

# ACC

**The Assertive Continuing Care Protocol:  
A Clinician's Manual for Working with Adolescents After  
Treatment of Alcohol and Other Substance Abuse Disorders**

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**Second Edition**

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## **Acknowledgments, Disclaimer, and Contact Information**

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This is the second edition of the original manual, which was initially published in December 2001. We want to acknowledge that this work was built directly on an earlier manual about case management with adolescent substance abusers, *A Case Manager's Manual for Working with Adolescent Substance Abusers* (Godley, 1995) published by Lighthouse Institute. We also want to note that this manual is designed to be used together with another treatment manual, *The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users* (Godley, Meyers, Smith, Karvinen, Titus, Godley, Dent, Passetti, & Kelberg, 2001) published by the Center for Substance Abuse Treatment.

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The opinions expressed in this document are solely those of the authors and do not represent official positions of NIAAA or any other governmental agency.

This manual can be ordered from Chestnut Health Systems (<http://www.chestnut.org>). Please contact Dr. Mark Godley at [mgodley@chestnut.org](mailto:mgodley@chestnut.org) with technical questions about ACC, this manual, or related studies.

### **Publications Related to the Assertive Continuing Care Protocol Study**

Dennis, M.L., Funk, R.R., Godley, S.H., Godley, M.D., & Waldron, H. (2004). Cross validation of the alcohol and cannabis use measures in the Global Appraisal of Individual Needs

(GAIN) and Timeline Followback (TLFB; Form 90) among adolescents in substance abuse treatment. *Addiction*, 99, 120-128.

Garner, B.R., Godley, M.D., Funk, R.R., Dennis, M.L., & Godley, S.H. (in press). The impact of continuing care adherence on environmental risks, substance use and substance-related problems following adolescent residential treatment. *Psychology of Addictive Behaviors*.

Godley, M.D., & Godley, S.H. (in press). Continuing care following residential treatment: History, current practice, critical issues, and emerging approaches. In N. Jainchill (ed.), *Understanding and treating adolescent substance use disorders*. Kingston, NJ: Civic Research Institute.

Godley, M.D., Godley, S.H., Dennis, M.L., & Funk, R.R., & Passetti, L.L. (2002). Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment. *Journal of Substance Abuse Treatment*, 23 (1), 21-32.

Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (in press). The effect of assertive continuing care on continuing care linkage, adherence, and abstinence following residential treatment for substance use disorders in adolescents. *Addiction*.

Godley, S.H., Godley, M.D., & Dennis, M.L. (2001). The assertive aftercare protocol for adolescent substance abusers. In E. Wagner & H. Waldron (eds.), *Innovations in adolescent substance abuse interventions* (pp. 311-329). New York: Elsevier Science Ltd.

## **I. What Does “Assertive” Mean in Assertive Continuing Care**

In the early 1970’s, clinical researchers in Wisconsin (Marx, Test, & Stein, 1973) developed a comprehensive approach for providing support and assistance to mental health patients to help them participate in the benefits of independent community living and avoid readmissions to state institutions. This approach, known as Assertive Community Treatment (ACT), was inspirational in the development of Assertive Continuing Care (ACC). As we think about interventions for persons with a substance use disorder, an intervention becomes “assertive” when:

- Clinicians rather than adolescents are responsible for making sure sessions occur;
- Face-to-face sessions are conducted in settings that are convenient for the adolescent and increase the likelihood for service continuity/retention;
- Low client to clinician ratios are maintained to support case management functions as well as counseling; and
- Case management functions include advocacy, barrier reduction, and follow-up to assure participants link to needed services.

The ACC approach is one of several “assertive” interventions available to treat substance use disorders. The more common practice in outpatient clinics requires the adolescent to attend appointments for treatment at the clinic. This practice is logical, efficient, and has worked reasonably well in medicine, but works less well in community treatment of behavioral health problems. It is especially problematic for adolescents for the following reasons: a) lack of public or personal transportation; b) parents who work and cannot take off weekly to drive their child to treatment (if they have personal transportation); and c) the clinic may require extraordinarily long commute times, which serves to decrease attendance. There are a host of other, more psychosocial reasons that could be discussed as well, and of course, low motivation for treatment can be considered on its own or in combination with other attendance barriers.

ACC clinicians accept the fact that most adolescents and their families have a) already been through a recent treatment experience, and b) have competing issues, opportunities, and motivations that will lead to frequently missed or canceled office visits, and therefore, meet with the client/family at their home or other convenient community locations in order to promote recovery.

### **The problem of linkage from primary treatment to continuing care**

Chestnut Health Systems is currently evaluating ACC following primary outpatient treatment; however, published studies to date have focused on ACC following discharge from residential treatment. Clinicians agree that a continuum of care is needed for adolescents discharged from residential treatment and will try to transfer adolescents to another unit within their treatment center for continuing care or refer the adolescent to another organization for continuing care. Executing this continuing care strategy presents clinicians with two significant challenges. First, data from USA-wide government supported treatment programs suggests that fewer than 50% of adolescents are successfully discharged from residential treatment (OAS, 2005). If residential clients run away or are asked to leave for disciplinary reasons, they have a low likelihood of receiving continuing care (Godley & Godley, in press). Second, even those adolescents with a

successful discharge are not especially likely to participate in a continuing care service if the “receiving organization” does not reach out to them to make continuity of care a reality (Godley & Godley, in press).

A traditional practice approach assumes that adolescents have the resources and motivation to attend clinic appointments. Some adolescents or their parents will do this consistently and comply with all or most clinic appointments, but national data suggests that far more will not attend regularly or complete outpatient treatment. Many families who might otherwise be willing to attend will learn that the clinic has a several week wait time for a first appointment, become disheartened and never initiate continuing care.

The ACC clinician overcomes the problem of unplanned discharge by obtaining consent to participate in ACC during the first or second week of treatment. It is also important to obtain permission to contact/exchange information with family members and other service providers at this time. Thus, if adolescents leave prior to completing treatment, an ACC clinician already has permission to contact them and initiate continuing care services. ACC clinicians recognize that the possibility of relapse starts at discharge. Research on adolescents discharged from residential treatment indicates that the highest period of vulnerability to relapse is in the initial days and weeks following discharge. In fact, there is a steady progression of discharged clients who begin using in the first few days after discharge that only begins to level off after about 90 days. By this time, approximately 75 percent will have experienced one or more relapses (Godley, Godley, Dennis, Funk, & Passeti, 2002; in press). Thus, it is important to link adolescents to continuing care as early as possible during the first 90 days in the community and to sustain services throughout the first 90 days following discharge. It is during the initial days and weeks following discharge that ACC clinicians operationalize “assertiveness.” Covering a broad multi-county area in central Illinois, ACC clinicians have been able to link over 90% of all ACC participants, linking 55% within the first week post-discharge.

### **Why should we provide an outpatient continuing care service like ACC for youth who do not complete residential treatment?**

Adolescents who leave residential treatment prior to completion/planned discharge usually leave against staff advice or at staff request. Such unplanned discharges might be considered more appropriately served by another form of residential treatment. In our experience, only a small percentage of youth will enter another residential treatment program within 90 days following an unsuccessful discharge. ACC provides another option to give these youth another opportunity. Given that many of these youth will be under legal pressure to participate in treatment, this could be a very significant opportunity. The ACC clinician provides in-community sessions and helps the youth link to other needed services (including residential for a small percentage). It is always gratifying to see youth who would otherwise fall through the “treatment system cracks” achieve stable recovery or even make progress despite some relapses.

The ACC clinician recognizes that some youth, especially those with unplanned discharges, will be less than enthusiastic about recovery or even seeing a clinician. Such youth will test the ACC clinician’s “assertiveness.” The approach followed by the clinician is to empathize with the adolescent’s plight, to build rapport, by learning more about the adolescents likes, dislikes,



hobbies, and to slowly develop the relationship such that some recovery-oriented work can take place. Training in the Adolescent Community Reinforcement Approach (A-CRA) is very well-suited to building this relationship and engaging in recovery work. Assertiveness under suboptimal conditions means being willing to return often to continue to build a trusting relationship and not to force recovery work but to pursue it in accordance with ACC and A-CRA guidance. With reluctant/resistant clients, the ACC clinician is working harder than the client. In such cases, the clinical supervisor can say to the clinician, “We are going to make every effort consistent with the manuals (ACC and A-CRA manuals) to engage this client for the next 12 weeks. After that time, we will either extend the client if we have found a way to be helpful or offer to help them access another continuing care service, and then close the case.” Time-limited intervention models (e.g., 12 weeks) sound contradictory to new thinking about chronic disease management, and certainly with outpatient practice guidelines that recommend discharge only after the client meets treatment goals. But time-limited models have advantages, too. For example, dropping out of outpatient clinic-based counseling programs is a major problem (clients often stop coming), but by offering a treatment with a fixed ending point, adolescents are more likely to agree to participate because they have clear expectations for their length of involvement. We encourage programs to follow the fixed length model with the option of supervisor-approved extensions when a) negotiated with the client needs; b) to finish a referral; or c) to help resolve a pending issue.

Another important finding about the initial 12-week period of care is found in recent research on both adult and adolescent clients. This research demonstrated that an early period of sustained abstinence (approaching 12 weeks) dramatically increases the odds of remaining abstinent (Higgins, Badger, & Budney, 2000; Godley et al., in press). Given these findings, there is sound clinical logic to use assertive approaches such as ACC to quickly enroll, engage and meet with discharged adolescents and their families during early and often through the first three months of continuing care.

### **Other assertive techniques to use**

In addition to meeting adolescents and their families at their homes, schools, after work, and other places in the community, assertive clinicians also use the telephone as an important tool to reach their clients. ACC clinicians are asked to reach the adolescent by phone once per week in between sessions in order to a) remind the client/parent of the next scheduled session; and b) to review status of “homework” agreed to in the last session. Each telephone call presents an opportunity to reinforce the adolescent for following through with “homework” or to find out what barriers exist to completing the assignment. Telephone calls may also present opportunities to use A-CRA problem solving, relapse prevention, or other procedures. Unannounced home visits are another assertive technique employed if the adolescent has failed to meet on two or more consecutively scheduled sessions. ACC clinicians often find that providing transportation to the client (e.g., to probation meeting, job interview, etc.) not only helps the client address a need, but also has related benefits of strengthening the relationship and providing additional opportunities for A-CRA procedural work.

## Case illustrations of assertiveness in action

This chapter closes with six brief case illustrations contributed by Chestnut ACC clinicians. These vignettes illustrate “assertiveness” by describing how the clinicians reached out to their clients in order to engage them during the three months immediately following discharge from primary treatment. As you read these vignettes, please note the importance of executing releases of information to speak to various family members, friends, and providers associated with clients. To the extent possible such releases should be obtained when you first enroll the client/family in ACC (e.g., during first week of primary treatment).

### Example 1

*Having no other option available, Ada was discharged from residential treatment to her ex-step-dad's trailer. She was 15, pregnant, had a history of being physically abused by her ex step-dad and no other family support. Ada moved three times during the 12 weeks of ACC, the first time after being beaten by step-dad. The way I maintained contact with Ada was through a friend's cell phone where I could leave messages. I also kept in contact with her pregnancy case manager and dropped by her house without an appointment at times if she missed an appointment earlier in the week. Probably the most useful thing I did to engage Ada was to let her know that I could help her get to doctor appointments, help her get items for her baby, and help her achieve emancipated status. I saw Ada 13 times in 14 weeks.*

### Example 2

*Clint was discharged from outpatient treatment successfully. After a week of not being able to get a hold of him, I spoke with his outpatient counselor about the best time to get in touch with the family. I learned that Clint went back and forth between his divorced parents' homes, held a job, and was involved in after school activities. Clint's mom worked two jobs and had not returned my calls to schedule appointments. I contacted the Chestnut student assistance counselor at his high school and set up a meeting to meet him at school. I met with Clint weekly for the next five weeks and then he dropped off again. I succeeded in reaching his mom during this time (two week span), and she filled me in about why he had not been meeting with me (he relapsed). She let me know that he was staying with his dad and provided dad's phone number. I was able to talk with Clint again and set up another meeting with him. I was able to meet with Clint nine times in 12 weeks.*

### Example 3

*Kinda was discharged to her aunt and uncle's home. She was 15 and a heavy drug user with a history of abuse by significant males in her life. Meeting with Kinda was challenging because she didn't have a stable home environment and was rarely ever there. At first we met at a local restaurant. I was able to maintain contact with her through calling her on her cell phone, contacting her aunt, contacting school officials and meeting with her at school. I would take the time to stop by her house or other areas of her neighborhood where I thought she might be when she missed sessions. I provided case management services for issues that she was dealing with*

*such as transportation for her to get to probation meetings and to complete community service hours. I was able to meet with Kinda nine times in 12 weeks.*

#### Example 4

*James ran from residential treatment after being there for several months. He was court ordered to treatment, so a warrant was immediately issued for his arrest. I contacted his parents who both told me they wanted him to return to jail and didn't want anything to do with him. Mom and Dad both said that James wouldn't contact them and they didn't know where he was. His residential counselor recommended calling a grandmother because she was the only family member who visited him while in residential. I called his grandma and built a great rapport with her, but she had no idea where James was either. I gave her my contact number and sent her a letter to give to James if she saw him. I also sent a letter to James' lawyer to give to James if he contacted him. Grandma called several times over 10 weeks to check in or to say that James had called or stopped by her house, but she was never able to convince him to call me. Finally, in week 11, his grandma called to say that James was in juvenile detention. I saw James twice and extended him for two additional weeks. After his release from juvenile detention, I saw him once at his dad's house. During that last session, we talked about a relapse prevention plan and I took him to get job applications. Even though we had only three sessions, he expressed a lot of appreciation and surprise that I would still want to see him after he avoided me for 10 weeks.*

#### Example 5

*Christy ran away from residential treatment after being there less than a month. She went to live with her mom and mom's partner for about six weeks. During that time, I met with Christy weekly and could easily reach her on her cell phone. On one occasion, she didn't show up for an appointment so I went to her home unexpectedly and was able to meet with her. Christy had an argument with her mother and moved in with her grandma for about three weeks and lost her cell phone privileges. I lost contact with her for a week, but was able to reconnect after getting grandma's contact information from mom. Christy and her grandma fought a lot and she subsequently moved in with her father. I was able to get his contact information from Christy's grandma and met with her once after she moved in with Dad. I was able to meet with Christy and caregivers for 10 sessions in 12 weeks.*

#### Example 6

*Janelle, age 13, was discharged from residential to her mother's (and step-father's) house. Her mother was resistant to meeting with me but did want Janelle to participate. Janelle routinely scheduled appointments and then failed to show when I went to her home. Her mother rarely knew where she was. Janelle enrolled in an alternative school but usually hung out with her much older boyfriend and frequently missed school. I continued to stay in contact with her school and was able to visit her during her free period when she attended, however, Janelle got into fights with teachers and peers and was eventually suspended. I talked to her teachers, and principal, as well as Janelle about these situations and helped her work on getting back into school. I also kept in contact with her probation officer. During this time, I often provided*

*transportation for her to attend school. I extended Janelle an additional two weeks and had nine sessions with her and two with her mother.*

## **II. Assertive Continuing Care Protocol: An Overview**

### **Brief Description**

The Assertive Continuing Care Protocol (ACC) is a continuing care intervention specifically designed for adolescents following a period of residential treatment. Substance abuse treatment systems for adolescents vary across the United States; however, many communities offer a period of residential treatment followed by a period of outpatient treatment that is commonly referred to as aftercare or continuing care. A strong continuing care intervention is particularly relevant in those states or communities that have adopted the use of the American Society of Addiction Medicine (ASAM; 2001) placement criteria because they require that those who have the most severe problems are placed in residential treatment. ASAM outlines five levels of substance abuse treatment services for adolescents: 1) early intervention; 2) outpatient treatment; 3) intensive outpatient treatment; 4) medically-monitored inpatient treatment; and 5) medically-managed intensive inpatient treatment. Recent analyses have validated that when substance abuse treatment professionals make treatment placement decisions based on these criteria that the adolescents with the most severe problems are placed in the most restrictive environments (Godley, Godley, & Dennis, 2001). Those adolescents that are placed in residential treatment are, therefore, among the most severely impaired and are at great risk for relapse when they are discharged.

ACC is delivered primarily through home visits. ACC clinicians are assertive in their attempts to engage participants. They deliver Adolescent Community Reinforcement Approach (A-CRA) procedures (Godley, Meyers et al., 2001) that include functional analyses of substance use and pro-social behaviors, encouragement of prosocial behaviors, and other relapse prevention skill training procedures. Clinicians also provide typical case manager services, including barrier reduction/advocacy, crisis management, linkage to other support services, ongoing assessment of needs, and transportation.

### **Theoretical approach**

The primary theory underlying this approach is the recognition of the strong impact of the environment in encouraging or discouraging alcohol and other drug use which draws from Bandura's social learning theory (1977). If one accepts the power of the environment and its ability to shape and reinforce certain behaviors, then it follows that the intervention must attempt to rearrange environmental contingencies so that non-using behavior becomes more reinforcing than using behavior. ACC uses a blend of an operant model with a social systems approach. The operant model acknowledges that substance use is reinforcing, not only because of the physical sensations it produces, but also because of the social opportunities it provides. In order to change this reinforcing behavior, the adolescent must find competing behaviors reinforcing and be motivated to change in anticipation of promised reinforcers and concerns over undesirable consequences with continued use. The social systems approach acknowledges that the environment within which adolescents operate consists of a social system that includes their families, schools, and others depending on their unique situations (e.g., criminal justice, child welfare). With some adolescents, their social systems may provide poor modeling of substance use behavior (e.g., parents, friends). With many adolescents, these social systems also introduce

punishment for the substance abuse behavior (e.g., parental punishments, school suspensions, failing grades, probation). However, these systems also provide the opportunity for appropriate modeling and reinforcers of healthy behavior. A substance abuse treatment approach targeting adolescents must consider the social system and its impact on the adolescent. ACC also acknowledges the important role of motivation and cognition in shaping behavior and so the intervention includes procedures to enhance motivation and strengthen cognitive skills related to maintaining substance use abstinence (e.g., relapse prevention).

Critical to understanding the ACC approach is an appreciation of the critical juncture at which it enters the treatment process. Adolescents who participate in residential treatment usually have had a period of abstinence from alcohol and drugs because access to substances has been controlled within the facility, freedom to leave the facility has been limited and usually earned by demonstrating certain behaviors, and the total emphasis of all activities has been on leading a substance free life. Adolescents usually return to the environment that was conducive to their drug use upon discharge from treatment. Therefore, continuing care services need to help the adolescent and his or her parents work to shape an environment that rewards sober behavior.

## **History of ACC**

The initial idea for this intervention came from practitioners who identified a gap in the service system. Chestnut Health Systems was one of the first agencies in Illinois to develop specialized services for adolescent substance abusers. It began offering specialized residential services for adolescents in 1985. In the spring of 1990, the federal government, through its Office of Treatment Improvement (later renamed the Center for Substance Abuse Treatment), made funding available to enhance substance abuse treatment services for a number of populations. In conversations with Jolene Baum, who was then the director of adolescent services, a number of possible enhancements were discussed. Primary among these was a concern that system problems existed when trying to link adolescents to residential treatment initially and then to continuing care services following their residential treatment episode. This linkage was especially difficult within the rural areas served by CHS residential programs as these locations had fewer options for outpatient substance abuse treatment. A proposal was submitted to OTI that outlined a case management model specifically designed to address these needs and in addition to add services for adolescents who had dual diagnoses. In the fall of 1990, OTI provided three years of funding for the proposal. This initial funding led to the development of case management services that were available during screening, residential treatment, and following residential treatment that were the first iteration of ACC.

The emphasis on case management in the first project was drawn from its application with persons with persistent mental illness (Franklin, Solovitz, Mason, Clemons, & Miller, 1987) and children with severe emotional disturbances (Behar, 1993; Stroul & Friedman, 1986) who, like adolescent substance abusers, often have problems in multiple areas and need help accessing services. Case management has a history of over 100 years in the United States (Weil & Karls, 1989). It has been called “the most essential unifying factor in service delivery” (Behar, 1993). According to Stroul and Friedman (1986), case management includes aggressive outreach, brokering of services, advocacy, ensuring that an adequate treatment plan is developed and is being implemented, reviewing participant progress, and coordinating services. Osher and Kofeod

(1989) describe case management models that were developed for the treatment of individuals with long-term mental illness. These models include assertive outreach, linkage with direct services, monitoring of patient progress, education of patients about psychiatric and substance abuse disorders, reiterated treatment recommendations, and the coordination of treatment planning across programs. Case management appeared to be an important component of a continuing care approach because one of the primary problems that had been identified by those in service delivery was the need to improve linkage to continuing care services.

During the 1990s several investigators were recommending common approaches to continuing care (Bukstein, 1994; Catalano, Hawkins, Wells, Miller, & Brewer, 1991; CSAT, 1993; Donovan, 1998; McKay, 2001; Meyers, Brown, & Mott, 1995; Vik, Grizzle, & Brown, 1992). These recommendations included that programs: a) offer sufficient intensity and duration of contact; b) target multiple life-health domains (e.g., educational, emotional, health, vocational, legal, psychiatric); c) be sensitive to the cultural and socio-economic realities of the adolescent; d) encourage family involvement; e) increase pro-social leisure habits; f) encourage compliance with a wide range of social services to provide additional support; g) focus on relapse prevention; and h) provide cognitive behavior and problem solving skill training to help reduce cravings and cope with anger, depression and anxiety. In addition, research on family involvement in treatment began to emerge demonstrating that it can have a positive impact on adolescent engagement, retention, substance use and other problems (Bry, Conboy, & Bisgay, 1986; Joanning, Quinn, Thomas, & Mullen, 1992; Henggeler et al., 1991; Lewis, Piercy, Sprenkle, & Trepper, 1990; Liddle, Dakof, & Diamond, 1991; Santisteban et al., 1996; Szapoznik, Kurtines, Foote, Perez-Vidal, & Hervis, 1983). It is logical to assume that family involvement can either positively or negatively impact on re-entry to home and community after residential treatment. Unfortunately, while there were recommendations regarding what continuing care services for adolescents should look like, there were no studies that empirically evaluated continuing care approaches or even adequately described what the current practice was.

A review of early outcome studies of adolescent treatment do reveal reason to be concerned about relapse following residential treatment. Reported relapse rates ran 60% during the first 90 days after discharge from residential treatment (Brown, Vik, & Creamer, 1989; Catalano et al., 1991; Kennedy & Minami, 1993). In addition, an examination of adolescents discharged from residential treatment in Illinois revealed that only 36% of the adolescents attended one or more continuing care sessions at community substance abuse providers (Godley, Godley, Dennis, Funk, & Passetti, 2002). Taken together, these findings reinforced our belief that a different approach to adolescent continuing care needed to be developed, especially for adolescents who returned to a service poor environment.

Substance abuse treatment researchers also have begun to emphasize the chronic nature of substance abuse and have noted that developing effective models of providing continuing care monitoring and re-intervention occupies a central role in the long-term management of other chronic diseases. They have supported adapting the disease management model to the management of substance use disorders (e.g., McLellan, Lewis, O'Brien, & Kleber, 2000). Empirically, several longitudinal studies with both adults and adolescents have concluded that participation in formal continuing care and/or self-help group meetings is a significant predictor

of improvement at follow-up (Donovan, 1998; Hoffman & Kaplan, 1991; Alford, Koehler, & Leonard, 1991). Though a review of the published literature did not find experimental studies of continuing care with adolescents, McKay's (2001) review of 12 experimental and two quasi-experimental continuing care studies with adults revealed mixed results. Findings from four of the 14 studies indicated that adults with more intensive continuing care did significantly better than those with no continuing care, while the remaining 10 studies showed slight improvement or no difference between continuing care conditions.

Initial attempts at evaluating the OTI funded project were rudimentary, but suggested that the services had promise. When adolescents who received case management were compared with a quasi-experimental comparison group of adolescents who did not have case management (Godley, Wallace, & Godley, 1994), we found that they were more likely to have gone to AA or some other self-help meeting (3.52 vs. 2.32;  $d=0.496$ ) and had fewer days of alcohol use (5.15 vs. 9.00;  $d=2.406$ ). For days of relapse, however, the effect depended in part on the severity of relapse. The differences in days of substance use for adolescents receiving case management were much larger among those with major relapses (case management group  $X = 12.3$  vs. non-case management group  $X = 24.8$  days;  $d=2.500$ ) than those with only a few lapses (respectively: 1.56 vs. 2.17;  $d=0.381$ ). This suggests that case management might be particularly more effective for the major relapsers. This preliminary analysis was severely limited by the lack of randomization (there were some pre-existing differences between these groups), prospective classification, and inadequate follow-up rates. However, the results indicated that a continuing care intervention warranted further study. During our initial study, it also became clear that we needed to further define the continuing care intervention by outlining procedures that the clinician used during the home visits with the adolescent. As we studied the recommended approaches to continuing care described earlier, it appeared that adapting a CRA approach for adolescents and including at least some continuing care sessions with parents fit well with these recommendations.

This led to the development of a research proposal for NIAAA, which was funded as a five-year study in 1996. In this study, over 100 adolescents (approximately 76% male) who stayed at least 7 days ( $M = 49$  days) in residential treatment were randomly assigned to receive either usual continuing care (UCC) or UCC plus an Assertive Continuing Care Protocol (ACC) involving case management and an adolescent community reinforcement approach (A-CRA). Participants were interviewed at intake and again at three, six, and nine months post discharge. Preliminary findings based on 114 adolescents who had completed their three-month follow-up interview revealed that those assigned to ACC were significantly more likely to participate in any outpatient/continuing care services and to engage in more days of continuing care services. ACC participants remained abstinent from marijuana use longer (median of 90 vs. 30.7 days,  $p<.05$ ), were more likely to be abstinent from marijuana at three months post discharge (52% vs. 31%,  $p<.05$ ), reduced their days of alcohol use more and showed a trend toward fewer past month symptoms of abuse or dependence (1.77 vs. 2.29 of 11; Godley et al., 2002).

### **Intervention Components**

ACC has two critical components including community reinforcement approach (CRA) procedures (Azrin, Sisson, Meyers, & Godley, 1982; Meyers & Smith, 1995) that have been



adapted for adolescents (Godley, Meyers et al., 2001) and case management. The Adolescent Community Reinforcement Approach (A-CRA) is a behaviorally based intervention that seeks to increase the positive, prosocial day-to-day activities of alcohol and drug abusing adolescents. The more positive alternative activities that can be generated and maintained, it is postulated, the less likely these individuals are to have an alcohol or drug relapse. A-CRA therapy is accomplished by conducting a functional analysis of using behaviors as well as social activities, developing a list of goals, and monitoring success in these goal areas through personal happiness rating scales. Therapeutic techniques include prosocial and other reinforcer access priming and sampling, problem solving, and communication training. The latter two procedures are also incorporated into sessions with caregivers. Optional sessions for coping with a lapse, anger management, and job finding are also available. These procedures are described in the A-CRA companion manual to this one.

Case management services were included in ACC to provide adolescents with assistance linking to needed services and regularly accessing prosocial and recreational activities after they returned to their home. Case management procedures for this study were taken from Godley (1995) and include the followings: a) linking the participant to necessary services and activities; b) monitoring lapse cues and attendance at other needed services and activities; c) advocacy for the participant to access services when needed; and d) social support for coping with a lapse or other challenging issues. In the study, adolescents could be discharged to communities up to 75 miles away from the residential treatment center. All participants assigned to the ACC condition received home visits from the clinician to increase the likelihood of engagement and participation in continuing care services. In addition to home visits, the ACC clinician provided some transportation for job finding and other prosocial activities. Since much of the service area covered by this study was rural, transportation services, including home visits were a critical component of the intervention. In Part III of this manual, case management procedures are described in detail.

## ACC Goals

The goals of ACC home-based sessions with adolescents are to:

- **Promote abstinence from marijuana, alcohol, and other drugs.** ACC helps promote abstinence by working with adolescents to modify the conditions that promote substance use. The clinician incorporates A-CRA (Godley, Meyers et al., 2001) procedures towards this end. One of the most important procedures is the Functional Analysis of Substance Use that helps the adolescent identify (a) the antecedents to marijuana, alcohol, and other drug use, (b) the actual marijuana or other drug using behavior, and (c) the positive and negative consequences of use.
- **Promote positive social activity.** ACC assumes that adolescents can be more successful at terminating substance use behavior if they can learn to increase their involvement in positive, reinforcing behaviors. An A-CRA procedure called the Functional Analysis of Pro-social Behavior helps adolescents identify positive social activities that they have or currently enjoy and helps them see the benefits of being involved in these activities. The clinician gradually encourages participants to spend more time in these activities.

- **Promote positive relationships with friends.** This goal is closely related to the goal regarding positive social activity. Substance abusing adolescents often center their activities with friends around substance use. To address this goal, ACC clinicians help adolescents identify friends who are willing to enjoy substance-free social activities with them.
- **Promote improved relationships with family.** Within most families, adolescence is a stressful time in the relationship between caregivers and their adolescent children. This is probably even truer in families in which the adolescent is a substance abuser and has had problems severe enough to warrant residential treatment. In addition, the family is challenged when the adolescent re-enters the family after being away for a period due to residential treatment. ACC clinicians use A-CRA communication procedures with family members as a way to promote improved relationships.

**The goals of the ACC sessions with the caregivers are to:**

- **Motivate caregiver participation in the ACC process.** It is possible that some caregivers may be reluctant to participate in ACC. They may have already participated or are currently participating in family programs during residential or outpatient treatment and feel this is enough. They may feel they have already done everything they can to help their adolescents. The ACC clinician seeks to convince caregivers that they have an important role in helping the adolescent maintain gains from residential treatment and that working with the ACC clinician will help them achieve their goals for their adolescent.
- **Teach the caregivers to promote the adolescent's abstinence from marijuana, alcohol, and other drugs.** Using A-CRA procedures, the ACC clinician teaches family members behavioral skills aimed at discouraging the adolescent's drug use. The goal is to help caregivers understand how their behavior impacts the adolescent's substance use so that the caregivers will be motivated to change their behavior to promote the adolescent's abstinence.
- **Provide information to the caregivers about important parenting practices.** The information is based on research by Richard Catalano (1998), Hyman Hops (1998), and Brenna Bry (1998). The following practices are important to help keep the adolescent from relapsing:
  - To be a good role model by refraining from using illegal drugs and refraining from using alcohol in front of the adolescents in their care. This is the single most important practice for caregivers.
  - To increase positive communication between themselves and the adolescents in their care.
  - To monitor the adolescent's whereabouts, including knowing with whom he or she is with and where.
  - To become involved in the adolescent's life outside of the home by encouraging and promoting prosocial activities.
- **Teach and practice positive communication and problem-solving skills in the family.** Improving communication and problem-solving skills within the family promotes a more

positive relationship between the adolescent and the caregivers and helps create a familial environment that is more conducive to recovery.

### **ACC goals related to working with Community Resources**

- Help the adolescent link to existing continuing care services. These services could include continuing care treatment available at substance abuse treatment centers or self-help groups such as AA if they are appropriate for the adolescent.
- Improve the adolescent's environment. An adolescent may be interacting with several different systems, such as school and the probation department. The clinician serves as an advocate for the adolescent in these settings. There may be times when the clinician interacts directly with the school or helps teach the caregivers skills so that they can advocate for their adolescent at school. If the adolescent is on probation, the clinician can work with the adolescent and probation officer to help promote the adolescent's fulfillment of the probation requirements.

### **Parameters of ACC**

#### ***Format***

ACC sessions are either with the adolescent individually, the caregiver, or the two together. This format is in part dictated by the setting of the intervention: in the adolescent's home or community. Researchers also have suggested, however, that there are benefits to individual treatment. It can increase the adolescent's engagement and retention in continuing care, since the clinician and adolescent and/or caregiver have a better opportunity to build a relationship in individual sessions than they would in group sessions. Individual sessions also allow the clinician to individualize the intervention both in terms of A-CRA procedures and typical case management activities. The individual format of ACC also complements the predominate format of adolescent continuing care outpatient services which is group-based.

#### ***Duration of ACC and Length of Sessions***

ACC has been offered in 12 to 15 sessions, typically in a three-month period following the adolescent's discharge from residential treatment. Typical reasons a participant would receive more sessions than 12 would be that at the 12-session mark the clinician is involved in helping the participant resolve a crisis situation or the need to complete a linkage with a community based service organization. A typical ACC session can be from one to two hours long.

It is also possible that extended contact (e.g., up to six months or even longer) with continuing care participants might prove even more beneficial than the length tested in the study. What happens during an ACC session is not determined by the session number, but rather it depends on what the adolescent presents during a home visit. Many of the procedures could be used repeatedly; doing so should help increase the adolescent's ability to generalize and apply skills outside of the ACC session.

## ***Setting***

ACC is delivered in the home environment. The clinician may meet with the adolescent in his or her home or in another location (e.g., a fast food restaurant or a basketball court) in the adolescent's home community. It is home-based because prior research has suggested that adolescents are much more likely to continue in continuing care if a treatment professional goes to their home than if they have to come into an office. Providing service in the home also allows the clinician to have an understanding of the challenges an adolescent faces in his or her home environment.

## ***Participants and Caseload Size***

ACC has been evaluated with adolescents aged 12 to 18 who are primarily alcohol and marijuana abusers who have had a minimum of one week of residential treatment. The appropriate caseload size will vary based on the geographic area a clinician needs to cover. During the study, one clinician had too much "down time" when the caseload dropped below seven participants. More than 11 participants was overly burdensome because of the large geographic area covered by the project (31 counties). In large metropolitan areas it may be possible to carry 15-20 participants, if travel distances are greatly reduced. In a rural area with a large geographic area to cover a caseload of seven to 11 is probably appropriate. It is important to recognize that during the school year adolescents attending school often will be constrained to after school hours for appointments and if the adolescent works, clinicians will only be able to see them outside of work hours. In some cases, and by special arrangement with school officials, some participants may be seen at school during their lunch or other free time such as study hall. It is important, however, that prospective clinicians be made aware of the need to work evenings and/or weekends.

## ***Contact Frequency***

The goal is for an ACC clinician to have at least weekly face-to-face contacts using A-CRA procedures with each ACC participant. Often, it is desirable or necessary for the clinician to see participants more often, for example, when providing assistance with transportation, job interviews, advocating for admission to community program, or for a similar activity. In addition, it is frequently necessary to arrange a separate appointment with a caregiver during the same week a session is conducted with the participant.

ACC clinicians are also encouraged to make frequent (at least weekly) telephone contacts with participants. The purpose of telephone contacts are: a) to confirm appointment times; b) to check on the progress of homework assignments (e.g., did the participant attend his or her appointment at a community based agency, the doctor, or go for a job interview); c) to provide encouragement, support, and answer questions; and d) to provide information to the participant on an organization, self help group, etc. that the clinician investigated for the participant. Finally, the telephone contacts are used to reinforce positive activities and steps taken by the participant as well as to provide an opportunity for early intervention if the participant has relapsed or is otherwise having difficulty.

### ***Compatibility With Adjunctive Treatments/Services***

ACC is designed to be compatible with a variety of other treatments that an adolescent or his or her family might need because it is understood that these adolescents have multiple problems and may need to draw from multiple service providers. Adjunctive treatment services might include:

- Substance abuse outpatient group or individual counseling
- Mental health treatment including individual or family therapy or psychotropic medication
- Self-help groups including Alcoholics Anonymous (AA) or Narcotics Anonymous (NA)
- Student Assistant Program services
- Educational or vocational services

### **Active Ingredients of ACC**

Behavioral and psychosocial researchers note that it is important to identify the common and unique aspects of a therapeutic approach (Carroll & Nuro, 1996). For example, ingredients that are common to most psychotherapeutic approaches are rapport building and offering support. Interventions also have unique techniques or procedures that distinguish them from other interventions. The following descriptions help explain the details of this approach.

### ***Essential and Unique Interventions***

ACC uses a combination of case management and A-CRA procedures. A-CRA procedures are based on the Community Reinforcement Approach of Meyers and Smith (1995). Key active ingredients include the following:

- Home visits
- Clinician activities directed at actively linking the adolescent to needed services including existing substance abuse continuing care services
- Positive (cheerleader) approach with the adolescent
- Functional Analysis of Prosocial Behavior
- Procedures to increase Prosocial Behavior
- Caregiver introduction to the most important things they can do to help prevent relapse
- Combined adolescent and caregiver communication and problem solving training
- A-CRA Happiness Scale (this differs from the CRA Happiness Scale developed for adults)
- A-CRA Goals of Counseling (this differs from the CRA Goals of Counseling developed for adults)

### ***Essential But Not Unique Interventions***

Since A-CRA builds on CRA and there are similarities between MET and CBT approaches and CRA, there are a number of procedures that are considered essential to ACC, but are not necessarily unique to this approach. These include:

- Functional Analyses of Substance Abuse

- Identification and debriefing of past and future high-risk situations
- Providing skills training in relapse prevention skills, communication skills, and problem-solving skills
- Practice of skills within sessions
- Providing feedback on urinalysis results
- Meeting resistance by backing off and exploring possible reasons to comply

### ***Recommended But Not Unique Interventions***

These are interventions that are not unique to ACC or A-CRA that should be delivered as needed:

- Implementing failure to attend procedures when needed
- Implementing job finding procedures
- Teaching and practicing anger management skills
- Monitoring alcohol and other drug use
- Exploring positive and negative consequences of alcohol and other drug use

### ***Interventions Not Part of ACC***

The following interventions are not a part of the ACC approach, although they might be included in other adolescent substance abuse treatment approaches.

- Extensive self-disclosure by clinician
- Use of confrontation for denial of use or to address other issues
- Lecturing or teaching about the harmfulness of alcohol and other drugs
- Requiring the adolescent to attend self-help sessions
- Extended discussion of 12-step recovery philosophy
- A high degree of examination of the adolescent's cognitive process related to substance use
- Use of disease model language or slogans
- Extensive discussion of underlying causes for substance abuse
- Use of family systems techniques
- Interventions associated with reality therapy, rational-emotive therapy or other prescribed approach

### **Flexibility of the ACC Approach**

There are a number of different types of treatment manuals for different types of interventions (Godley, White, Diamond, Passetti, & Titus, in press). For example, cognitive behavior therapy manuals are often session based and prescribe what procedures are provided by session number (e.g., Sampl & Kadden, 2001). The ACC approach is procedure based and the sequencing of those procedures depends to a certain degree on the needs presented by the participant. While there may be a suggested timing for certain procedures, the clinician is always encouraged to pay attention to maintaining the therapeutic alliance and to responding to the clinical needs of the continuing care participant. For example, if the participant raises an issue that provides an

opportunity to teach a procedure, the clinician should follow the need presented by the participant rather than rigidly stay with a session plan. Similarly, if the participant has a “case management” need (e.g., a psychotropic medication refill, a need to meet with school officials about re-entering school) the clinician must be prepared to assist in these matters. A common occurrence early in the continuing care relationship is for a participant to raise an issue that provides a “teachable moment” for the problem-solving procedure. For example, the clinician may have planned to complete the functional analyses of substance use procedure on that day, but when the adolescent raised a problem, the clinician may decide it is a better use of time to show the application of the problem-solving procedure and this is acceptable. The clinician should make a note to return to the functional analysis procedure at a subsequent session.

Because this approach attempts to use the reality of the participant’s social environment, the clinician does not follow a didactic format with prescribed examples but uses real life opportunities for learning when they occur. Focusing on issues presented by the adolescent enhances engagement. Interaction between the clinician and the participant during the presentation and practice of procedures also helps enhance engagement and reinforces learning. Thus, the clinician should always endeavor to involve the participant with questions, discussion, or rehearsal when teaching a procedure.

Supervisors note that this flexible approach may increase the difficulty of training ACC clinicians. It is easier to teach direct service providers how to deliver individual procedures than to weave procedures into sessions as opportunities occur. Quality clinical supervision incorporating tape reviews is essential to the training process.

### **Recommendations for Service Providers Considering Adopting this Approach**

ACC is appropriate for agencies who serve adolescents following a residential treatment episode for substance abuse whether the residential treatment has been provided by the same or a different agency. Since it is a home-based intervention, it relies on case management staff that are willing to make home visits. In a rural service area, this could mean that staff spend a considerable amount of time on the road.

Since this approach is so different from existing continuing care approaches that are primarily office based, it is important to have strong organizational support to implement ACC. It is also critical to set up a supervision process as outlined in this manual and train staff in the use of this and the companion A-CRA manual. The most important ingredient to a successful implementation of this approach in the case management staff. As is described in the next section, certain personality characteristics are as critical to their success as is their professional training.

### **Purpose, Development, and Organization of the Manual**

This manual provides guidance on how to set up the ACC intervention and how to conduct case management activities. A companion manual, *The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users* (Godley, Meyers et al., 2001), provides details about how to implement the A-CRA procedures. Together, these two manuals provide the blueprint for

executing ACC. This manual was developed after extensive interviews with practicing clinicians and their supervisor to ensure that it is an accurate description of case management.

The manual is organized into twelve sections. Section I describes what it means to be assertive in Assertive Continuing Care. Section II provides an introduction and overview of ACC. Section III provides information about the logistics needed to set up an ACC program. Section IV provides details on case management procedures. Section V discusses home visits and safety. Section VI describes the structure and format of the sessions. A description of the first session is contained in Section VII. Clinical issues are discussed in Section VIII. Section IX is an overview of the final session. Section X describes the ACC certification process and ongoing supervision guidelines. Section XI is the reference section and Section XII is listing of related resources.



### **III. Implementation of ACC and Resources Needed**

This section provides guidance on choosing ACC clinicians and provides an overview about their training and supervision as well as information on resources the ACC clinicians need to perform their job. Very detailed directions for implementing quality assurance procedures can be found in Part IX.

#### **Choosing and Supervising Staff**

##### ***Staff Qualifications***

*Training, credentials, and experience required.* An ACC clinician should have at least a bachelor's degree in a counseling-related field. It is helpful for an ACC clinician candidate to have an orientation toward a behavioral and/or cognitive behavioral approach. Prior experience working with adolescents and/or treating substance abuse is preferred.

*Clinician's recovery status.* A person's recovery status is basically irrelevant when providing ACC. The most important attributes of a clinician are that he or she has the desired personality characteristics and the ability to stay within the protocol.

*Ideal personality characteristics of clinicians.* Preferred qualities for clinicians include a positive, optimistic, nonjudgmental attitude and a willingness to follow established ACC procedures. Other desired traits include enthusiasm, persistence, flexibility, perseverance, open-mindedness, willingness to learn, an outgoing personality, and a sense of humor.

##### ***Staff Supervision and Training***

Ideally, the person providing ACC clinician supervision has prior experience with case management and in providing or supervising A-CRA procedures. Preferably, he or she would have a master's degree in counseling or a related field and be able to provide guidance about how to address crisis situations that the clinician encounters.

ACC clinicians should go through training (described in more detail in Part IX) and then participate in regular ongoing clinical supervision. The supervision process is also described in more detail in Part IX, but it includes providing feedback based on reviewing tapes or accompanying a clinician on a home visit and completing competency scales related to case management skills in general (e.g., empathy) and ones based on specific A-CRA or case management procedures.

##### ***Clinician and Adolescent Relationship***

The relationship between the ACC clinician and the adolescent is multidimensional. The clinician strives to be empathetic and supportive and is rarely, if ever, confrontational with the adolescent. At various times during the therapeutic relationship, the clinician may act as a therapist, a coach, or a teacher. Unlike more traditional therapy in an office setting, the ACC clinicians have at least two major tasks to fulfill. First, they conduct therapeutic procedures based

on the A-CRA manual. These procedures are implemented in naturalistic settings, typically the home, a restaurant, or the clinician's car. Clinicians report that the natural setting can be either a blessing or a curse depending on whether there are noisy distractions or not. Typically, clinicians find that home visits facilitate rapport because: a) they can demonstrate respect and concern by driving to meet the participant; b) they allow the participant to be less guarded; c) clinicians can ask participants to demonstrate their hobbies and interests in their home; and d) they provide the opportunity for clinicians to observe communication in the home and to intervene with procedures when problems or communication issues arise.

The second significant role that the ACC clinician has is to help the participant access pro-social activities and services that are incompatible with alcohol and other drug use. Examples of these types of activities include: a) helping participants enroll in high school; b) providing transportation to job interviews; c) taking participants to community recreation centers to assist them in obtaining a membership; d) driving the participant to appointments for psychiatric evaluations and outpatient treatment; e) doing recreational activities with the participant (e.g., going to a movie or to the mall) to celebrate reaching goals; f) helping pregnant participants obtain prenatal care, WIC services, and attend new parent classes; and g) taking a participant to visit another teenager they befriended while in residential treatment. While labor-intensive, these activities are critical to ACC for two reasons. First, each activity demonstrates concern, caring, and genuine interest in the participant. For several different reasons, the clinician is often times the only adult in the adolescent's environment who can be reliably counted on for this kind of assistance. Second, these activities represent the single most effective way in which the clinician primes and reinforces the development of prosocial activities incompatible with alcohol and other drug use.

### ***What ACC Clinicians Can and Can Not Do***

ACC clinicians are expected to follow and stay within the boundaries of the protocol outlined in the manual. The manual helps define the roles of the clinician and adolescent and procedures/activities to be delivered within a set of guidelines.

It is undesirable and impossible for a clinician to address all the service needs for ACC participants and their families. It is likely that participants will have multiple problems or issues going on in their lives. The clinician has to guard against becoming overwhelmed by every issue. It is important that he or she stays focused on the ACC goals and continually develops knowledge about available resources. The clinician's task is to assess problems, make referrals as needed, and attempt to link participants with appropriate services. For example, if it becomes clear that a family is in need of intensive family therapy, the clinician should make a referral to an appropriate provider and assist them in linking to that service. Once the family has linked with the provider, the clinician would monitor their attendance and participation in that service. As with any professional helpers, clinicians should know and respect the ethical boundaries of delivering services. They should also know and respect the boundaries of the participants and families that they are seeing. As discussed below, home visits present special challenges and may present different ethical dilemmas than office-based therapy. Any potential ethical dilemmas should be discussed with the clinical supervisor.

### ***Common Problems Involved in Training Novice Clinicians to Use This Approach***

In terms of the A-CRA procedures used during sessions, the focus of supervision for novice therapists tends to be on developing specific skills related to carrying out the procedures and learning the appropriate time to introduce different procedures during an ACC visit. Technical skills can be learned relatively quickly, but it often takes additional time and experience to understand the appropriate timing for introducing procedures. Novice therapists often become so concerned with the manualized procedures that they get stuck in the details, risk appearing to be rigid, and thus risk losing their alliance with the participant or not addressing the participant's issues or concerns. Another problem can occur when a clinician becomes so focused on what a participant wants to talk about that he or she does not look for cues to introduce the A-CRA skill-building procedures or he or she rushes to work in some procedures in the last few minutes of a session. During supervision sessions, it is helpful for the supervisor to emphasize that it is important for the clinician to focus on the goal for the session and the approach in general and not get lost in the participant's problems or issues. It is sometimes easy for novice clinicians to become overwhelmed with all of the problems/issues going on in a participant's life. Novice clinicians need to learn that they should trust in the ACC process and not get lost in trying to solve the participant's problems of the day. The goal during sessions is to weave procedures in and out of the participant's content (problems/issues) that are important to them and constantly focus on rapport building. Some clinicians may have a tendency to jump right into procedures, but neglect the rapport/alliance issues. Juggling all of the behaviors that need to occur for an effective session can be difficult at first. It takes time for a novice clinician to become smooth at this process. Usually this process and clinical decision-making gets better as clinicians feel more comfortable with the manual and know the material.

If the clinician is also new to case management, working with adolescents, or the service system where the ACC program is located, he or she will also have much to learn a lot about this aspect of the job. It is important for the clinician to have a thorough orientation to local mental health, substance abuse, criminal justice, and school system services. If the clinician needs further information about a given geographic area or service, then it is important for the supervisor to be able to provide this information or a friendly contact person that can help with the information. During the study, the director of the adolescent substance abuse treatment services routinely participated in supervision, primarily, so that she could provide information about the local service system.

Since clinicians work in the natural environment, less experienced clinicians may not be aware of some of the situations or problems that they may run into out in the field and how to handle them. It is important for supervisors to be accessible to the clinicians as needed if they have questions or need to process concerns.

### ***Common Problems Involved in Training More Experienced Clinicians to Use This Approach***

When training more experienced clinicians, there may be an initial resistance due to the perception that manual driven treatment is too restrictive. After experience using the ACC and A-CRA manuals, the clinician learns that these provide a blueprint for work with the participant and he or she directs the timing of procedures, while the participant needs determine the content

of the interventions. In this way, the approach is individualized to each participant's needs. Over time more experienced clinicians may have a greater tendency to drift from the manual to attend to different problems that an adolescent manifests, for example, psychiatric issues. While it is important for clinicians to ensure that problems in these areas are addressed, they must understand their limitations and refrain from attempting to solve problems they are not qualified to solve. A referral to a mental health professional should be made even if the clinician believes that he or she is qualified to deal with a particular problem. The main goal of the supervisor is to assure that the clinician stays within the guidelines of the protocol. The use of manuals, checklists and related rating scales help provide clear-cut goals and guidelines for training and evaluation of competence of experienced therapists (see Part IX).

More experienced therapists may be used to providing services in the office and having the participant come to them and discharging a treatment participant if they do not come to appointments. A critical aspect of ACC is the assertive outreach approach and a reluctance to give up on a participant. This philosophy may be more of a problem for experienced therapists who may have been trained under different substance abuse treatment paradigms than for novice clinicians.

### ***Strategies to Address Case Management Drift in Treatment Delivery***

Audiotape reviews, procedure checklists, and skills rating scales are very important tools that supervisors use to prevent clinician drift. They are used specifically to train, monitor general quality, competence, adherence, and correct drift should it occur. If a clinician drifts from the manual, the frequency of supervision, monitoring, and training should increase. If a clinician fails to meet satisfactory performance as measured by the rating scales, then it may be necessary to replace him or her.

Clinicians are also encouraged to refer to the manuals frequently. After clinicians get used to delivering ACC, they may begin to neglect referring back to the manuals as much as they should and increase the possibility of drift.

### ***Strategies to Help Clinicians Balance Adherence and Competence***

Adherence and competence are related but different concepts. Adherence refers to whether or not a clinician is using procedures outlined in the A-CRA and ACC manuals. Competence refers to how well the clinician appropriately times the introduction of the procedures and implements them. In order to assure that an intervention is implemented, it is important that the service provider follows a manual and that there is a system for determining that the individual has achieved and is maintaining an adequate level of competence. Tape reviews, clinician and supervisor completed rating scales and checklists help insure a certain level of competence is maintained. By completing checklists and listening to tapes, ACC clinicians improve their compliance over time and tend to increase adherence through this self-monitoring process. Once a clinician has mastered the techniques, appropriate timing develops along with good clinical judgment and increasing competence.

## **Facility and Other Material Needs**

Along with the materials already described in the A-CRA manual, it is helpful for clinicians to have access to an agency car, cellular phone, credit card, and computer. Depending on the size of the geographic area they cover, clinicians may drive many miles throughout the week and it is not desirable that they would have to put these miles on their personal vehicles. Cellular phones are necessary for safety reasons since clinicians go into homes and unfamiliar areas and increase their availability to participants. Credit cards are ideal to fill up the cars with gas and be able to purchase participant related expenses. The computer helps the clinician stay in touch with his or her supervisor who may be off-site and provides access to the web for research purposes and word processing software that can be used for writing clinical reports.

The clinician also needs office space for preparing for home visits and keeping track of paperwork. The clinician provides home visits, but could also see a participant in the office if a participant chooses to do so. Clinicians could share office space since their time in the office and participant contact within the office is so limited.

## **Financing and Cost Issues**

In many states (including Illinois) “continuing care” is not a reimbursable service. In some localities ACC may be reimbursable as outpatient care, however, as tested to date, it was a supplement to outpatient care rather than a replacement. At this time, it is not recommended as a stand-alone approach to aftercare or continuing care since the effects of ACC without step down outpatient care have not been evaluated. Accordingly, there are additional personnel and costs to provide ACC that most community-based treatment programs are not currently offering. These costs are primarily for ACC clinician and supervisory time. In the original NIAAA study, a bachelor’s level clinician and master’s level supervisor effectively served this project. The clinician worked full-time providing services to as many as 60 adolescents per year. The actual number of participants that can be handled by a clinician will vary depending on the geographic catchment area. In this study, ACC services were made available to adolescents in 31 counties with one way travel distances often requiring as much as one and a half to two hours. Because all services are provided via home visits, the cost of travel is significant; during the study the clinician logged approximately 20,000 miles annually. Another necessary expense is a cellular phone for use by clinicians, so they can receive and make calls back to the office or to participants while on the road. An annual budget for an ACC intervention would include the full-time salary and fringe for a clinician, 20% of a supervisor’s salary and associated fringe, mileage reimbursement allotted for estimated miles to be traveled, cell phone, and desktop computer.

We hope that the positive findings from research about this approach will encourage funders to develop reimbursement mechanisms for it.

## **IV. Core Case Management Activities**

Below are descriptions of the core case management activities. A perusal of these activities shows that there is overlap between these and what might be considered traditional therapist activities. For example, the first core activity, engagement, is one that is critical in any therapeutic relationship. Many therapists will also work to link adolescents to other services. For many of these activities, what becomes different is that the clinician is not office-bound and sees these activities as of equal importance to the therapeutic procedures (i.e., A-CRA) that take place during a session. So, for example, linkage is not merely referring an adolescent to another professional, but it may include taking him or her to the appointment and discussing it with the referral afterwards.

### **Confidentiality Guidelines**

Before describing core ACC activities, it is important to address confidentiality guidelines. When meeting an adolescent and his or her family for the first time, clinicians should let the adolescent and family know that no information is shared with anyone unless s/he gives permission, except for suicidal ideation, homicidal intent, or recent suspected child abuse. Not sharing with anyone includes probation officers, family, TASC, and other staff members.

If the adolescent has been in treatment at the same agency as the ACC clinician, then the clinician should review every release of information from the adolescent's chart with the adolescent. The clinician should ask if these individuals can be contacted, and if these are individuals with whom the clinician can share drug screen results. The clinician should also ask if there is anything the adolescent wants to change about the release, ensure the releases will not expire within 14 weeks, and sign new releases if needed. The clinician should let the adolescent know that s/he can change his/her mind about releases at any time by notifying the clinician.

While working with adolescents, clinicians should ask the adolescent before sharing information that could affect him/her negatively, even if s/he has given information before, when possible. The clinician should let caregivers and service providers know that information is not released without the adolescent's permission, so they will not assume that everything is fine. The clinician should not wear visible name badges to adolescent homes or other locations to meet adolescents. Sessions can and should be held outside the home if the environment does not feel private inside the home. The clinician should avoid sharing information about other adolescents or cases, including their involvement in ACC. This is true even if the adolescent says s/he know another adolescent is receiving ACC. The clinician should consult with the clinical supervisor if there are any questions about sharing information.

### **Participant and Caregiver Engagement**

The goal of engagement is for the participant and caregiver to accept the clinician as a helper and continue to want to meet with him or her during the continuing care period. In ACC, the clinician does this through many ways, including: a) communicating to the participant that the clinician's main role will be to support him or her; b) using humor in an initial session—joking around with the participant; c) asking adolescents what they like to do and what interests they have; d)

portraying the relationship as one that is more on an equal level than one based on power differential with the clinician as an authority figure; e) being non-judgmental about substance use; f) showing good listening skills and avoiding confrontation. Engagement is a continuous process and the clinician continues the process by helping the adolescent accomplish some of his or her goals whether they be accessing a community resource, helping to pursue a social or recreational activity, finding a job, or enrolling in a GED program. When adolescents are successfully engaged, they begin to see the clinician as someone who can and will help them. In the process, the clinician begins to accrue some leverage with the adolescents.

With some adolescents, it is very effective to do something fun with them to break the ice rather than sitting down and talking like a therapy session. Clinicians have been known to go out and shoot basketballs, go to the mall, or play frisbee. These activities usually make the adolescent feel comfortable and they begin to talk.

The clinician uses similar techniques with parents while communicating respect for them in their parental role. The clinician emphasizes that his or her role is to help their daughter or son and provide a support network for them. In caregiver sessions, the clinician provides them the opportunity to talk and vent about the stresses of parenting. Eventually, the clinician will provide some help with improving communication and problem-solving skills, but never intimates that the parent is a bad parent. The clinician communicates to parents that he or she is there to help them as well. Most parents have proven to be receptive that someone is willing to help their family.

The following are examples of clinicians describing activities designed to enhance engagement:

*Today I went to see Adam, a new client in Springfield. I talked to both him and his mom about the ACC project and what I can do to help him stay sober and find other prosocial activities. Right now he would like to find a job, and his mom would like him to enroll in GED classes. He didn't seem real interested in enrolling in the classes but was eager to go frisbee golfing. So we went out to Bradley Park and played frisbee for awhile. Later we drove around, and he showed me some different places he'd like to go to next time I see him, such as put-put golfing and bowling. We'll work on the GED classes in a later session.*

*Yesterday, I went to Rantoul to meet with Matt; however, his mom said she didn't know where he was, or when he would be home. So I went ahead and had a session with her instead. I talked to her about the ACC program, i.e. benefits and services we provide during the 12 weeks. She seemed very interested in our program and agreed to meet with me in the future. I also set up another appointment to meet with Matt tomorrow evening.*

*Today, I focused more on rapport building. We played Nintendo and talked about how his week went. He plans on working with his mom's boyfriend doing dry wall on the weekends, and that things have been going well between him and his mom.*

## Assessment

Assessment is viewed as an ongoing process in the ACC approach and the clinician has multiple sources of information. These sources include a comprehensive assessment from the beginning of residential treatment, the opportunity to discuss the participant with his or her counselor from residential treatment, the A-CRA Functional Analysis of Substance Use, A-CRA Functional Analysis of Prosocial Behavior, and the A-CRA Happiness Scale.

Since participants have already participated in residential treatment, the clinicians have access to the completed Global Assessment of Individual Needs (GAIN; Dennis, 1999), which is used as the biopsychosocial clinical assessment at the treatment program and is completed upon admission to residential treatment. The content of the GAIN is divided into eight areas: background and treatment arrangements, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational. In each area, the questions check for major problem areas and the recency of any problems. If a given problem occurred in the past year, additional symptom-based questions (e.g., criteria for alcohol dependence) are asked for the past year to clarify the problem. If it occurred in the past 90 days, detailed behavioral counts are collected (e.g., days of alcohol use, days of drinking 5+ drinks per day, etc.). The GAIN also asks detailed questions about lifetime and current (past 90 days) service utilization, as well as changes in the participant's cognitive state (e.g., self efficacy to resist alcohol/drug use, resistance to treatment, motivation to be in treatment, and what services the participant currently wants from treatment). In addition to the GAIN assessment information, the clinician also has access to the adolescent's counselor from residential treatment who can provide additional information about the adolescent's participation in and response to residential treatment. Two A-CRA procedures, the Functional Analysis of Substance Use and the Functional Analysis of Prosocial Behavior, provide additional assessment information about potential risk situations and potential prosocial activities that the adolescent might like to sample. Finally, the A-CRA Happiness Scale is used several times during the ACC program to assess the participant's happiness or satisfaction with 11 life areas including school, relationships, work, criminal justice involvement, and money management.

Assessment information can be used to direct additional work with the adolescent in terms of their goals.

The following are examples of clinicians talking about assessment activities:

*Yesterday, I met Mark at the alternative school he is attending. We went over a Functional Analysis for Use regarding alcohol. He was fairly open and said he used mainly at night by himself to get away from his problems and to be alone. However, he denied any negative consequences to his use, and said his legal issues all resulted when he was sober.*

*Today I picked Luke up from High School and we had Mexican fast food. We talked about the Functional Analysis of drug use and how using has effected his life. His main drug of choice is alcohol. He enjoyed using because he was less inhibited around others and had more energy. However, we talked about the numerous negative consequences i.e. legal, family, friends, etc. and he agrees that it is not worth it in the long run. I asked how things have been with his mom,*



*and he said that they have improved because they have been talking more. He seems pretty motivated about school and wants to hang around non-using peers more. I feel that Nick genuinely wants to straighten his life out. He has commented numerous times that he wants to focus on school and attending AA meetings.*

### **Scheduling and Confirming**

Since ACC is delivered through home visits and a clinician can sometimes drive an hour to get to a participant's home, it is important to maximize the possibility that the adolescent will be there.

It is also a goal to see participants at least weekly. To set an appointment, clinicians have found it important to: a) make sure the adolescent writes the appointment down on a calendar; often, the clinician has helped the adolescent buy an appointment book to keep track of appointments; b) try to schedule the appointment for the following week while still at the house for the current week's appointment; c) if, for some reason, the clinician was not able to schedule an appointment for the following week, then he or she calls until the participant confirms an appointment. In addition, it is important for the clinician to call the day or morning ahead of a visit to ensure that the adolescent or parent remembers the appointment and plans to be there. If a family does not have a telephone, talk to the family about a phone number that can be called (maybe another family or neighbor) to leave messages. If all else fails, the clinician may time an appointment for when he or she knows the school bus will be arriving or meet the adolescent after school or work.

Here are some examples of clinicians describing scheduling and confirming activities:

*I talked to Tiffany's mother today on the phone and explained the ACC program. She agreed to work with me in the future and gave me their new phone number and address. I then called Tiffany and talked to her about her vacation and how she's been doing. She sounded really excited about going back to school and wants to stay involved so that she won't be tempted to use. She also plans on trying out for the school play, and has a job working at an Italian restaurant. She said she has not relapsed and has avoided contact with some of her old friends. She seemed open to working with me and I set up an appointment to see her this Friday.*

*I wasn't able to see Matt last night because he had company over; however, he did reschedule for tonight at around 5:00.*

### **Barrier Reduction/Advocacy**

These are activities related to accessing services or pro-social activities for adolescents when a barrier exists. Typical barriers are transportation to and from jobs or pro-social activities or the cost of activities. Clinicians can sometimes provide transportation, help the adolescent get bus passes, or help secure lower fees for something like a YMCA membership. It is also possible that a clinician may need to help a participant and a family negotiate a bureaucratic application process for services. For example, we had a case in which a participant needed to see a psychiatrist and the paperwork was more than the family could or wanted to handle on their own.

Situations in which clinicians have advocated for participants include helping an adolescent to get back into a residential program after he has left on poor terms or helping a participant get into

a new school. The clinician may call a probation officer and tell him or her how a participant is staying clean and working hard on accomplishing his or her goals. As one clinician noted, it is important to be honest with other service providers, but even if the adolescent has had some substance use, it is important to emphasize the positive steps that he or she has taken.

Some examples from clinicians of these activities are:

*I've talked to schools to help advocate to get clients back in school if they were kicked out.*

*I worked with an Outpatient program to see if I could help a client because they owed a hundred dollars . . . to see if he could make small payments on a plan instead of paying it all at once because the family can't afford it.*

### **Integration of A-CRA Procedures**

Clinicians are trained to “weave” A-CRA procedures into the session. During initial sessions, clinicians often have an idea of a procedure they would like to go through with the participant, but whether or not they proceed with it depends on what the participant presents during the session. The clinician is evaluating the information the adolescent presents and assessing whether or not this is going to be a teachable moment.

It takes skill, but with experience and practice, clinicians are able to do this as is illustrated in the following quotes:

*We also did some problem solving regarding time management. I had him write down all of his appointments, meetings, work schedule and things he needed to take care of for next week. We talked about the importance of writing things down so that he can plan his schedule and avoid feeling overwhelmed. After we talked about this, I took him to a discount store to buy a daily planner so that he could manage his time more efficiently and keep track of all of his appointments. He was very grateful for the appointment book, and said he thought it would help alleviate stress and prevent him from feeling overwhelmed with all of his commitments.*

*Sometimes I'll just say, “Hey, this is something I wanted to talk to you about, “ or sometimes I'll weave it in, like “So, tell me a little about your drug use.” I won't bring out the paper and be like, “OK, this is a Functional Analysis, because they don't care about that.” And sometimes I can, though, sometimes I can bring it out and show them the questions and go through it like us sitting together and some of them are cool. But then some of them you just have to weave it in differently. It just depends on the adolescent. And with problem solving that's easy. If they have a problem, just be like, “OK, let's think of some things we can do.” So, I'll try to have them state the problem. Get them to where I kind of understand what they're dealing with...and we'll go through different ideas that they could try. And then I'll write it down and have them look at it and be like, “Well, is there anything you wouldn't want to try?” . . . [W]ith the Happiness Scale, I just bring that out and say, “Do you mind doing this? This helps me understand how you're doing today.”*

## ***Crisis Management***

Inevitably, when working with multi-problem adolescents and their families, crisis situations will arise. There will be times with part or all of a session may center on managing a specific crisis rather than doing regular session or procedure work. If at any time the welfare and safety of a participant is in danger, the clinician should intervene immediately and appropriately for the protection of those involved, with consultation from the supervisor. There are a series of steps that are helpful in dealing with crisis situations. The first is to define the problem from the participant's point of view. Second, ensure that the participant is not in physical and/or psychological danger from self or others. Third, provide support in an accepting and unconditional, positive way, while utilizing other support persons if available. Fourth, examine alternatives or appropriate choices available to the participant. It is important to try and keep it simple and realistic to their situation. Fifth, assist the participant to develop a plan of action. The more severe the crisis the more directive and action oriented the clinician needs to be. If possible, the clinician should consult with a supervisor when crisis situations arise. If this is not possible, the clinician should always debrief the situation and solution with the supervisor after the fact.

*Today, I met with Joe in Morton. When I arrived, I talked to his parents about how things have been going. They both informed me that if he doesn't find a job by tomorrow that he can no longer live in the house. They said they have given him a month to find a job and that all he does is hang out with his friends. Joe said that he is only going to be 18 once and wants to have fun now. We worked on some goals and problem solving regarding what he needs to accomplish. He agreed that he needs to find a job because he just found out his girlfriend is pregnant. Right now his girlfriend and child are his main motivators to stay sober and find a job. Today we also went over another Happiness Scale and talked about the different changes. The most significant change involve his relationship with his parents. Joe made a few homicidal remarks today; however, when I called him back to assess the situation, he said that he was just blowing off steam and didn't mean anything by it. He said he would never do anything to his parents. I will continue to look out for any further homicidal remarks.*

## ***Linkage to Other Support Services***

Of all the case management activities, the clinicians spend most of their time working on linkages to other services because the adolescents have multiple problems and need multiple services. They also know that the continuing care services they provide are time-limited and they need to ensure that when they have to terminate their services, the participants and their families have linked with supportive services and/or are fully engaged in pro-social activities.

Clinicians usually begin by reviewing recommended services on a discharge plan. If a participant left outpatient or residential treatment unsuccessfully (got kicked out, ran away, etc.), the ACC clinician will still work with the adolescent. The clinician might try to work toward getting the adolescent back into treatment, but at a minimum, the clinician would assess needs/problems, refer to appropriate services, and help link him or her. Several adolescents that have been ACC participants have had multiple residential treatment stays. For example, one adolescent was asked to leave two different residential treatment programs, was able to complete the program at a third program, and then worked well with the clinician during three months of ACC. The

clinician had facilitated linkages with the second and third residential treatment programs because he risked going to the Department of Corrections if he did not successfully complete a residential treatment stay.

It is always important for the clinician to contact treatment staff who should have suggestions about appropriate follow-up services. Other needed services can often become obvious during a home visit. Linkage to outpatient substance abuse treatment services is always a high priority after residential treatment, although there will be occasional instances when an adolescent is barred from those services because of passed transgressions. The clinician should also encourage the adolescent to attend AA or another relevant support group. Other linkages that clinicians typically work on are: a) linkage to a pro-social activity (e.g., a gym, public parks and recreation programs, Big Brothers/Big Sisters); b) educational programs, including regular schools, alternative schools, GED classes, community colleges, or other higher education programs; c) helping the participant find jobs, including getting information on joining a branch of the military; d) mental health services, including psychiatric services or family counseling. Basically, the clinician tries to help the adolescent follow recommendations from treatment staff regarding needed services and also assesses services needed based on his or her observations, then attempts to link the adolescent to these services. It is important to obtain the names and contact information of the client's current service providers (i.e., mental health) upon treatment discharge, as the information will be helpful in linking the client with other services. Often a clinician will research service options by making phone calls or searching the Internet. Frequently, the clinician will encourage the participant to make these calls following practice calls with the clinician.

Here are some examples of clinicians talking about linkage activities:

*Today, I talked to the County Health Dept, Catholic Social Services, Planned Parenthood, and Department of Human Services about the different prenatal services they provide. I also obtained additional information regarding eligibility for the WIC program and medical card. I will talk to Anne this week to set up an appointment and to find out if she is eligible for these services.*

*Today, I went to see Sean in Champaign. I spent most of the day trying to enroll him at the alternative school in East Peoria called the "Academy at ICC." We talked to admissions at ICC, and then went to his old high school to get his transcripts and referral papers. ICC said they would look over his records and tell him tomorrow if they decided to accept him into the program. Another option Sean can explore is the Adult Education program in town that holds night classes during the week. However, his first choice is the Academy at ICC. Today, we set up an appointment to talk to his advisor on Monday and he is has an orientation meeting tonight at the Academy at 5:30. We also went to a restaurant where Sean has a job interview on Monday at 5:00. Next week I am going to help him enroll at the local mental health center for anger management and outpatient treatment.*

Here a supervisor talks about a case:

*Yesterday, we were meeting with the clinician and talking about the need for her to get the*

*participant to contact his probation officer because we had heard the probation officer is about at his rope's end with the client and kind of ready to recommend the Department of Corrections, but yet the client is doing some reasonably good things since he got on medication and we want that client to reach out to his probation officer and say, 'You know, I have made some changes in my life. I'm doing this and doing that.' He needs to let the probation officer know what he is doing now instead of waiting for that probation officer to just come down on him out of anger. In this case, we need to encourage the participant to link back to his probation officer.*

### ***Transportation of Participant***

It is a regular occurrence for clinicians to provide transportation for program participants since many of the adolescents participating in the program do not have their own cars or parents who are able to provide transportation. Clinicians will work with the participants to arrange other means of transportation (e.g., bus passes or through parents) as their time together progresses. It is often critical, however, for the clinician to provide transportation to that first outpatient appointment or meeting with a probation officer after residential discharge. Places that a clinician will transport a participant include to outpatient appointments, to potential employers to submit job applications, or to take an adolescent home after he or she has completed residential treatment. Providing transportation is one of the ways that a clinician shows that he or she is tangible support for a participant.

Here are clinician reports about transportation:

*Transportation was a huge thing that clients needed. And so many times I would get them a bus pass to get them to where they need to go. They needed transportation to see their probation officer, to get to their outpatient groups, or sometimes even to get to jobs.*

*I took him to two restaurants and a music store to fill out job applications. He said that he is going to call them back tomorrow to find out about the status of his application. Last week, I took him to enroll at the local outpatient substance abuse treatment program.*

### ***Other Case Management Activities***

The clinician will often work with the participant in ways that are not necessarily defined above, but that fall under case management. These types of activities are discussed in weekly supervision sessions to be sure that there is agreement that they are appropriate case management activities. One of the most common activities mentioned by clinicians in this category is helping the adolescent with homework or GED studying. For example, a clinician took one participant to the local bookstore to buy a GED study book and spent time reviewing it with him. Another clinician helped a participant buy a car by talking about what to look for and how to go through the negotiating process. The goal of these activities is to help adolescents learn important life skills. If the adolescent become more self-sufficient and takes pride in his or her accomplishments then this may help him or her stay substance free.

Here is a clinician talking about helping a participant in regard to a health issue that was very important to him:

*Later, in the afternoon, I saw Steve in Normal. I was going to take him to the treatment program; however, he wanted to find out his HIV results instead. Steve was ecstatic to find out the negative results of the test.*

## **Urine Tests**

Urine tests are conducted to obtain an objective measure of a participant's abstinence and to provide the opportunity to give feedback to participants based on test results. Participants are asked to provide three random urine tests during the three months of ACC. Participants should be informed about the frequency and general procedures for urine testing during the initial session. When the participant is due for a urine test, the clinician informs him or her at the beginning of the session and explains that this is the day that has been randomly chosen for a urine test. The clinician collects the sample and either tests it at the location it has been provided or transports it in a small cooler back to the office for testing. If the participant is not able to provide a sample, she or he is asked to try again at the end of the session. If the participant misses the week that a urine is due, the test can be performed the following session. If a participant is attending an outpatient substance abuse treatment center or meeting regularly with a probation officer and is providing urine samples in these situations, the clinician can obtain results from these tests rather than conducting the urine tests themselves. A signed release of information must be obtained prior to any consultation about urine test results from another provider.

After the test is read, the clinician provides feedback based on the results. When the test indicates that drugs are not present in the urine, the clinician provides strong positive reinforcement and support. They discuss aspects of the participant's living environment that have been conducive to abstinence and encourage continued development of drug-free activities. The clinician asks about any problems with cravings or emotional distress that were experienced during the abstinent period. This is followed by questions about how the participant coped successfully with these problems. The clinician asks the participant, "What is your biggest motivation for not using?" The purpose of this discussion is to instill confidence that the adolescent can face stresses without using and to reinforce reasons for not using.

When the test indicates that drugs are present, the clinician probes to understand the context for the participant's use. He or she is not judgmental or confrontational. External and internal triggers associated with the adolescent's use are examined and potential solutions to use if a similar circumstance is encountered in the future are generated. The results of urine tests are not the focus of ACC treatment because ACC primarily relies on identifying reinforcers and taking a positive approach. However, a negative urine test provides the opportunity to reinforce abstinence, whereas a positive urine test provides additional information to the clinician that can be used to prompt appropriate procedures (e.g., relapse prevention). For more information on the actual test used, along with other information related to doing urine testing within this model, see the A-CRA manual.

### **Bringing in Others (e.g., girl or boyfriend) into the Session**

A clinician can bring another person into session if he or she thinks it would be helpful and the participant is interested in having them in session. There are many situations in which it would be beneficial to have a supportive person in session. For example, if a girl is having relationship problems with her boyfriend, the clinician could do some communication skill training and problem-solving with both in session. Other procedures/activities could include: use refusal skills, sampling prosocial activities together, anger management, asking for support, increasing motivation, job finding, etc. Some examples of supportive people in the participant's life may include but are not limited to: coaches, teachers, girlfriends, boyfriends, self-help sponsors, and other family members (sisters, brothers, aunts, uncles, etc.).

## V. Home Visits and Safety

The ACC clinician uses home visits as the primary method of initiating and maintaining contact with the adolescent and caregiver. There are several advantages to conducting home visits, notably: (a) they are the most effective way to maintain ongoing contact with the adolescent and caregiver because the clinician travels to the adolescent's home rather than relying on the adolescent to attend sessions at the clinic; (b) the clinician has the opportunity to observe family interactions and understand more about the family than through office visits; (c) when large geographic distances (e.g., rural areas) are involved, it may be the only practical way of delivering services; (d) engagement is facilitated since the home visit allows the clinician to learn about adolescents' hobbies, such as music, video games, etc.; and (e) many adolescents need help with transportation.

### Challenges of Home Visits

Home visits present special challenges that must be addressed in clinician training and supervision. As one clinician said, "Going into the home was probably one of the toughest things because whatever you prepared for, you didn't see it... you always saw something different and things change so rapidly that it was tough to stay on top of how you would prepare for the next home visit." Since home visits contain an element of unpredictability, clinicians should always remain alert and conscious of personal safety through frequent monitoring and assessment of the environment.

Challenges that accompany home visits include the travel time to participants' homes and occasionally, the clinician will encounter difficulty with interruptions, loud noises, or eavesdropping. Because of the travel time, clinicians need to carry a lower caseload than outpatient counselors typically carry; both urban and rural areas could present travel difficulties. ACC clinician to participant ratios are similar to those found in assertive community treatment programs for the severely mentally ill. Clinicians are instructed to minimize interruptions by inviting the participant to go to the park or a restaurant for a snack. This approach has usually been successful in gaining the necessary privacy and control over a session that occasionally is difficult in home visits. It may also add to a participant's comfort level. One clinician explained, "If I see that the client is uncomfortable, I'll say, 'Well, we can go somewhere and have a session.' I've had sessions at like the bookstore or restaurant or a park or something like that if the client isn't comfortable staying at the house." Though meeting in public places can be more comfortable than meeting in the home for certain participants, it is important to keep privacy in mind. Therefore, it is advised that the clinician:

- Should not wear his/her company badge or name tag
- Remind the participant before going to a park or restaurant that if people are around, he/she is not expected to discuss anything personal or uncomfortable
- Let the client lead the discussion, only talking about issues they feel comfortable bringing up in public
- Try to find a table or area away from other people as much as possible

It is important to note that probably the most frequent difficulty in conducting procedure-based sessions in ACC has more to do with what is going on in the participant's life on the day the



clinician visits. During traditional office-based continuing care, if the participant is distraught over some situation in his/her life, he/she may simply “no show” for an appointment. Thus, the clinician must be prepared to encounter a participant at home who is not willing to work on “procedures.” In these situations, the clinician may find the participant open to working on the problem or sufficiently disturbed that it would better to go for a drive, to the mall, or some other diversion that simply communicates, “I care.” Typically, the next session may provide a better opportunity for procedure-based work.

Finally, one of the biggest challenges of home visits is the safety of the clinician. Safety considerations and important items to take into account are discussed later in this chapter.

### **Safety Considerations**

A clinician should not go into a highly threatening area alone. Safety should always be stressed and never taken for granted. If there is any question of safety, the clinician is encouraged to meet the participant on neutral ground, in a public place, or if possible, with another staff member.

Some situations where the clinician may not want to do a home visit:

- If a participant has many visitors at his/her house and the clinician suspects that illegal activity, perhaps drug sales, is taking place
- If a male participant makes inappropriate sexual remarks to a female clinician

Part of the training regiment for the ACC clinician includes safety awareness during home visits. In addition, the clinician is instructed to pay attention to his/her perceptions and instincts. Clinicians have implicit permission to leave a home at any time they sense the possibility of danger. However, since the clinician’s approach with participants is decidedly positive and constantly searching for positive aspects of behavior to praise, we believe that this attitude serves to prevent untoward situations from occurring. Confrontation of denial or unseemly behavior could potentially predispose certain participants to more threatening verbal or physical behavior.

### **Before Leaving for the Appointment**

Before leaving for an appointment with a participant, there are several things that the clinician should keep in mind in regards to safety. These points can help the clinician leave a situation quickly, help him/her from becoming lost, and inform him/her of the type of situation he/she is entering in the home.

- Review the participant’s history, as the clinician can learn much about the home environment
  - Look at the participant’s treatment chart to be aware of any history of violence or mental health issues
  - Talk to treatment staff who have had experience with the participant
  - For example, one clinician reported this situation: “This participant was discharged from the residential unit for violent and bizarre behavior. Before going to his house, I talked with several residential staff who said that he had only been violent

when people were confrontational with him. I reviewed his chart thoroughly and knew which of his mental health symptoms had led to violence in the past. I also talked to his mom and made sure she would be home during the appt. During the appointment, I called a coworker to let them know I was there and when I would be leaving. I sat in a chair closest to the door and had the client bring his urine tests out to me rather than going to the bathroom to get the results. I also met with him at his other treatment provider's office when possible. The participant never showed any signs of violence or frustration during our visits."

- Wear clothes that do not restrict movement; no sandals, skirts, or dangling earrings
- Locate the address on a map and carry a paper copy to the appointment
- As the clinician approaches the participant's home, assess the neighborhood
  - Before getting into the car, it may be helpful to ask coworkers if they have been to the area before, how they felt visiting there, etc.
  - If the clinician is not comfortable parking the car and approaching the house, he/she may want to consider returning at another time with a coworker
  - Always avoid questionable areas after dark
- The clinician should let someone in the office know where he/she is going and what time he/she will be returning
- Carry only the necessities and keep personal items to a minimum
  - Store valuables and personal items out of sight
  - Do not wear an identifying badge or name tag
  - Transport paperwork in a locked briefcase
- Call ahead if there is an appointment scheduled
  - Confirm that the participant or caregiver is expecting the clinician
  - Get directions from the participant or caregiver
  - Ask the participant or caregiver to chain or seclude any pets (i.e., dogs) before the clinician arrives
- Always have a cellular phone in case of an emergency; make sure the phone is fully charged
- Make sure that there is enough gasoline in the car
- Drive with the windows rolled up and the doors locked
- If the clinician decides to bring a coworker: Agree ahead of time on a word or phrase that can be used to signal the need to leave a situation immediately

### **Before Getting Out of the Vehicle**

When the clinician arrives in the participant's neighborhood and before parking and exiting the vehicle, he/she should drive by the address and assess the surroundings. There are many details about the surroundings to consider if the clinician needs to leave a situation quickly and safely. Some things to consider:

- Are there people walking/standing/sitting outside the location or in the neighborhood?
  - For example, one clinician said, "We have had the situation when a large group of people congregated outside someone's door when we drove up for an appointment. In that instance, we drove away and attempted to call the person we wanted to meet

inside. After 15 minutes or so, the crowd dissipated, and we went in.”

- Is there suspicious activity (e.g., several cars stopping by one house for short periods of time, someone hanging around on a street corner)?
- Are there pets or signs of pets in the yard?
- Park as close as possible to the location
- Park near available light sources
- Avoid parking in driveways to prevent a blocked exit

### **Before Entering the Adolescent’s Home**

Upon parking and exiting the vehicle, the clinician should bring only the necessary items into the home. The clinician should keep his/her hands out of pockets and walk in front of or behind a coworker (if present), not side-by-side. It is important that the clinician have an air of confidence without being threatening.

At the door, the clinician should identify himself/herself following confidentiality guidelines set for the agency. He/She should never enter a home unless the door is answered and he/she is invited inside. Upon entry, call a coworker from the cell phone to let them know of the arrival and when to expect to be back in the office; this also lets people in the home that someone is keeping track of the clinician.

### **Inside the Adolescent’s Home**

Once inside the participant’s home, there are several things to be aware of. These points can help the clinician leave a situation quickly and inform him/her of the type of situation taking place in the home:

- Always keep a cell phone turned on and accessible
- Ask the participant if there is anyone else in the home
- Regarding hand-shaking
  - Some clinicians prefer not to shake hands with anyone in the home; if a hand is offered, the clinician could state that he/she seems to be “coming down with something” and does not want to make the person ill
  - Conversely, other clinicians feel that shaking hands, especially with a caregiver, helps build rapport; a hand-shake may be appropriate as long as the situation feels safe
- Avoid walking in front of anyone other than a coworker (if present)
- Scan the environment
  - Are there other people in the house (e.g., parents, siblings, friends)?
  - Are there pets or signs of pets (particularly large dogs)?
  - Are there signs of distress (e.g., overturned furniture)?
  - Are there weapons visible?
  - Is there drug paraphernalia visible?
  - Where is the nearest exit?
  - Listen for sounds

- If a coworker is present, know where he/she is at all times and maintain visual contact
- During the session, stay on the same level as the participant or caregiver (e.g., sit if the other person sits, stand if the other person stands)
- Stay in the common areas of the home; do not go into a bedroom
- Station oneself closest to the nearest exit, preferably with the back to a corner or the front door (in order to survey the entire room)
  - Avoid sitting on the floor or furniture that will be difficult to get up from
  - Avoid leaning back; sit forward
- Decline offers of food or drink
  - The clinicians should politely state that he/she is on a diet, has an allergy, etc.
  - The clinician may accept if he/she feels comfortable after the first or second sessions

If the environment is questionable for conducting a session, offer to have the session in a restaurant or at the office.

### **Concluding the Home Visit**

The clinician should leave the participant's home immediately after business is concluded. If a coworker is present, the person furthest from the door should exit the home first. The clinician should scan the outside environment for any changes that may have occurred during the visit. Have car keys ready and inspect the car for anything out of the ordinary (e.g., a door left open, problems with windows or tires). It is also important to wait until the clinician returns to the office to organize materials from the visit. Once the clinician returns to the office, he/she should note any problems finding the house or entrance, specify where driving directions can be found, and indicate any safety issues.

### **Behaviors to Monitor**

As a clinician working in participants' homes, it is imperative to monitor certain behaviors:

- Anxiety: Sweating, pacing, wringing of hands, changes in speech or breathing patterns, lack of eye contact
- Defensiveness: Swearing, yelling, accusing
- Acting out: Throwing objects, threatening physical harm

While these behaviors are not inherently indicators that the clinician's safety is at risk, it is important that the clinician be aware of these behaviors present in the participant or another person in the home.

However, there are certain situations in which the clinician should always immediately leave the home:

- When a weapon is visible
- When drug dealing or open substance use occurs while the clinician is in the home
- When the clinician suspects that the participant is under the influence

- For example, one clinician reported this situation: “I showed up at this participant’s house for a scheduled session. I talked to him for about five minutes and realized he was likely high, due to blood shot eyes, trouble paying attention, and strange responses to questions. I quickly made up an excuse that I didn't feel well and would rather meet next week. I was friendly and nonconfrontational. I told him I would call tomorrow to reschedule and left. I did call him the next day and we were able to meet again the next week.”
- When someone threatens the clinician or another person in the home
- Anytime the clinician feels threatened or unsafe

If the clinician feels that he/she needs to leave the home quickly and safely, there are statements he/she could make in order to leave politely:

- “I forgot something that I need for our session”
- “I’m not feeling well; I’ll call you tomorrow to reschedule”

## **VI. Structure and Format of Sessions**

### **Before the Session**

In preparing for a session, after reviewing the manuals, the clinician should consider the goal of the session for the day. The clinician might think, “Well, it’s been two weeks since I’ve done a Happiness Scale, so I want to make sure I check in on that and have the participant do a scale.” The goal for each session will differ based on how long the participant has been involved with ACC and material that was covered during the last session. A main goal of one session could be to provide transportation to an outpatient session, but during the ride the clinician may take the opportunity to work on a procedure like problem solving. If the clinician wishes to conduct a Functional Analysis, Happiness Scale, or work on the Goals of Counseling, it is important to have the appropriate paperwork on hand. After the first session, it will almost always be necessary to review completion of homework, so it is important for clinicians to review progress notes from previous sessions to remind themselves of what homework was assigned.

### **Beginning the Session**

Sessions with participants generally begin in a very casual way that fits with a home visit. The clinician will usually greet the participant enthusiastically. He or she might say something like, “Oh, good, I’m so glad that we can get together today.” The clinician praises the adolescent for being on time for the appointment or for meeting with him or her. Then the clinician begins the conversation by saying something like, “Hey, how’s it going? What’s been going on this week? What did you do this weekend? How is school going?” The main purpose of the session opening is to help the participant be comfortable, show an interest in him or her, and get basic information about how everything is going. Following the praise for attendance, and questions that assess how the adolescent’s week has been, the next part of the session is to check on homework completion. The clinician may say something like, “Hey, were you able to follow through with that job interview?” If the participant did complete the job interview, the clinician will offer praise for doing so and ask about the result. If the participant did not complete the homework, then this usually provides an opportunity for some problem solving or it might involve actually helping them complete the homework during the session.

Sessions with caregivers will also begin with praise and sharing with them in a general way what the clinician is doing with their child. The clinician wants to build rapport with the parents by praising them for their work with their adolescent, for meeting with the clinician, and for their support as they work together to try and help the adolescent.

### **Session Topics and Themes**

The bulk of the session will depend on what the clinician hopes to cover during the session (e.g., goals of counseling, problem solving skills) and what the participant shares during the session opening. There are times when the bulk of the session will be used to provide transportation or to visit another service provider and complete paperwork. The clinician will almost always ask about substance use, social and recreational activities, relationships, family issues, and attendance at outpatient treatment or self-help groups. Other issues that may be discussed,

depending on the adolescent's situation, include school, jobs, and legal issues. The direction the clinician goes after these questions depends on what the adolescent presents. For example, if an adolescent has relapsed, the clinician will most likely analyze the relapse with him or her and review relapse prevention procedures. If the adolescent is not very talkative, the clinician may bring out a Happiness Scale, have the adolescent rate his or her happiness in the 11 life areas and use this as the beginning of the conversation. If the clinician believes it is appropriate to introduce and work with a procedure (e.g., problem solving, Functional Analysis of Substance Use), then it is important to keep the focus on completing the procedure and not be easily distracted into discussing other issues. A certain amount of structure is important in order for the adolescent to learn from the procedures, but the most important aspect of successful application is knowing the appropriate time to introduce them.

As is evident in the A-CRA manual, the caregiver sessions are more scripted and have specific material to cover and practice during the four sessions designed for them.

### **Ending the Session**

Before concluding the session, there are two tasks the clinician strives to accomplish. The first one is to identify with the participant the homework they will do before the next session. The homework can be directly related to a procedure covered during the session or it can be to sample (try out) a new prosocial activity. Ideally, the clinician will work with the participant to identify the when, where, and how of the activity: what day the participant will do it, where they will do it, and how they will get to the activity or solve any problems related to it. The clinician may use time during the session to have the participant call for further information about the activity so they can figure out together how to remove any barriers related to completing the activity. The other important task before ending the session is to set up the next appointment and ensure that the participant has written it down. The clinician should always try to end the session on a positive note. A session may go long if there is something bothering the adolescent that the clinician feels needs to be discussed.

### **Sequencing of Adolescent Sessions and Content**

In the first session, a clinician generally begins with a Happiness Scale because it provides information about how the adolescent feels about different areas of his or her life. The discussion of the Happiness Scale leads naturally into the Goals of Counseling. Completing the Goals of Counseling helps the clinician and adolescent know what to focus on in subsequent sessions. Both of these (Happiness Scale and Goals of Counseling) can be repeated as often as needed. The clinician should also try and complete Functional Analyses of Substance Use and Prosocial Behaviors in the first three to four weeks of ACC because these procedures provide important information about how to avoid situations that may lead to relapse and begin to help define possible social and recreational activities that adolescent can increase.

There are situations and participants in which this order does not work because of something that might have occurred. For example, the adolescent may have had a big fight in the past week with a sibling or a parent, may have gotten in trouble at school, or may need to see a probation officer.

The clinician has to assess what is the greatest need at the moment and learns this through experience and the supervision process.

### **Sequencing of Caregiver Sessions and Content**

The clinicians are expected to meet with caregivers for four face-to-face sessions (two with the caregiver alone and two with the caregiver and adolescent). Because the number of sessions and time with the caregivers is limited, these sessions are more structured than ones with adolescents. The content of these sessions is described in the A-CRA manual. The first session provides an opportunity for the clinician to give an overview of the treatment goals and develop rapport. During the second session, the therapist and caregiver work on learning and practicing communication skills. In the remaining two sessions, the clinician works with the caregiver and adolescent together to reinforce and practice caregiver-adolescent relationship skills.

Since the clinicians go to the home, they often run into parents on their visits. On these chance meetings, it is a good idea to check-in with the caregiver to see what his or her perspective is on how the adolescent is doing and how things have been for the family in the past week.



## VII. First Session

The ideal situation is for the clinician to meet the new participant a couple of weeks before he or she is discharged. This can usually happen if the adolescent is going to have a planned discharge. Many times, however, the adolescent will leave residential treatment in an unplanned manner and in this case, the first session with the adolescent will be on a home visit. Even when the adolescent leaves residential treatment in an unplanned manner, depending on the particular residential program, there may be warning signs that this is going to happen (for example, if the adolescent is put on a jeopardy status). In any case, it is important for the clinician to stay in contact with staff on the residential unit in order to stay abreast of the participant's anticipated discharge date and status. It is also important for the clinician to review the adolescent's residential treatment case record and discuss his or her response to treatment with residential counselor.

### Approach/Material to Be Covered

- In our setting, participants are told that they will have the opportunity to have a clinician during the intake to residential treatment. Some are happy about the prospect, others are not and few remember much about the particulars of the ACC program by the time they have their first meeting with the clinician. The clinician will need to provide an overview of what it will mean to be in ACC. Here are some important aspects for clinicians to remember about the approach and material covered:
  - The goal of this first meeting with the participant is to “sell” him or her on continuing to meet with the clinician.
  - Emphasize that it will be fun for the participant to work with the clinician.
  - Explain that the clinician is not an extension of the treatment program per se in that the approach will be very different. At the same time, emphasize that the clinician is not an extension of the probation department and will not be running to tell his or her probation officer if the adolescent uses. One clinician said he introduced ACC this way:
    - This is not your typical treatment . . . you are not held accountable for what you do every day and you do not have to report to groups and report to certain sessions and all that. Neither is it like the normal counseling type session, where you just sit in an office and talk. This is something that you are going to want to do to if you want to get where you what to go . . . if you want to survive.
  - The adolescent is told that the clinician hopes to meet with him or her for 12 times on a weekly basis and with one or more caregiver for four sessions. These meetings will be at the participant's home or another comfortable place and there will be times that the clinician helps with transportation.
  - Emphasize that the participant will have a lot of control about goals that are set and topics that are discussed.
  - Ask for the adolescent's address and phone number in case there is incorrect information in the file.
  - Find out critical information (probation/parole status) and information that will help build the relationship and direct future visits (e.g., do they have a boyfriend/girlfriend, do they know if there is a good AA group in their area, what do they like doing for fun?).

- Emphasize that it is important for them to get involved in certain activities that were recommended upon discharge (e.g., outpatient treatment and AA).
- Emphasize that ACC has been very successful with other participants like them and these adolescents have been successful at meeting their goals.
- Set up the next appointment and emphasize that it is important for the participant to call the clinician if he or she cannot make the appointment. In our program, the clinician would leave a card with a toll free number that the participant could call if he or she was not going to be available for a home visit.

The clinician has to be attuned to the signals that the adolescent is sending and respond accordingly. Here is an example of a first session that started out poorly, but took a turn for the better with the clinician's responsiveness:

*The clinician said she was getting these vibes from the new participant as she was explaining the program and things they'd do and he was like getting fidgety and asked how much longer the session was going to go because he didn't want to miss his friends. He was supposed to get with his friends and he didn't want to miss them, so he wanted to know when it was going to be over. There were clear signs of boredom and resistance. And she kind of changed the topic and said, "You know, we do a lot of fun things too" and talked about going to play video games or going to the mall or taking in a movie or something like that and she could just see the guy perk up and he ended up talking at length and showing her some video games he had and that type of thing.*

## **VIII. Addressing Clinical Issues**

A number of clinical issues and problems arrive with this population. The following is a description of typical ones based on our experience and recommended responses.

### **Clinician Response to Lateness**

When no one is home for an appointment, the clinician should wait for a period of time, within reason, to see if the participant is running late. If the participant shows up late, the clinician can respond by saying, “Hey, I’m really glad you showed up! I’ve been looking forward to seeing you.” Then the clinician can clarify what the scheduled time for the appointment was supposed to be and explore the reasons the participant was late. The clinician avoids confrontation, but instead praises the participant and shows appreciation for his or her willingness to meet. By having a neutral stance, the clinician holds the participant responsible for trying to be on time for scheduled appointments, but does not alienate him or her through confrontation.

### **Clinician Response to Missed Sessions**

Once a participant has missed a session, the clinician should attempt to contact him or her by phone as soon as possible after the missed appointment. After reaching the participant by phone, the clinician explores the reasons the participant could not keep the appointment. If the participant does not have a phone or does not respond to messages left at the home, the clinician should follow up with a letter and/or attempt to recontact the participant in person at home, school, or other known hang out places. Once the clinician is able to establish contact, he or she is supportive and expresses eagerness to see the participant again, schedules the next appointment and requests that the participant call in the future if an appointment needs to be canceled. Again, the clinician should not be confrontational. Depending on the reason for the missed session, the clinician may want to use problem-solving procedures with the participant to address how to overcome barriers to treatment attendance.

### **Clinician Response to Refusals to Meet**

Occasionally, an adolescent may refuse to meet with the clinician. In this situation, the clinician should explore the reasons the participant does not want to meet. The clinician does not give up on the participant easily. Continuous attempts to connect with the participant should occur. The treatment process is presented with a positive attitude that is respectful of the participant’s defenses. Early in the treatment process it is critical to identify the participant’s reinforcers or motivators and work on those. An attempt is made to try and “hook” them into treatment by making the connection with what each person wants to work on or achieve and how the ACC clinician will help him or her reach those goals. It is important for the clinician to always be cognizant of each participant’s wants and needs rather than focusing on his or her own agenda. For example, some participants may not want to talk about a relapse or when they used to use. In this case, the clinician can back off and try to find a safe area for building the therapeutic relationship.

Resistance and compliance issues are usually common and ongoing in a therapeutic relationship, especially when treating adolescents. Participants usually resist change because their present behavior is meeting a need or providing a payoff that the participant is hesitant to relinquish. ACC clinicians try to avoid power struggles by not confronting resistance. Appropriately responding to resistant behaviors is a critical aspect of ACC. Resistance can be either influenced or decreased by a clinician's behavior and style. It is difficult to articulate this approach in a procedure description because it involves multiple behaviors on the part of the clinician: listening with empathy, having genuine concern, being open-minded, affirming, reflecting, praising and expecting, accepting, and rolling with resistance. Compliance enhancement strategies begin before a clinician even meets the participant and continues through termination. It is an ongoing process.

### **Strategies for Dealing with Low Motivation**

Sessions should begin with an emphasis on empathy and skillful rapport-building as a means of building a strong therapeutic alliance and working through resistance. Motivators need to be identified and attended to early and throughout treatment to keep enhancing participants' interest and engagement. The clinician needs to actively engage participants and families by creating strong alliances, expressing interest in their participation, finding a goal that the participant is interested in working on, expressing optimism in their capacity to change, and persisting to contact the family during the earliest signs of disengagement. Home visits are very important in initiating and sustaining the involvement of most treatment resistant families.

### **Strategies for Dealing with Recurrent Crises**

If a participant or family are always presenting crisis situations, it is important for the clinician to explore what the crisis is and why it keeps coming up. In addition to the steps already discussed in the crisis management section, the clinician may need to do some problem-solving procedures, anger management procedures, communication skills, relapse prevention, or family sessions. The clinician assesses the need for additional services and, if indicated, helps the participant get linked to those services.

### **Clinician Response to Adolescents Who May Be Under the Influence**

If a participant is under the influence when a clinician arrives for their session, the clinician should reschedule the session for another day. Again, the clinician is not confrontational or accusing. He or she might say, "I can see you have been using" or "You have told me you have been using today, so why don't we go ahead and reschedule for another day." The follow-up session can be used to review the relapse and do some relapse prevention or other appropriate procedures.

### **Clinician Response to Co-Occurring Problems**

Our experience was that it was common for adolescents we were working with in ACC to have co-occurring problems. Often they had psychiatric problems and needed to be assessed by a psychiatrist for psychotropic medication. These problems were often identified in residential

treatment and if so, there were recommendations made for referrals to other services once discharged. The clinician helps the participant link to recommended service because the theory underlying ACC assumes that treating these co-occurring problems is important in creating an environment conducive to recovery. It is also possible that the clinician will become aware of these problems once the participant is in ACC. In this situation, the clinician needs to assess the problem, make appropriate referrals, and assist the participant in getting linked to the appropriate services. Once the linkage is complete, the clinician continues to provide support, encourages attendance and participation at the new service, and monitors the participant's response to it. It is important for clinicians to be aware of the limits of their own knowledge and expertise regarding co-occurring problems as well as the limitations of the protocol.

## **Gender and Cultural Competence**

Ethically, clinicians using any approach need to be sensitive to gender and cultural differences among the adolescents and families with whom they work. Gender and cultural competence have been identified as essential elements in developing successful therapeutic alliance between the clinician and those adolescents and families he/she seeks to help (Drug Strategies, 2003). Therapeutic alliance appears to be a powerful building block for change. If clinicians have not already had training to enhance their gender and cultural competence, it is important that they seek out opportunities to increase their competence in this area. Below are some examples of what ACC clinicians told us regarding cultural competence:

*In terms of Appalachian culture, there are a lot of times we feel like we have to do a little more to engage the family because they tend to be a little more closed off. They're closed to outsiders, so...they're not as open to you necessarily meeting in their home, those kinds of things...so making adjustments for that.*

*In our community, all of our clinicians are Hispanic-Mexican American. And like 98% [of the adolescents and families] are Hispanic-Mexican American, so we know our culture pretty well. There are differences...and so we are always learning about the way different families live and different subcultures...I think the socioeconomic differences are significant. Seeing families living with six, seven, or eight family members all under the same roof in one and two bedroom homes does happen. Extended family living in the home, so one of the things we are faced with is young parents with teenage kids who are living with their parents, who are living with aunt or uncle and then there is different rules to follow, so there is not a clear leader, so to speak. They do not know who to listen to because everybody is telling them something different and their mom tells them this, and then someone else comes in and says something different, so those issues come up...we just really have to look at each individual family and be sensitive to what their beliefs are.*

## **IX. Final Session: Discontinuing Case Management**

### **Discontinuing Case Management**

The ACC project on which this manual is based was designed to include 14 sessions over a 90-day period following discharge from residential treatment. Participants were told from the outset that they were participating in a three-month intervention, thus, they knew from the beginning when case management would end. Often, the length of ACC contact was extended by one or two weeks. Reasons for extending participation were: a) missed sessions due to illness or weather conditions; b) incomplete linkage to a service provider that the clinician was helping the participant to access; or c) the need to complete a combined caregiver/participant session (these are the most difficult due to scheduling difficulties with caregivers work schedules).

For those participants who complete eight or more sessions (most do) we provide them a certificate of completion of ACC. This symbolic gesture of closure is meaningful to many participants and it helps to conclude the relationship. There is, however, nothing “magic” about terminating at three months and, in fact, the flexible nature of ACC would allow recycling of many of the procedures (e.g., Happiness Scale, updating Goals of Counseling, problem solving, communication training, etc). In this way, ACC could continue well beyond three months and until it was mutually agreeable to terminate. It should be pointed out, however, that keeping a case open longer means that more clinicians will be needed to keep up with the flow of new participants into continuing care.

Regardless of when the case is closed, it is important for the clinician to help the participant feel positive about the experience and what he or she has accomplished. It is important to acknowledge the participant’s hard work during continuing care by reviewing progress made and to reinforce skills learned. Hopefully, this positive review of progress will provide motivation and encouragement to apply these skills in the future.

During the last session, the clinician will:

- Review Happiness Scales and demonstrate how they have changed over the course of the three months of ACC.
- Review the Goals of Counseling and discuss whether or not goals have been achieved. If there are any goals that have not been achieved, it is important that these be discussed and a plan to devised to complete them after the clinician is no longer visiting weekly.
- Recap the importance of any services participants have used during the continuing care experience (e.g., medication monitoring, WIC, GED, AA, etc.) and reinforce continuing with them if they are still needed.
- Review with adolescents their relapse prevention plans which are designed to help extricate them from relapse trigger situations or recover quickly should a lapse occur.
- Reinforce with the participant that he or she should and can return to primary treatment if the need arises due to a relapse.

## **X. Certification and Ongoing Supervision Guidelines**

Information regarding certification and ongoing supervision guidelines are located in the “Certification Requirements” and “Quality Assurance and Supervision” sections of this training notebook.

The A-CRA/ACC Training Team

## XI. References

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## XII. Resources

### Ordering Information:

*The Adolescent Community Reinforcement Approach for Adolescent Cannabis Users* (Godley, Meyers, Smith, Karvinen, Titus, Godley, Dent, Passetti, & Kelberg, 2001):  
Published by the Center for Substance Abuse Treatment. Available at the SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) web site:  
[www.health.org](http://www.health.org).

### Web Sites with Relevant Information:

Chestnut Health Systems: [www.chestnut.org](http://www.chestnut.org)  
Information about CHS and Lighthouse Institute, including ordering information for the GAIN and other Lighthouse Publications.

### Training Resources:

For information on ACC training, contact [ebtxquestions@chestnut.org](mailto:ebtxquestions@chestnut.org). Your inquiry will be answered by return email or phone call.

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