boys showed that at baseline the girls report using alcohol and other drugs 70% of the possible 90 days (not in a contained environment) prior to treatment, and the boys report using 73% of the days that it was possible for use. At 6 months post-baseline, the girls report using 23% of the possible days, while the boys report using 33% of those days. At baseline, the Latino(a) youth report using 71% of the possible 90 days prior to treatment, and the non-Latino(a) youth report using 74% of those days. At 6 months post-baseline, the Latino(a) youth report using 27% of the days during the 90 days prior to the interview, while the non-Latino(a) youth report using 33% of the days of possible use.

Pre-/post-analysis for criminal activity was examined using the General Crime Index (GCI). All subgroups evidenced significant reductions on the GCI at 6 months post-baseline. The girls scored lower at baseline (4.80) compared to boys (6.64) and showed somewhat less change at 6 months post-baseline (0.85=girls; 2.15=boys). Latinos(a) scored lower at baseline (5.67) compared to their non-Latino counterparts (6.36) and reported less change at 6 months post-baseline [1.78=Latino(a); 1.68=non-Latino(a)].

Pre-/post-analysis for mental health was examined using the General Mental Distress Index (GMDI). All subgroups evidenced significant reductions on the GMDI at 6 months post-baseline. Results indicate that at baseline, girls score higher (12.09) than boys (8.45), and girls reported greater change at 6 months post-baseline (7.28=girls; 5.88=boys). Latino(a) youth scored somewhat lower on the GMDI at baseline (9.28) compared to their non-Latino(a) counterparts (9.85) and reported greater change at 6 months post-baseline [5.48=Latino(a); 6.98=non-Latino(a)].

VIII) Best Practices

The most important and best practices that have been developed and implemented by the La Cañada staff are described in this manual. Involving youth in developing their treatment plans as well as empowering them to assist with decision-making ensures compliance and commitment to the overall treatment process. Treatment anchors such as the "first day" and the "candlelight ceremony" provide youth with structure and traditions for which they may share with their peers and family.

IX) Lessons Learned

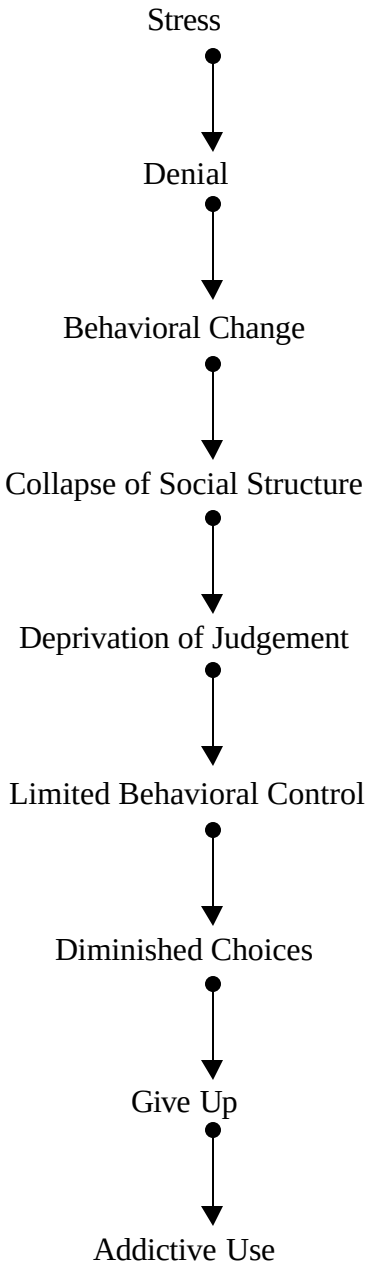
Many of the La Cañada personnel agree that it has been challenging managing the program between two large community agencies. Also, La Cañada personnel believe that the treatment could further increase positive outcomes if the residential component was increased to 90 days. Finally, accommodating the youth in terms of transportation may increase attendance to the aftercare groups component of treatment.

Appendices

1) La Cañada Catchment Area

2) Therapy Resources

a) Stages of drug use



b) Stages of drug use (clinician's copy)

Stress *(cognitive)*

- Explore examples (i.e., death of friend or family).
- Make certain each group member identifies an event that is stressful.

Denial *(cognitive)*

- Emphasize that the DENIAL is in response to the STRESS.
- Define denial as not accepting an event as being stressful, even though the event is stressful.
- Example phrases of denial are "It doesn't bother me," "I'm OK," and "It's no big

- Have the group explore own cognition of denial.

Behavioral Change *(behavioral)*

- Emphasize that the BEHAVIORAL CHANGE is in response to the DENIAL.
- The BEHAVIORAL CHANGE is manifest of the emotional turmoil within the person.
- BEHAVIORL CHANGE examples may include increased anger outbursts, experimenting with drugs.
- Have the clients identify additional examples of BEHAVIORAL CHANGE.

Collapse of Social Structure *(behavioral)*

- Emphasize that the COLLAPSE OF SOCIAL STRUCTURE is a direct result of behavioral change.
- In this stage, the person pushes away those who notice the change in behaviors (i.e., parents, teachers, peers).
- The person no longer has others to provide support and guidance.

Deprivation of Judgement *(cognitive)*

- Emphasize that the DEPRIVATION OF JUDGEMENT is a result of the COLLAPSE OF SOCIAL STRUCTURE.
- The person has no one to provide alternate viewpoints; those people were pushed away during the COLLAPSE OF SOCIAL SRUCTURE stage.
- Therefore, the person relies on own flawed judgement.

Limited Behavioral Control *(behavioral)*

- Emphasize that the LIMITED BEHAVIORAL CONTROL results from the DEPRIVATION OF JUDGEMENT.
- The person's behaviors get out of control because the person has poor judgement.

- Examples may include chronic drug use, illegal behaviors, and suspensions from school.

Diminished Choices *(behavioral)*

- Emphasize the DIMINISHED CHOICES resulted from LIMITED BEHAVIORAL CONTROL.
- The person has people making choices for them (i.e., probation officers, caseworkers, school officials).

Give Up *(cognitive)*

- Emphasize how the DIMINISHED CHOICES affect the GIVE UP stage.
- The person senses having no control over his or her life and therefore gives up.
- The person will most likely increase his or her drug use.

Addictive Use *(behavioral)*

- Emphasize how the stage of GIVE UP impacts ADDICTIVE USE.
- The person senses hopelessness and adopts addictive drug use as a coping method.

HINTS:

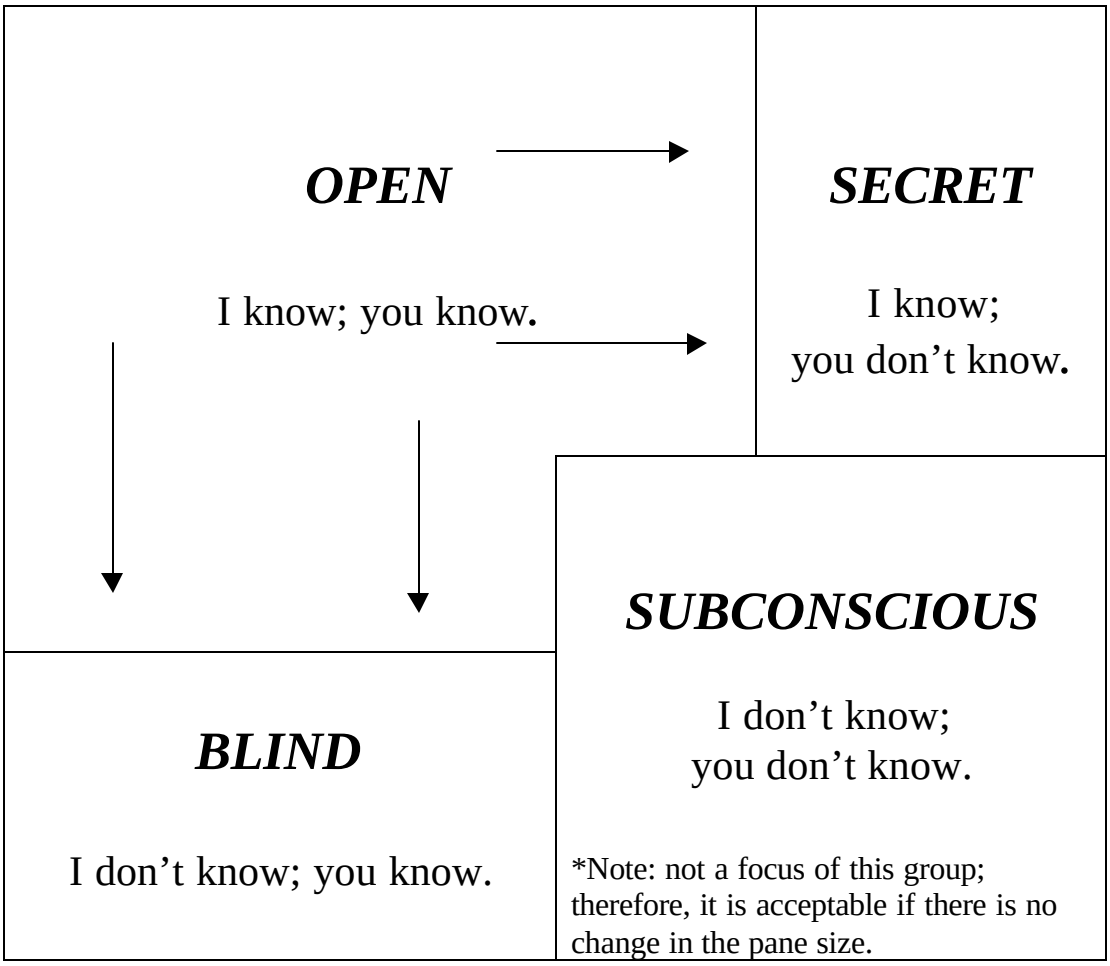
- The group facilitator must address how each stage is dependent upon the previous stage (i.e. BEHAVIORAL CHANGE impacted by DENIAL).
- The group facilitator needs to emphasize how cognition affects behaviors.
- The group facilitator reinforces that drug use begins prior to actual use (i.e., DENIAL, a cognitive stage).
- The ideal place to intervene is at the DENIAL stage.
- Instruct the group that this process may also apply to relapses.

c) Johari Window

OPEN I know; you know. This is the part of a person that is obvious and evident to everyone. This part is easy to share with others. For example, hair color, the car he or she drives.	SECRET I know; you don't know. This is the part of the person that is known only to himself or herself. This part is difficult for the person to share with others. For example, past trauma or illegal acts.
BLIND I don't know; you know. This part is unknown to the person, yet others can readily see it. For example, a person may use derogatory language often and is unaware.	SUBCONSCIOUS I don't know; you don't know. This part is consciously unknown to the person and others. This part may be accessed through hypnotherapy or other similar approaches.

- The purpose is for the person to broaden their OPEN part. As a result, the person is more able to share openly with others and more able listen to what others state, therefore having more meaningful, intimate and lasting relationships.
- Elicit responses from the group regarding past barriers to sharing secrets, in the SECRET pane. Alleviate barriers to sharing secrets.
- Emphasize the importance of feedback in group therapy, in the BLIND pane.
- Explore the SUBCONSCIOUS pane, in general terms. It is not a focus of this group.
- Emphasize the importance of having open relationships.

d) Johari Window (desired outcome)



- The person has increased the OPEN pane.
- The person has decreased the SECRET pane.
- The person has decreased the BLIND pane.
- It is acceptable if there is no change in the SUBCONSCIOUS pane.

e) Identification of feelings (clinician's copy)

Describe a time in your life when you felt the most happy, sad, scared, etc. Rate how you feel most of the time on a scale from 1 to 10, in the last box (1 = hardly ever; 10 = all the time).

Happy	***Definition**: Joyful memory. Time when things went really well.* ***Example**: A family trip to Disneyland. Being let out of detention.*	
Sad	***Definition**: Not joyful. Time when things went very wrong.* ***Example**: Death of a close friend/relative.*	
Scared	***Definition**: Immediate experience of fear (not to be confused with fearful).* ***Example**: Moving out of the way of a speeding car. Being shot at.*	
Lonely	***Definition**: The experience of being emotionally alone. (not physical loneliness). No one around to comfort or understand.* ***Example**: Being in a group where no one is accepting.*	
Hurt	***Definition**: Emotional pain.* ***Example**: Parents blaming. Family withholding affection.*	
Frustrated	***Definition**: Having many feelings happening at the same time.* ***Example**: Doing homework. Try to remember something, but can't. Being happy, angry, scared, anxious all at the same time.*	
Fearful	***Definition**: Concern about a future event.* ***Example**: Waiting for a urinalysis result, after you used drugs.*	
Loved	***Definition**: A sense of being cared about by another person.* ***Example**: Parent always on your side. Someone who believes in you.*	
Angry	***Definition**: Full of rage. Hatred.* ***Example**: Having a physical altercation with someone. Parent demeaning you.*	
Anxious	***Definition**: Anticipation of something you want to happen.* ***Example**: Completing treatment. Waiting to get out of detention.*	
Guilty	***Definition**: Feel bad for doing something.* ***Example**: Stealing from parents or friends.*	

f) Identification of feelings (handout)

Describe a time in your life when you felt the most happy, sad, scared, etc. Rate how you feel most of the time on a scale from 1 to 10, in the last box (1 = hardly ever; 10 = all the time).

Happy		
Sad		
Scared		
Lonely		
Hurt		
Frustrated		
Fearful		
Loved		
Angry		
Anxious		
Guilty		

g) Substance dependence (clinician's copy)

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. [Drug use for the past 12 months that causes problems. Make sure clients are aware they need to have three or more of the seven in order to have this diagnosis.]

1. Tolerance, as defined by either of the following:
   a. A need for markedly increased amounts of the substance to achieve intoxication or desired effects. **[*Use more to get the same effect, consume 10 drinks to get as drunk as 5 drinks used to take.*]**
   b. Markedly diminished effect with continued use of the same amount of the substance. **[*Drugs/alcohol has little effect, a joint doesn't get you high anymore.*]**

2. Withdrawal, as manifested by either of the following:
   a. The characteristic withdrawal syndrome for the substance. **[*Typical withdrawal symptoms. Alcohol—headache, sweating, nausea, hand tremors, vomiting.*]**
   b. The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms. **[*Keep on drinking to avoid headache, methadone to replace heroin.*]**

3. The substance is often taken in larger amounts or over a longer period than was intended. **[*Planning only to use on the weekend and end up using every day. Plan to drink a 40 ounce, end up drinking three 40 ounces.*]**

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use. **[*Try to use less, but can't. Tell yourself only going to smoke weed one time per day.*]**

5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects. **[*A lot of time looking for drugs. Coming down off methamphetamines.*]**

6. Important social, occupational, or recreational activities are given up or reduced because of substance use. **[*Give up fun activities. Quit sports team, band, etc.*]**

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 exacerbated by the substance. **[*Know drugs causing problems but keep on using. Losing weight but still using cocaine.*]**

*Adapted from the DSM-IV (American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association, 1994).

h) Substance abuse (clinician's copy)

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. **[*Drug use in the past 12 months that caused problems. Only need one or more of the four.*]**

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home. **[*Poor grades. Late for work. Not doing chores.*]**

2. Recurrent substance use in situations in which it is physically hazardous. **[*Continued use in dangerous situations, drinking and driving.*]**

3. Recurrent substance-related legal problems. **[*Arrested a few times because of substance use.*]**

4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance. **[*Chronic problems with people due to substance use. Arguments with family.*]**

SUGGESTIONS:

- Make the clients aware that a person can be either Substance Dependent or Substance Abuser, but not both.
- Substance Abuse is only used if the person does not qualify for Substance Dependence.
- The criteria for Substance Abuse are recurrent, happening more than once.
- One difference between Substance Dependence and Substance Abuse is that the dependent person makes an attempt to quit or cut down use.
- The abusing person has legal consequences, the dependent person does not.
- The substance abuser is often a binge type of user, versus the dependent person whose use is more habitual.
- The dependent person often learns how to function while impaired by substances, i.e., functional alcoholic.

*Adapted from the DSM-IV (American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association, 1994).

i) Substance dependence (handout)

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 effects.
   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.
   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 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, use the substance, 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 exacerbated by the substance.

*Adapted from the DSM-IV (American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association, 1994).

j) Substance abuse (handout)

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.

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

2. Recurrent substance use in situations in which it is physically hazardous.

3. Recurrent substance-related legal problems.

4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

*Adapted from the DSM-IV (American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. Washington, DC: American Psychiatric Association, 1994).

k) Timeline processing guide (clinician's copy)

(Refer to timeline example)

Explain to the client that the timeline is a way of getting a brief and comprehensive view of the client's life in regard to school, drugs, relationships, and traumas. The timeline is an assessment instrument of sorts, gathering information regarding themes in the client's life and the behavioral implications of those themes.

School. The school line provides a relatively low intrusive level of inquiry and therefore is more suitable to begin a dialog. Make observations regarding the client's progress in school. Pay close attention to instances of violence or drug use during school. The client needs to identify how drug use caused problems at school, in order to build the correlation between drug use and poor academic achievement.

- Have the client identify which school he first attended. This serves as a gauge of the client's ability to recall the past, and to begin a dialog in a non-threatening manner.
- Have the client identify the reason(s) for changing schools at 7 years old. Find out if the change was voluntary or involuntary. Discuss how the change in school affected client.
- Have the client identify the reasons for his fighting in school at 7½ years old. Have the client discuss what things triggered increasing incidents of his fighting at school. The clinician is looking for the client to identify stress in the client's life. Further, the clinician is seeking to understand the client's response to stress.
- Have the client discuss what precipitated a decrease in his academic performance at around 10 years old. The clinician is helping the client make a connection between decreasing academic performance and some life event, most likely the use of marijuana and the change in peer groups. It is important for the client to understand factors that contribute to poor academic standing. All too often clients are told that they are not smart enough for school, when in fact the client is preoccupied with other life matters. Therefore, the client's academic success may not be a result of innate ability, but of motivation or poor behavioral control.
- Have the client explore the causes of violence at school, and how violence negatively impacted his academic progress. Strive to find sources of behavioral dysfunction manifested at school. This is where the clinician may offer alternatives to violence.
- Have the client discuss the experience of not being in school. Examine if a lack of schooling is a problem to the client and does the client want to go back to school.

Drugs. Make note of how the client's pattern of drug use impacts or was impacted by life events.

- Have the client identify whom he had the alcohol with at age 7.
- Have the client discuss the reasons for drinking alcohol more frequently from ages 7 to 10. If the client's response is "because I liked it," probe deeper.
- Have the client identify who was around when he tried marijuana for the first time at age 10. Explore if the change in peer group facilitated the experimentation with

marijuana. Have the client explore the reasons for continuing marijuana use. The goal is for the client to gain insight into the pattern of drug use, by associating issues that are present during periods of drug use (for example, coping with sexual abuse at age 9, or coping with mother's drinking).

- Have the client identify who was around when he tried cocaine and crystal methamphetamine at about 11 years old. Again, the clinician is looking for peer influences on drug experimentation.
- Have the client explore the increase in crystal methamphetamine use and the decrease in marijuana use. Identify what the client liked about crystal meth during this period of his life. Additionally, the clinician is looking for examples of the client's change in behavior patterns as a result of increasing crystal meth usage (for example, the client's increase in fighting).
- Have the client explore what precipitated the increase in marijuana use and decrease in crystal meth use. For example, the client may have needed to control his aggressive behaviors, and marijuana effectively numbed his aggressions.
- Have the client identify who was present when he first tried LSD and Ketamine at age 16. Searching for peer influences on drug experimentation.

Relationships. Make note of how the client interacts with parents, peers, or authority figures. Observe for drug use affecting or being affected by client's relationships.

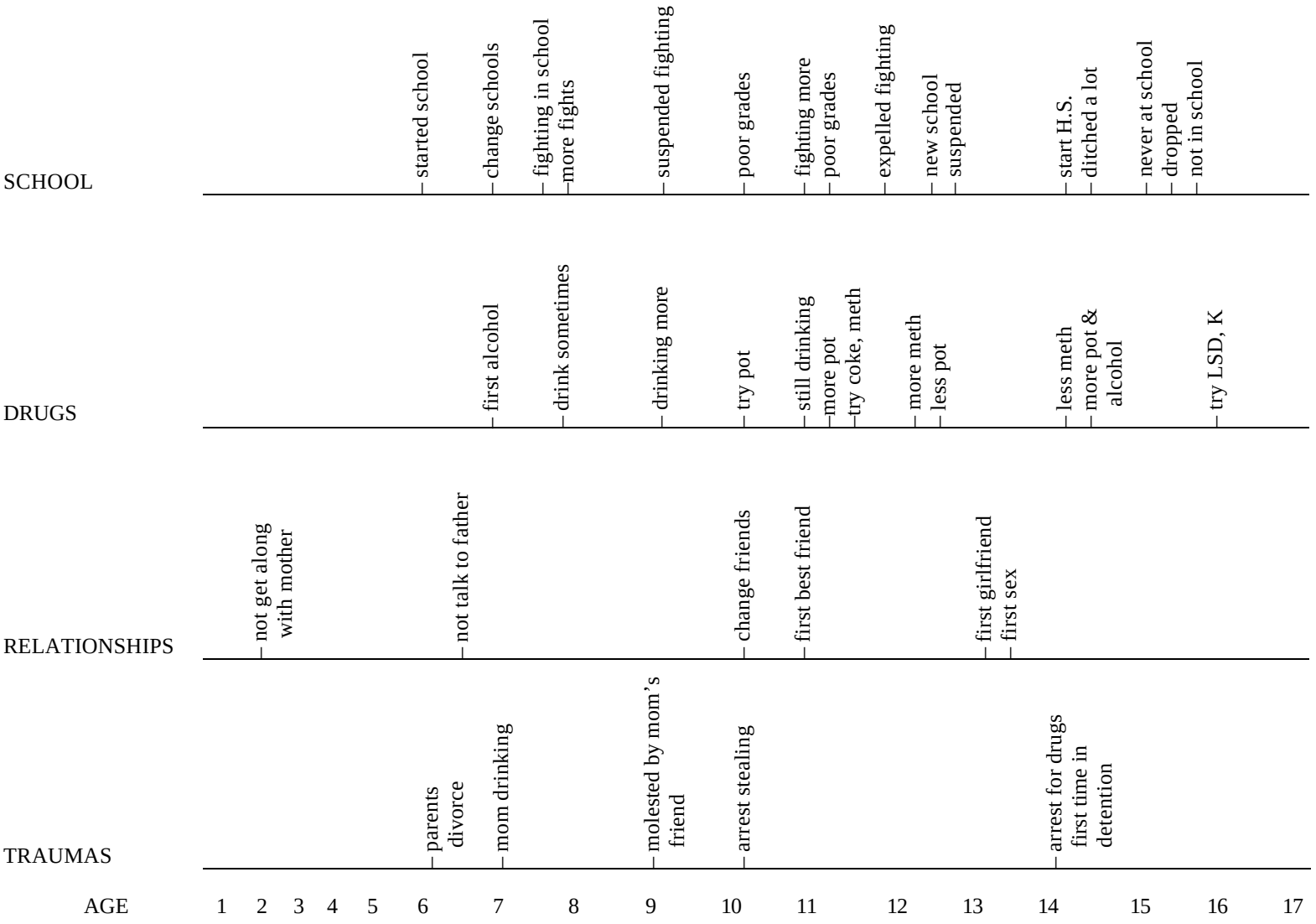
- Have the client identify what caused conflicts with his mother at age 2. Have client explore his poor relationship with his mother.
- Have the client explore how not having contact with his father impacted his life. The clinician will make a mental note of who serves as the male figure in the client's life.
- Have the client discuss what precipitated a change in friends at age 10, and how did his new peer group impact his behavior.
- Have the client discuss his best friend and the status of their relationship. Method of assessing if the client is able to maintain social relationships.
- Have the client discuss his first girlfriend. Explore if the relationship involved drug use.
- Have the client discuss his first sexual experience. The clinician will look for whether or not the first sexual experience was voluntary.

Traumas. Make note of significant life events that changed the client's patterns of drug use. Observe the behaviors exhibited by the client following a traumatic event.

- Have the client explore how the divorce of his parents affected his life then and now.
- Have the client explore how this mother's drinking impacted on his life at age 7, and presently (for example, does the client harbor resentment toward his mother for not being available for nurturing).
- Have the client explore his sexual molestation at age 9. Assess for a need for continuing interventions regarding sexual abuse.
- Have the client explore his first time being arrested at age 10. Make mental notes of drug use or peer influence involved in arrest.

- Have the client explore his second arrest and subsequent incarceration at the local juvenile detention center.

l) Timeline example



m) Timeline directions

1. Think about events in your life as they relate to School, Drugs, Relationships, and Traumas (*see descriptions below*).

2. Number from age 1 up to your present age.

3. Write your life events on the line that is appropriate.

4. Make sure your life events match up to your age (*see timeline example*).

*Hint. Give yourself enough room between ages to briefly describe the events.

School. Briefly describe significant events that have happened to you while at school. For example: changing schools, grade changes, suspensions.

Drugs. Identify the age you first tried each drug. Report any changes in drug use. For example: started using more or less and stopped using altogether.

Relationships. Briefly describe relationships you had. For example: first girlfriend/boyfriend, how you got along with parents, friends.

Traumas. Briefly describe events that had, or continue to have, an effect on you. For example: divorce of parents, victim of abuse, dog died.

n) Genegram processing guide (clinician's copy)

(Refer to genegram example)

The clinician will begin by explaining the purpose of the genegram, as a tool to observe patterns of family drug use and behavioral dysfunction, to the client. The clinician must bear in mind that often the client's primary source of family information comes from the parents. Therefore, the clinician will explore the consistency of the information given by the client. Further, the clinician will need to have the client describe the labels given to the family members in behavioral terms. A client might verbalize "my mom is depressed" but be unable to describe the depression. The clinician will have the client explore the mother's depression in behavioral terms, examples being spells of crying, poor appetite, and lethargy.

Maternal grandfather

- 60 years old.
- Alcoholic and violent.
- Have the client identify how the maternal grandfather is violent and his pattern of alcohol use.

Maternal grandmother

- 58 years old.
- Alcoholic and depressed.
- Have the client describe the maternal grandmother's use of alcohol and her behaviors that indicate depression.

Paternal grandmother

- 63 years old.
- Victim of sexual trauma, depressed, addicted to pain pills.
- Identify the pills the grandmother is addicted to.

Paternal grandfather

- 65 years old.
- Alcoholic and violent.
- Have the client explore the pattern of alcohol use and violence.

Maternal aunt

- 39 years old.
- Victim of sexual trauma, depressed, alcoholic.
- Ask the client to describe behaviors of the aunt that indicate depression and alcoholism.

Mother

- 37 years old.
- Depressed, alcoholic, marijuana addict, cocaine addict.
- Have the client describe the mother's pattern of drug use (i.e., how much and how often).
- Describe the mother's behavioral indicators of depression.
- Examine how the mother's drug use impacts the client's functioning.

Maternal uncle

- 33 years old.
- Marijuana addict, crystal methamphetamine addict, alcoholic, violent.
- The client will describe the maternal uncle's pattern of drug use.
- Witness to any violence by the maternal uncle and, if so, what effects have the violence caused.

Maternal aunt

- 28 years old.
- Depressed, victim of sexual trauma, eating disorder.
- Have the client describe the behavioral observations regarding depression and an eating disorder in the maternal aunt.

Father

- 41 years old.
- Violent, alcoholic, marijuana addict, cocaine addict.
- Get behavioral observations of the father's pattern of drug use and violence.
- Explore how the father's drug use and violent behaviors impact the client's functioning.

Paternal uncle

- 40 years old.
- Violent, addicted to cocaine.

Paternal uncle

- 37 years old.
- Depressed, mentally ill, crack cocaine addiction.
- Describe the mental illness.

Brother

- 20 years old brother.
- Violent, addicted to marijuana, LSD, alcohol, and cocaine.
- Examine the relationship between the client and the older brother in regard to drug use and violence.

Client

- 16 years old.
- Violent, addicted to marijuana, K, alcohol, and crystal methamphetamine.
- Find correlation between his pattern of drug use and his family's pattern of drug use.
- Explore prevalence of violence within the family.

Sister

- 10 years old.
- Depressed.
- Describe how the sister is depressed, in behavioral terms.

o) Genegram directions

1. Use a “box” to represent males and a “circle” to represent females.

2. Start from your grandparents and continue downward to your self (*see example*).

3. Give labels to each person (s*ee “labels”*), even if deceased.

4. List the age of the person. If the person is deceased, you will not need to list an age.

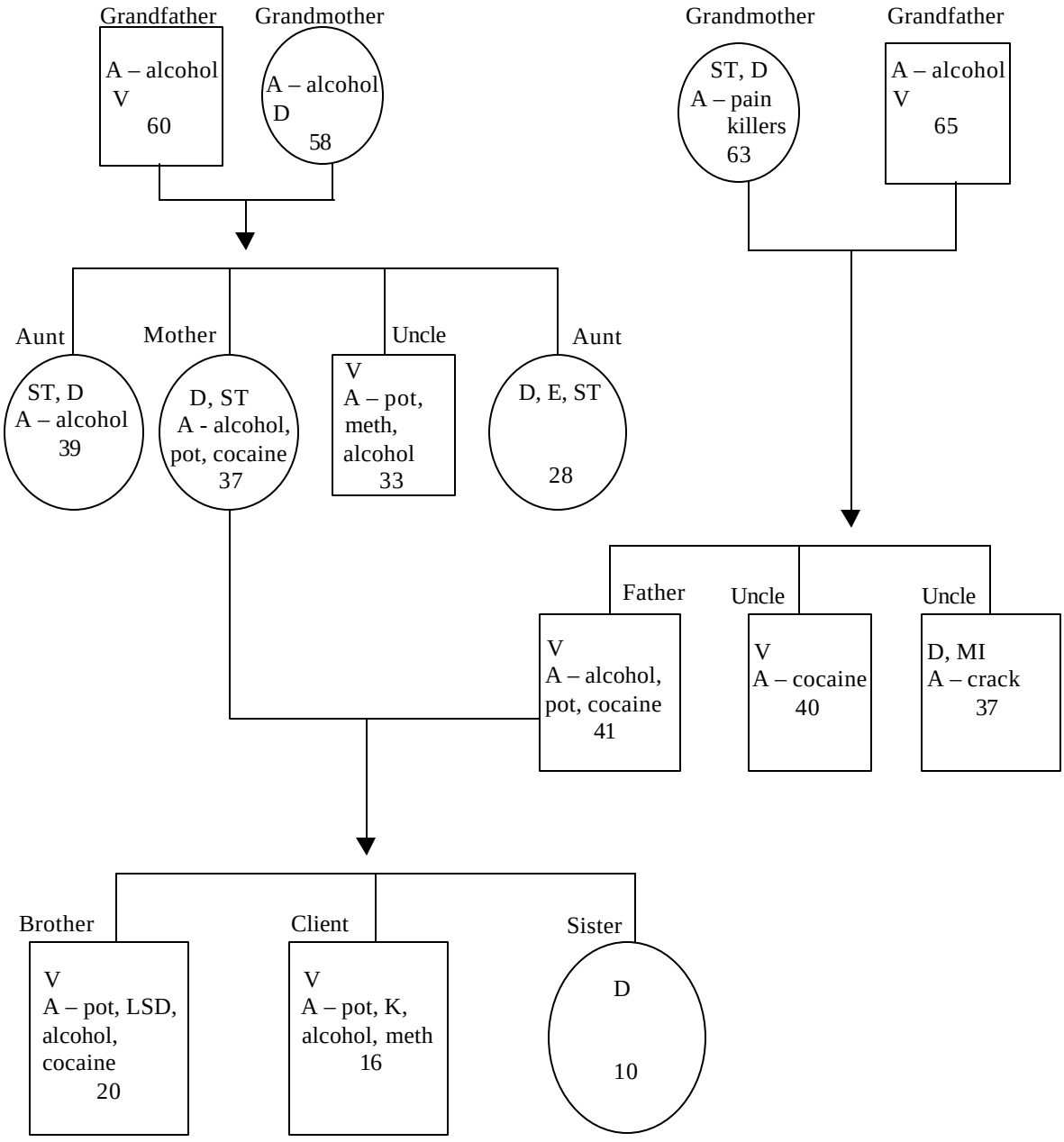
5. Draw a circle around the labels that no longer apply, for example, a parent who used to drink alcohol but does not drink any more.

6. Draw lines from your self to your immediate family members whom you have a lot of contact with, to show how you get along with them (*see “level of relationship” below*).

Labels:
A – addiction, person can’t control behaviors. Specify the addiction(s).
V – violence, the person is violent to others physically and verbally.
D – depression, the person seems sad most of the time.
E – eating disorder, the person eats too much or too little, or vomits up food on purpose.
ST – sexual trauma, the person was or is a victim of sexual abuse.
MI – mental illness, the person has trouble with reality (schizophrenia, major depression).

Level of relationship:
Distant - - - - -
Close ----------
Very close ==========
Conflicting ……..

p) Genegram example



- The genegram begins with the grandparents, proceeds to parents and aunts/uncles, then to client and siblings.
- Process how addiction and violence is prevalent in the family.
- Explore family dynamics.
- *Note: the levels of relationships are not present on this example*.

q) Body map processing guide (clinician's copy)

(Refer to body map sample)

Explain to the client that the body map is used to explore where the client experiences his feelings and where the drugs are experienced. The purpose is for the client to gain insight into how drug use is related to feelings. It may be necessary for the client to recall a time in his life when he experienced these feelings and drugs. Additionally, this exercise is an effective method for later work with body awareness.

- The client reports experiencing **Happy** in his head and chest. The client may say something like "it feels good" or "my head feels light." The clinician will need to further explore what "good" means to the client, in physical terms (for example, relaxation in his chest).

- The client reports experiencing **Sad** in his chest and stomach. Have the client explore what the experience of Sad is like in his chest and stomach. The client may say "I feel empty in my chest" or "I feel sick in my stomach." Have the client describe the sickness, shape, texture, etc.

- The client reports experiencing **Scared** in his arms and legs. The client may describe Scared as "tingling in my arms" or "shaking in my legs."

- The client reports experiencing **Lonely** in his chest. The client may describe Lonely as "feeling empty" or "nothingness in my chest." The clinician may want to follow up and explore the dimensions of the " nothingness." The clinician may want to have the client explore how drugs interact with the nothingness.

- The client reports experiencing **Hurt** in his chest. The client may describe Hurt as "a pain in my chest." The clinician will need to follow up and have the client exactly describe the pain (for example, is the pain sharp or dull, cutting or tearing, etc.). Examine what drugs affect the pain in the client's chest.

- The client reports experiencing **Guilty** in his chest. The client will need to explore what happens, physically in his chest, when he feels Guilty. The client may say "I feel tightness in my chest." Explore what drugs loosen the tightness in his chest.

- The client reports feeling **Angry** in his arms and legs. The clinician may want to explore what the client does with the Anger in his arms and legs. The client may respond "kick peoples' asses" or "I punch walls." Discuss what happens to his arms and legs when he gets angry (i.e., muscle contractions).

- The client reports experiencing **Frustrated** in his arms and legs. The clinician will need to have the client explore what physically happens when the client becomes Frustrated (for example, tension in the muscles, shaking or uncontrolled movements).

Now have the client explore where he experienced the drugs in his body. The client will need to describe the experience of the drug on the body part affected.

- The client reports experiencing **Marijuana** in his head and chest. The client may say "my head feels good." Make sure the client puts the experiences in terms of physical descriptions. The client may verbalize "I can't breathe as good from smoking marijuana." This is not the type of response the clinician may be looking for, but it is an opportune time to reinforce how marijuana use negatively impacts health.

- The client reports **Alcohol** as being experienced in his legs and head. Have the client explore how the alcohol is experienced. The client might say something like "it makes my legs feel heavy," "I can't walk," or "I can't feel my head." Have the client explore the numbing effects of alcohol within his body.

- The client reports experiencing **LSD** in his head. The clinician will make sure the client explores the physical experience of LSD, like a loosening of his mind.

- The client reports the experiencing **Cocaine** in his chest. The client may describe an experience like "my hearts beats fast." Have the client examine how the fast beating of his heart is in contrast to the nothingness of lonely and the pain of hurt.

- The client reports experiencing **Methamphetamines** in his legs and arms. The client may describe methamphetamines as "energy in his arms and legs." Have the client discuss what happens when his anger in his arms and legs combines with his "energy" of methamphetamine use.

r) Body map directions

1. Draw an outline image of yourself. You may include such items as clothing, glasses, jewelry, etc.

2. List these feelings on your paper: happy, sad, scared, lonely, hurt, guilty, angry, and frustrated. Next, create symbols for each of these feelings.

3. List all the drugs you have used, even the drugs you have only tried once. Next, create symbols for each of the drugs you have used.

4. Place the symbols representing feelings, on your body map, where you experience the feelings. Place the symbols representing drugs where you experience the drugs.

5. See sample, for a general idea of what the body map should look like.

s) Family roles guide (clinician's copy)

Dependent
- May appear lazy.
- Wants things on own terms.
- Use charm to get what he or she desires.
- Draw focus from family dysfunction.

Co-Dependent
- Attempt to fix or cure family.
- Externally focused.
- Labile mood.
- Low self-worth.

Hero
- Does everything correctly.
- Family's ambassador.
- Private life different than public perception.
- Alone.

Scapegoat
- Focal point of blame for family's dysfunction.
- Angry.
- Candidate for gang involvement.

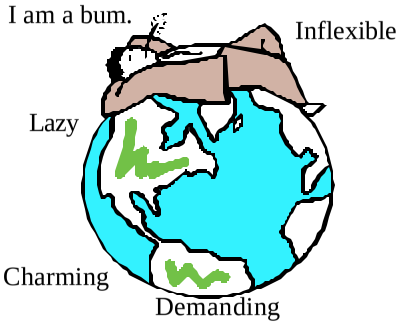
Lost child
- Invisible.
- Lonely.
- Misunderstood.
- One less person to cause dysfunction within family.

Mascot
- Reduce tensions due to family's dysfunction.
- Distraction.
- Childish.

t) Family roles (handout)

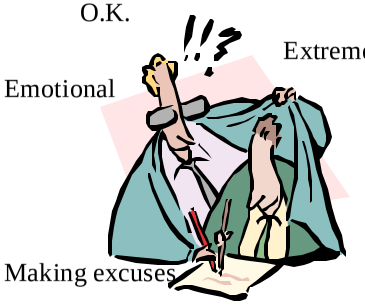
DEPENDENT

I'm scared my family will fall apart.
I sometimes feel guilty for taking advantage of my family.
If my family has to worry about me all the time, then they have to stay together.



CO-DEPENDENT

I feel happy only when my family is happy.
I sometimes get angry about always having to do everything.
I know what is best for my family.
If I keep everyone happy, everything will be O.K.

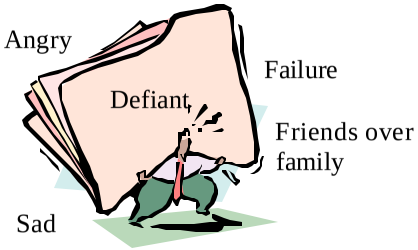


HERO

I am lonely.
I'm not good enough. I'm not better than my family.
If I look good, then people will think good about my family.

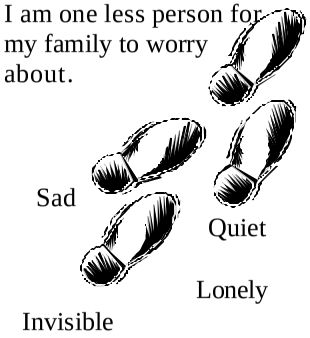
SCAPEGOAT

I am angry with my family. Why do I always get blamed?
I feel like crap.



LOST CHILD

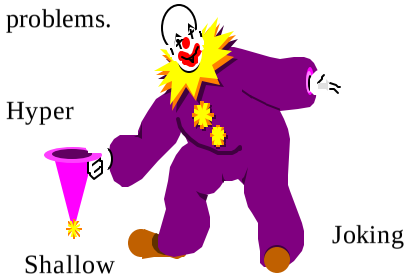
Nobody understands me.
I am so lonely.
I am one less person for my family to worry about.



MASCOT

If I make everyone laugh, then there will be less problems.

I don't know what to feel.



u) Identity/self-worth example

v) Identity/self-concept example

GANGSTER PARADISE

GET MONEY!!

1. Fuck the world
2. If I ruled the world
3. Chronic
4. Fuck the police
5. Big pimpin’
6. Me and my shotgun
7. Can’t get right
8. Ride or die
9. Cash over ass
10. Haters

w) Residential daily schedule

Focus of the Week

There are two areas of focus for every week of the program. The first area of focus is a specific substance or group of related substances, assisting the clients in educating themselves about these substances, as well as exploring issues or consequences related to these substances. The second focus is on different areas of the clients lives that have been affected by their substance use; examples are self-esteem, family and relationships, emotions and feelings, and life management skills.

Focus of the Day

Every day has a focus that is directly related to the focus for the week. For example, a weekly focus of self-esteem would have daily focuses of trust, identity, or self-awareness. Incorporating the daily focus into the daily activities and groups is important so that they can be tied to the weekly focus.

Morning and Bedtime Routines

Routine time and schedules are posted on the wall so that the participants know what is expected of them. Routines are structured to ensure safety and efficiency. Here are some basic guidelines:

<u>Morning routines</u>

- Clients are woken up by staff.
- Clients change clothes, brush teeth, comb hair, and straighten room and bed.
- After the rooms have been checked by staff, clients eat breakfast.
- Staff members are responsible for preparing breakfast, with assistance from clients.
- Breakfast is cleaned up before any other activities are started.

<u>Bedtime routines</u>

- All clients are in their rooms reading, writing, or drawing while they wait to use the shower.
- Clients take a 10-minute shower.
- After showers, they straighten their rooms and get into bed clothes.
- After showers and a room check by staff, the clients have a snack and watch TV.
- After snack and TV, the clients brush their teeth, get drinks, and use the bathroom.
- Quiet time occurs in clients' rooms (reading, writing, or drawing).
- After quiet time, clients have lights out.

It is very important that all staff members are consistent with schedules and guidelines, as well as providing “cues” and “consequences” to clients who are not following the schedule.

Check-In Group or Rap Session

Check-in group occurs every shift and is a vital part of the overall group cohesion. The object of the check-in group is to inform the clients of the daily schedule and expectations for the shift. A good and thorough check-in group ensures that the shift will be good.

Shift Change

Shift change serves two purposes: (1) it allows for some quiet time among the clients for reflection, homework, reading, writing, or drawing, and (2) it provides staff members with an opportunity to do paperwork, exchange information, and plan the next shift. Shift change is imperative and mandatory.

Meal Times

Meal times are very important to the structure of the house, as they provide the opportunity for the staff to model appropriate life skills. Staff members prepare every meal according to the menus and encourage clients to get involved if possible. Involvement helps to build rapport with the client as well as teach life management skills. The meals follow the time schedule. Consideration must be given to preparation, eating, and clean-up time within the allotted time schedule. When the meal is ready, everyone sits at the table and eats. This helps to build group rapport, and staff members have another opportunity to model appropriate life skills. After the meal, everyone does their chores and is involved in the straightening of the house (including the staff).

Week 1

Weekly Focus

1) Cocaine/Crystal Methamphetamine
   Education includes (1) history of use and (2) physical, (3) psychological, and (4) social effects.

2) Self-Esteem—Clients explore issues and build upon their self-esteem by
   - Trust-strengthening activities
   - Team building and group challenges
   - Self-awareness education
   - Positive message groups
   - Gaining and giving respect
   - Defining goals and dreams.

Monday

Daily Focus: Trust-strengthening activities

7:00–8:00	Morning Routines
8:00–9:00	Breakfast/Clean-Up
(9:00 Medication Rounds)	
9:00–9:30	Rap Session
9:30–10:30	Secret Game
10:30–11:15	Substance Group—Introduction Group
	Trust Lunch/Chores
(1:00 Medication Rounds)	
1:00–3:00	CODAC Group
3:00–3:30	Shift Change/Quiet Time
3:30–4:00	Rap Session
4:00–5:30	Mask Making
5:30–6:30	Dinner/Trust Chore
6:30–7:00	Trust Group
(7:00 Medication Rounds)	
7:00–8:45	NA Meeting
8:45–9:15	Bedtime Routines
9:15–9:30	Quiet Time
9:30	Lights Out

Tuesday

Daily Focus: Team building

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Substance Group (Physical Effects Group)
10:30–11:30 Indoor/Outdoor Challenge
11:30–12:30 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
4:00–5:00 Indoor/Outdoor Challenge
5:00–6:00 Dinner/Chores
6:00–7:00 Group Game/Gym Time
(7:00 Medication Rounds)
7:00–8:00 AA Meeting
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Wednesday

Daily Focus: Self-Awareness

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Gender Group
10:30–12:00 Group Awareness
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 Body Mapping
2:00–3:00 Shift Change/Quiet Time (have clients continue working on body maps)
3:00–3:30 Rap Session
3:30–4:30 Substance Group (Psychological Effects Group)
4:30–5:30 Mask Painting
5:30–6:30 Dinner/Chores
6:30–7:30 Body Mapping Process Group
(7:00 Medication Rounds)
7:30–8:00 Group Game
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Thursday

Daily Focus: Identity

7:00–7:45 Morning Routines
7:45–8:30 Breakfast/Clean-Up
8:30–8:45 Rap Session
9:00–11:00 Ropes Groups
11:30–12:30 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
(4:00–6:00) Nursing Assessments (AzCA)
4:00–5:00 Family Portrait
5:00–6:00 Dinner/Chores
6:00–7:30 Family Portrait Process Group
(7:00 Medication Rounds)
7:30–8:30 Computer/Study Time—Project FIRST
Bedtime Routines
9:15–9:30 Quiet Time
9:30 Lights Out

Friday

Daily Focus: Positive Routines

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–11:00 Mask Sharing
11:00–12:00 Message Group
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 Library Club/Field Trip
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
4:00–5:00 Substance Group (Social Effects Group)
5:00–6:00 Dinner/Chores
6:00–8:00 Movie Night
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Saturday

Daily Focus: Respect

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–10:00 AA House Meeting
10:00–10:30 Rap Session
10:30–12:00 Respect Group
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 Board Games
2:00–4:00 Shift Change/Family Visits/Recreation Time
4:00–4:30 Rap Session
4:30–5:30 Dinner/Chores
5:30–6:30 Substance Group (Week Review)
6:30–8:00 Recreation Night
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Sunday

Daily Focus: Goals and Dreams

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
(9:00–11:00) Nursing Assessments (at AzCA)
9:30–11:00 Nature Club
11:00–12:00 Autobiography (Past-Present-Future)
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 Goals Group
2:00–4:00 Shift Change/Family Visits/Recreation Time
4:00–4:15 Rap Session
4:15–5:00 Super House Clean
5:00–6:00 Dinner/Chores
6:00–8:00 Week Wrap-Up/Presentations
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Week 2

Weekly Focus

1) Alcohol
   Education provided regarding (1) history of use and (2) physical, (3) psychological, and (4) social effects.

2) Relationships/Family—Clients explore relationships and family situations through
   - Communications-building activities
   - Problem-solving activities
   - Cultural awareness
   - Understanding prejudice and discrimination
   - Sexual awareness education
   - Identifying morals and values
   - Exploring family history.

Monday

Daily Focus: Communication

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Substance Group (Introduction Group)
10:30–12:00 Charades/Role Play
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Rap Session
3:30–4:30 Telephone Game
4:30–5:00 Debate
5:00–6:00 Dinner/Chores
6:00–7:00 Debate
(7:00 Medication Rounds)
7:30–8:30 NA Meeting
8:30–9:15 Bedtime Routines
9:15–9:30 Quiet Time
9:30 Lights Out

Tuesday

Daily Focus: Problem Solving

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Role Play
10:30–11:30 Indoor/Outdoor Challenge
11:30–12:30 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
4:00–5:00 Substance Group (Physical Effects Group)
5:00–6:00 Dinner/Chores
6:00–7:00 Mystery Game
(7:00 Medication Rounds)
7:00–8:00 AA Meeting
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Wednesday

Daily Focus: Cultures and Traditions

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Cultural Identification Group
10:30–12:00 Substance Group (Psychological Effects Group)
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 Cultural Arts
2:00–3:00 Shift Change/Quiet Time
3:00–3:30 Rap Session
3:30–5:00 Cultural Sharing
5:00–6:00 Dinner/Chores
6:00–8:00 Cultural Event
(8:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Thursday

Daily Focus: Prejudice and Discrimination

7:00–7:45 Morning Routines
7:45–8:30 Breakfast/Clean-Up
(8:00 Medication Rounds)
8:30–8:45 Rap Session—Tag Exercise
9:00–11:00 Ropes Group
11:30–12:30 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
(4:00–6:00) Nursing Assessments (at AzCA)
4:00–5:00 Discrimination Group (Types)
5:00–6:00 Dinner/Chores
6:00–7:30 Our Own Prejudices
(7:00 Medication Rounds)
7:30–8:30 Computer/Study Time—Project FIRST
AA Meeting
9:15–9:30 Bedtime Routines
9:30 Lights Out

Friday

Daily Focus: Sexual Awareness

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 HIV/AIDS Group
10:30–11:00 Sex Feud
11:00–12:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 Library Club/Field Trip
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
4:00–5:00 STD Group
5:00–6:00 Dinner/Chores
6:00–8:00 Movie Night
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Saturday

Daily Focus: Morals and Values

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–10:00 AA House Meeting
10:00–10:30 Rap Session
10:30–11:30 Lifeboat Ethics
11:30–12:00 Morals/Values Survey
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 Substance Group (Week Review)
2:00–4:00 Shift Change/Family Visits/Recreation Time
4:00–4:30 Rap Session
4:30–5:30 Dinner/Chores
5:30–6:30 Family Crest
6:30–8:00 Recreation Night
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Sunday

Daily Focus: Family History

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
(9:00–11:00) Nursing Assessments (at AzCA)
9:30–11:00 Nature Club
11:00–12:00 Family House
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 Family Roles
2:00–4:00 Shift Change/Family Visits/Recreation Time
4:00–4:15 Rap Session
4:15–5:00 Super House Clean
5:00–6:00 Dinner/Chores
6:00–8:00 Week Wrap-Up/Presentation
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Week 3

Weekly Focus

1) Hallucinogens
   Education includes (1) history of use and (2) physical, (3) psychological, and (4) social effects.

2) Life Management—Clients learn and practice life skills through
   - Hygiene and manners education
   - Identifying jobs and careers
   - Money-budgeting exercises
   - Learning and practicing home skills
   - Exploring school and education
   - Planning and organizing practice
   - Identifying hobbies and interests.

Monday

Daily Focus: Hygiene and Manners

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
10:30–12:00 Hygiene Education
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Rap Session
3:30–4:30 Substance Group (Introduction Group)
4:30–5:30 Dinner/Chores
5:30–7:00 Hygiene Jeopardy
(7:00 Medication Rounds)
7:30–8:30 NA Meeting
8:30–9:15 Bedtime Routines
9:15–9:30 Quiet Time
9:30 Lights Out

Tuesday

Daily Focus: Jobs and Careers

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Career Quiz/Job Resources
10:30–11:30 Applications/Interviews
11:30–12:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
4:00–5:00 Substance Group (Physical Effects Group)
6:00–7:00 Work Ethics
(7:00 Medication Rounds)
7:00–8:00 AA Meeting
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Wednesday

Daily Focus: Money and Budgeting

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Budget Your Day
10:30–12:00 Substance Group (Psychological Effects Group)
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 Checking and Savings Account
2:00–3:00 Shift Change/Quiet Time
3:00–3:30 Rap Session
3:30–5:00 Budgeting and Shopping
5:00–6:00 Dinner/Chores
6:00–7:30 Build a Tower Game
7:30–8:00 Budget Your Day (Process Group)
(8:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Thursday

Daily Focus: Home Skills

7:00–7:45 Morning Routines
7:45–8:30 Breakfast/Clean-Up
(8:00 Medication Rounds)
8:30–8:45 Rap Session
9:00–11:00 Ropes Group
11:30–12:30 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
(4:00–6:00) Nursing Assessments (at AzCA)
4:00–5:00 NA Meeting
5:00–6:00 Dinner/Chores
6:00–7:30 Process Group
(7:00 Medication Rounds)
7:30–8:30 Computer/Study Time—Project FIRST
Bedtime Routines
9:15–9:30 Quiet Time
9:30 Lights Out

Friday

Daily Focus: School and Education

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:00 How Do You Learn?
10:00–11:00 Substance Group (Social Effects Group)
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 Library Club/Field Trip
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
4:00–5:00 Education and Careers
5:00–6:00 Dinner/Chores
6:00–8:00 Movie Night
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Saturday

Daily Focus: Planning and Organizing

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–10:00 AA House Meeting
10:00–10:30 Rap Session
10:30–11:30 TBD
11:30–12:00 TBD
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 Substance Group (Week Review)
2:00–4:00 Shift Change/Family Visits/Recreation Time
4:00–4:30 Rap Session
4:30–5:30 Dinner/Chores
5:30–6:30 TBD
6:30–8:00 Recreation Night
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routine
9:00–9:30 Quiet Time
9:30 Lights Out

Sunday

Daily Focus: Hobbies and Interests

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
(9:00–11:00) Nursing Assessments (at AzCA)
9:30–11:00 Nature Club
11:00–12:00 TBD
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 TBD
2:00–4:00 Shift Change/Family Visits/Recreation Time
4:00–4:15 Rap Session
4:15–5:00 Super House Clean
5:00–6:00 Dinner/Chores
6:00–8:00 Week Wrap-Up/Presentations
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Week 4

Weekly Focus

1) Marijuana
   Education including (1) history of use and (2) physical, (3) psychological, and (4) social effects.

2) Emotions and Feelings—Clients explore their emotions and feelings through
   - Emotional identification exercises
   - Emotional expression exercises
   - Anger management techniques
   - Grief and loss processing
   - Love and commitment discussions
   - Conflict resolution techniques
   - Self-fulfillment exercises.

Monday

Daily Focus: Identifying Emotions

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Substance Group (Introduction Group)
10:30–12:00 Emotions Identification
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Rap Session
3:30–4:30 Group Emotions
4:30–5:00 Debate Preparation
5:00–6:00 Dinner/Chores
6:00–7:00 TBD
(7:00 Medication Rounds)
7:30–8:30 NA Meeting
8:30–9:15 Bedtime Routines
9:15–9:30 Quiet Time
9:30 Lights Out

Tuesday

Daily Focus: Expressing Emotions

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Emotions Group
10:30–11:30 Process Emotions Group
11:30–12:30 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
4:00–5:00 Substance Group (Physical Effects Group)
5:00–6:00 Dinner/Chores
6:00–7:00 Mystery Game
(7:00 Medication Rounds)
7:00–8:00 AA Meetings
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Wednesday

Daily Focus: Anger Management

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 Discussion of Anger
10:30–12:00 Substance Group (Psychological Effects Group)
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 CODAC Group
2:00–3:00 Shift Change/Quiet Time
3:00–3:30 Rap Session
3:30–5:00 TBD
5:00–6:00 Dinner/Chores
6:00–8:00 TBD
(8:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Thursday

Daily Focus: Grief and Loss

7:00–7:45 Morning Routines
7:45–8:30 Breakfast/Clean-Up
(8:00 Medication Rounds)
8:30–8:45 Rap Session
9:00–11:00 Ropes Group
11:30–12:30 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 CODAC Group
3:00–3:00 Shift Change/Quiet Time
3:30–4:00 Rap Session
(4:00–6:00) Nursing Assessments (at AzCA)
4:00–5:00 TBD
5:00–6:00 Dinner/Chores
6:00–7:30 TBD
(7:00 Medication Rounds)
7:30–8:30 Computer/Study Time—Project FIRST
Bedtime Routines
9:15–9:30 Quiet Time
9:30 Lights Out

Friday

Daily Focus: Love and Commitment

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
9:30–10:30 CODAC Group
10:30–11:00 TBD
11:00–12:00 Substance Group (Social Effects Group)
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–3:00 Library Club/Field Trip
3:00–3:30 Shift Change/Quiet Time
3:30–4:00 Rap Session
4:00–5:00 TBD
5:00–6:00 Dinner/Chores
6:00–8:00 Movie Night
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Saturday

Daily Focus: Morning Routines

7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–10:00 AA House Meeting
10:00–10:30 Rap Session
10:30–11:30 Nature Time
11:30–12:00 TBD
12:00–1:00 Lunch/Chores
(1:00 Medication Rounds)
1:00–2:00 Substance Group (Week Review)
2:00–4:00 Shift Change/Family Visits/Recreation Time
4:00–4:30 Rap Session
4:30–5:30 Dinner/Chores
5:30–6:30 TBD
6:30–8:00 Recreation Night
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out

Sunday

Daily Focus: Self-Fulfillment
7:00–8:00 Morning Routines
8:00–9:00 Breakfast/Clean-Up
(9:00 Medication Rounds)
9:00–9:30 Rap Session
(9:00–11:00) Nursing Assessments (at AzCA)
9:30–11:00 Nature Club
11:00–12:00 TBD
12:00–1:00 Lunch Chores
(1:00 Medication Rounds)
1:00–2:00 Nature
2:00–4:00 Shift Change/Family Visits/Recreation Time
4:00–4:15 Rap Session
4:15–5:00 Super House Clean
5:00–6:00 Dinner/Chores
6:00–8:00 Week Wrap-Up/Presentations
(7:00 Medication Rounds)
8:00–9:00 Bedtime Routines
9:00–9:30 Quiet Time
9:30 Lights Out