



Mindful
Continuing Education

Treating Stimulant Use Disorders- Part One



I. Introduction to the Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders

Approach and Package

The Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders (IOP) package provides a structured approach for treating adults who abuse or are dependent on stimulant drugs. The approach followed in the treatment package was developed by the Matrix Institute in Los Angeles, California, and was adapted for this treatment package by the Knowledge Application Program of the Center for Substance Abuse Treatment of the Substance Abuse and Mental Health Services Administration (SAMHSA). The Matrix IOP package comprises five components:

- ***Counselor's Treatment Manual*** (this document)
- ***Counselor's Family Education Manual***
- CD-ROM that accompanies the ***Counselor's Family Education Manual***
- ***Client's Handbook***
- ***Client's Treatment Companion***

The Matrix IOP model and this treatment package based on that model grew from a need for structured, evidence-based treatment for clients who abuse or are dependent on stimulant drugs, particularly methamphetamine and cocaine. This comprehensive package provides substance abuse treatment professionals with an intensive outpatient treatment model for these clients and their families: 16 weeks of structured programming and 36 weeks of continuing care.

Background

The Matrix IOP method was developed initially in the 1980s in response to the growing numbers of individuals entering the treatment system with cocaine or methamphetamine dependence as their primary substance use disorder. Many traditional treatment models then in use were developed primarily to treat alcohol dependence and were proving to be relatively ineffective in treating cocaine and other stimulant dependence (Obert et al. 2000).

To create effective treatment protocols for clients dependent on stimulant drugs, treatment professionals at the Matrix Institute drew from numerous treatment approaches, incorporating into their model methods that were empirically tested and practical. Their treatment model incorporated elements of relapse prevention, cognitive-behavioral, psychoeducation, and family approaches, as well as 12-Step program support (Obert et al. 2000).

The effectiveness of the Matrix IOP approach has been evaluated numerous times since its inception (Rawson et al. 1995; Shoptaw et al. 1994). SAMHSA found the results of these studies promising enough to warrant further evaluation (e.g., Obert et al. 2000; Rawson et al. 2004).

In 1998, SAMHSA initiated a multisite study of treatments for methamphetamine dependence and abuse, the Methamphetamine Treatment

Project (MTP). The study compared the clinical and cost effectiveness of a comprehensive treatment model that follows a manual developed by the Matrix Institute with the effectiveness of treatment approaches in use at eight community-based treatment programs, including six programs in California, one in Montana, and one in Hawaii. Appendix A provides more information about MTP.

Matrix IOP Approach

Overview

The Matrix IOP approach provides a structured treatment experience for clients with stimulant use disorders. Clients receive information, assistance in structuring a substance-free lifestyle, and support to achieve and maintain abstinence from drugs and alcohol. The program specifically addresses the issues relevant to clients who are dependent on stimulant drugs, particularly methamphetamine and cocaine, and their families.

For 16 weeks, clients attend several intensive outpatient treatment sessions per week. This intensive phase of treatment incorporates various counseling and support sessions:

- Individual/Conjoint family sessions (3 sessions)
- Early Recovery Skills group sessions (8 sessions)
- Relapse Prevention group sessions (32 sessions)
- Family Education group sessions (12 sessions)
- Social Support group sessions (36 sessions)

Clients may begin attending Social Support groups once they have completed the 12-session Family Education group but are still attending Relapse Prevention group sessions. Overlapping Social Support group attendance with the intensive phase of treatment helps ensure a smooth transition to continuing care.

The Matrix IOP method also familiarizes clients with 12-Step programs and other support groups, teaches clients time management and scheduling skills, and entails conducting regular drug and breath-alcohol testing. A sample schedule of treatment activities is shown in Figure I-1.

Program Components

This section describes the logistics and philosophy of each of the five types of counseling sessions that are components of the Matrix IOP approach. Detailed agendas and instructions for conducting each type of group and individual session are provided in the designated sections of this manual and in the *Counselor's Family Education Manual*.

The Matrix materials use step-by-step descriptions to explain how sessions should be conducted. The session descriptions are methodical because the treatment model is intricate and detailed. Counselors who use these materials may want additional training in the Matrix approach, but these materials were designed so that counselors could implement the Matrix treatment approach even without training. The Matrix materials do not describe intake procedures, assessments, or treatment planning. Programs should use the procedures they have in place to perform these functions. If the guidelines presented in this manual conflict with the requirements of funders or credentialing or certifying bodies, programs should adapt the guidelines as necessary. (For example, some States require that sessions last a full 60 minutes to be funded by Medicaid.)

Figure I-1. Sample Matrix IOP Schedule

Schedule	Intensive Treatment Weeks 1 through 4*	Intensive Treatment Weeks 5 through 16†	Continuing Care Weeks 13 through 48
Monday	6:00–6:50 p.m. Early Recovery Skills 7:15–8:45 p.m. Relapse Prevention	7:00–8:30 p.m. Relapse Prevention	Nothing scheduled
Tuesday	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings
Wednesday	7:00–8:30 p.m. Family Education	7:00–8:30 p.m. Family Education or 7:00–8:30 p.m. Social Support	7:00–8:30 p.m. Social Support
Thursday	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings
Friday	6:00–6:50 p.m. Early Recovery Skills 7:15–8:45 p.m. Relapse Prevention	7:00–8:30 p.m. Relapse Prevention	Nothing scheduled
Saturday and Sunday	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings	12-Step/mutual-help group meetings

* 1 Individual/Conjoint session at week 1

† 2 Individual/Conjoint sessions at week 5 or 6 and at week 16

All Matrix IOP groups are open ended, meaning that clients may begin the group at any point and will leave that group when they have completed the full series. Because the Matrix groups are open ended, the content of sessions is not dependent on that of previous sessions. The counselor will find some repetition of information among the three Individual/Conjoint sessions as well as group sessions. Clients in early recovery often experience varying degrees of cognitive impairment, particularly regarding short-term memory. Memory impairment can manifest as

clients' difficulty recalling words or concepts. Repeating information in different ways, in different group contexts, and over the course of clients' treatment helps clients comprehend and retain basic concepts and skills critical to recovery.

Individual/Conjoint Sessions

In the Matrix IOP intervention, the relationship between counselor and client is considered the primary treatment dynamic. Each client is assigned one primary counselor. That counselor

meets individually with the client and possibly the client's family members three times during the intensive phase of treatment for three 50-minute sessions and facilitates the Early Recovery Skills and Relapse Prevention groups. The first and last sessions serve as "bookends" for a client's treatment (i.e., begin and end treatment in a way that facilitates treatment engagement and continuing recovery); the middle session is used to conduct a quick, midtreatment assessment of the client's progress, to address crises, and to coordinate treatment with other community resources when appropriate.

Conjoint sessions that include both the client and family members or other supportive persons are crucial to keeping the client in treatment. The importance of involving people who are in a primary relationship with the client cannot be overestimated; the Matrix IOP approach encourages the inclusion of a client's most significant family member or members in each Individual/Conjoint session in addition to Family Education group sessions. The counselor who tries to facilitate change in client behavior without addressing family relationships ultimately makes the recovery process more difficult. It is critical for the counselor to stay aware of how the recovery process affects the family system and to include a significant family member in part of every Individual/Conjoint session when possible.

Early Recovery Skills Group

Clients attend eight Early Recovery Skills (ERS) group sessions—two per week for the first month of primary treatment. These sessions typically involve small groups (10 people maximum) and are relatively short (50 minutes). Each ERS group is led by a counselor and co-led by a client who is advanced in the program and has a stable recovery (see pages 7 and 8 for information about working with client co-leaders). It is important that this group stay

structured and on track. The counselor needs to focus on the session's topic and be sure not to contribute to the high-energy, "out-of-control" feelings that may be characteristic of clients in early recovery from stimulant dependence.

The ERS group teaches clients an essential set of skills for establishing abstinence from drugs and alcohol. Two fundamental messages are delivered to clients in these sessions:

1. You can change your behavior in ways that will make it easier to stay abstinent, and the ERS group sessions will provide you with strategies and practice opportunities to do that.
2. Professional treatment can be one source of information and support. However, to benefit fully from treatment, you also need 12-Step or mutual-help groups.

The techniques used in the ERS group sessions are behavioral and have a strong "how to" focus. This group is not a therapy group, nor is it intended to create strong bonds among group members, although some bonding often occurs. It is a forum in which the counselor can work closely with each client to assist the client in establishing an initial recovery program. Each ERS group has a clear, definable structure. The structure and routine of the group are essential to counter the high-energy or out-of-control feelings noted above. With newly admitted clients, the treatment routine is as important as the information discussed.

Relapse Prevention Group

The Relapse Prevention (RP) group is a central component of the Matrix IOP method. This group meets 32 times, at the beginning and end of each week during the 16 weeks of primary treatment. Each RP group session

lasts approximately 90 minutes and addresses a specific topic. These sessions are forums in which people with substance use disorders share information about relapse prevention and receive assistance in coping with the issues of recovery and relapse avoidance. The RP group is based on the following premises:

- Relapse is not a random event.
- The process of relapse follows predictable patterns.
- Signs of impending relapse can be identified by staff members and clients.

The RP group setting allows for mutual client assistance within the guiding constraints provided by the counselor. Clients heading toward relapse can be redirected, and those on a sound course to recovery can be encouraged.

The counselor who sees clients for prescribed Individual/Conjoint sessions and a client co-leader facilitate the RP group sessions (see pages 7 and 8 for information about working with client co-leaders).

Examples of the 32 session topics covered in the RP group include

- Guilt and shame
- Staying busy
- Motivation for recovery
- Be smart, not strong
- Emotional triggers

Family Education Group

Twelve 90-minute Family Education group sessions are held during the course of the 16-week program. This group meets once per week for the first 3 months of primary treatment

and is often the first group attended by clients and their families. The group provides a relatively nonthreatening environment in which to present information and provides an opportunity for clients and their families to begin to feel comfortable and welcome in the treatment facility. A broad spectrum of information is presented about methamphetamine dependence, other drug and alcohol use, treatment, recovery, and the ways in which a client's substance abuse and dependence affect family members as well as how family members can support a client's recovery. The group format uses PowerPoint slides, discussions, and panel presentations.

The counselor personally invites family members to attend the series. The often negative interactions within clients' families just before beginning treatment can result in clients' desire to "do my program alone." However, Matrix treatment experience shows that, if clients are closely involved with significant others, those significant others are part of the recovery process regardless of whether they are involved in treatment activities. The chances of treatment success increase immensely if significant others become educated about the predictable changes that are likely to occur within relationships as recovery proceeds. The primary counselor educates participants and encourages involvement of significant others, as well as clients, in the 12-session Family Education group. The material for the twelve 90-minute Family Education group sessions is in the *Counselor's Family Education Manual*.

Social Support Group (Continuing Care)

Clients begin attending the Social Support group at the beginning of their last month in primary treatment and continue attending these group sessions once per week for 36 weeks of continuing care. For 1 month, intensive treatment and continuing care overlap.

Social Support group sessions help clients learn or relearn socialization skills. Persons in recovery who have learned how to stop using substances and how to avoid relapse are ready to develop a substance-free lifestyle that supports their recovery. The Social Support group assists clients in learning how to resocialize with clients who are further along in the program and in their recovery in a familiar, safe environment. This group also is beneficial to the experienced participants who often strengthen their own recovery by serving as role models and staying mindful of the basic tenets of abstinence. These groups are led by a counselor, but occasionally they may be broken into smaller discussion groups led by a client-facilitator, a client with a stable recovery who has served as a co-leader and makes a 6-month commitment to assist the counselor.

Social Support group sessions focus on a combination of discussion of recovery issues being experienced by group members and discussion of specific, one-word recovery topics, such as

- Patience
- Intimacy
- Isolation
- Rejection
- Work

The Role of the Counselor

To implement the Matrix IOP approach, the counselor should have several years of experience working with groups and individuals. Although detailed instructions for conducting sessions are included in this manual, a new counselor may not have acquired the facility or the skills necessary to make the most of the sessions. The counselor who is willing to adapt and learn new treatment approaches is an appropriate Matrix IOP counselor. The counselor

who has experience with cognitive-behavioral and motivational approaches and has a familiarity with the neurobiology of addiction will be best prepared to implement the Matrix IOP intervention. Appropriate counselor supervision will help ensure fidelity to the Matrix treatment approach.

In addition to conducting the three Individual/Conjoint sessions, a client's primary counselor decides when a client moves from one group to another and is responsible for integrating material from the various group-counseling formats into one coordinated treatment experience.

Each client's primary counselor

- Coordinates with other counselors working with the client in group sessions (e.g., in Family Education sessions)
- Is familiar with the material to which the client is being exposed in the Family Education sessions
- Encourages, reinforces, and discusses material that is being covered in 12-Step or mutual-help meetings
- Helps the client integrate concepts from treatment with 12-Step and mutual-help material, as well as with psychotherapy or psychiatric treatment (for clients who are in concurrent therapy)
- Coordinates with other treatment or social services professionals who are involved with the client

In short, the counselor coordinates all the pieces of the treatment program. Clients need the security of knowing that the counselor is aware of all aspects of their treatment. Many people who are stimulant dependent enter treatment feeling out of control. They are looking to the program to help them regain control. If the program appears to be a disjointed series of unrelated parts, these clients may not feel that the program will

help them regain control, which may lead to unsuccessful treatment outcomes or premature treatment termination. Appendix B provides more notes on the counselor's role in group facilitation.

In facilitating sessions, the counselor should be sensitive to cultural and other diversity issues relevant to the specific populations being served. The counselor needs to understand culture in broad terms that include not only obvious markers such as race, ethnicity, and religion, but also socio-economic status, level of education, and level of acculturation to U.S. society. The counselor should exhibit a willingness to understand clients within the context of their culture. However, it is also important to remember that each client is an individual, not merely an extension of a particular culture. Cultural backgrounds are complex and are not easily reduced to a simple description. Generalizing about a client's culture is a paradoxical practice. An observation that is accurate and helpful when applied to a cultural group may be misleading and harmful when applied to an individual member of that group. The forthcoming Treatment Improvement Protocol *Improving Cultural Competence in Substance Abuse Treatment* (CSAT forthcoming) provides more information on cultural competence.

Working With Client Co-Leaders and Client-Facilitators

Using clients as group co-leaders is an essential part of the Matrix IOP approach. Clients who have completed at least the first 8 weeks of the program and been abstinent over that period can be client co-leaders for ERS groups. Ideally, client co-leaders for RP groups will have completed the full year of Matrix treatment and been abstinent over that period. These advanced clients bring a wealth of experience to group

sessions. As persons who are recovering successfully, the client co-leaders are in a position to address controversial, difficult issues from a perspective similar to that of clients in the group, often by sharing personal experiences. The client co-leaders also are able to strengthen their recovery in the process and give back to the program and to other clients.

Client co-leaders should be chosen carefully. Clients may be considered for co-leading an ERS group if they meet the following criteria:

- A minimum of 8 weeks of uninterrupted abstinence from illicit drugs and alcohol
- Regular attendance at scheduled RP group and Individual/Conjoint sessions
- A willingness to serve as co-leaders once or twice a week for at least 3 months

Clients may be considered for co-leading an RP group if they meet the following criteria:

- A minimum of 1 year of uninterrupted abstinence from illicit drugs and alcohol
- Completion of the Matrix IOP intervention (i.e., completed 1 year of treatment)
- Active participation in a Social Support group and attending 12-Step or mutual-help group meetings
- A willingness to serve as co-leaders once or twice a week for at least 6 months

When selecting client co-leaders, the counselor also should consider whether clients are respected by other group members and are able to work well with the counselor.

The counselor should ask client co-leaders to sign a formal agreement; an example of such an agreement is in Appendix C.

Before clients begin serving as co-leaders, the counselor needs to orient them to the role. Client co-leaders need to understand the following:

- They are not counselors; their input needs to be made in the first person (e.g., “What helped me was ...” rather than “You should ...”).
- They must maintain the confidentiality of group participants.
- They need to be willing to talk to the counselor about any issues or problems that arise for them while they serve as co-leaders.

The counselor should meet with the co-leader before each group session to discuss briefly the topic and any issues that might arise. After each group session, the counselor should meet again with the co-leader to

- Make sure the co-leader is not distressed by anything that occurred during group
- Discuss briefly how the group went and provide feedback on anything the co-leader did particularly well or that could use improvement (e.g., monopolizing the conversation, confronting a client inappropriately, giving advice rather than relating his or her own experience)

Meeting regularly with client co-leaders provides opportunities for the counselor and co-leaders to improve the way they work together and to maximize the benefits to the co-leaders and other group members.

Clients who have served as co-leaders for ERS or RP group sessions can act as client-facilitators for Social Support group sessions. The counselor should follow the guidelines above when selecting and working with client-facilitators.

The Matrix IOP Package

- *Client's Handbook*—This illustrated handbook contains an introduction and welcome and all the handouts that are used in the Matrix IOP program, except for those used in the Family Education group sessions. Counselors will notice that the *Client's Handbook* uses large type and has art on most of the pages. People in recovery from stimulant use experience memory impairments. But these impairments are much worse for word recall than for picture recall. Clinical experience has shown that clients respond better to the Matrix approach when the treatment materials are accompanied by pictures and visual cues.

If the counselor has enough copies of the *Client's Handbook* to distribute one book to each client, he or she should do so. If not, the counselor should make copies of the handouts (either from the *Counselor's Treatment Manual* or from the *Client's Handbook*) and give one set to each client at the client's first ERS session. Clients keep their handbooks at the clinic, take notes in them, and are given them to keep when they graduate from the Matrix intervention.

Note: During the course of MTP, which served as the model for this treatment manual, copies of the *Client's Handbook* were stored in a locked cabinet until group members arrived, when clients retrieved their handbooks for use during the session. In the interests of client confidentiality, clients put only their first names on the handbooks; no other client-identifying information was listed.

- *Counselor's Family Education Manual* and Slide Presentations—The *Counselor's Family Education Manual* contains

- Introductions to the Matrix IOP package and to the manual
- Instructions for conducting each session
- Handouts for participants

Session instructions are presented in a format similar to that provided for the other types of sessions.

The *Counselor's Family Education Manual* is accompanied by a CD-ROM containing slide presentations for 7 of the 12 sessions.

- *Client's Treatment Companion*—The *Client's Treatment Companion* is for clients to carry with them in a pocket or purse. It contains useful recovery tools and concepts and provides space for clients to record their relapse triggers and cues, write short phrases that help them resist triggers, and otherwise personalize the book. Ideas are included for ways to personalize and make the *Client's Treatment Companion* a useful tool for recovery.

Introduction to the *Counselor's Treatment Manual*

This manual contains all the materials necessary for a counselor to conduct individual and group sessions using the Matrix IOP approach. After the introductory sections, this manual is organized by type of session (i.e., Individual/Conjoint, Early

Recovery Skills, Relapse Prevention, and Social Support). The presentation of each type of session begins with an overview that includes a discussion of

- The general format and flow of the individual or group sessions
- Any special considerations relevant to the particular type of session
- The overall goals for each type of session

The overview is followed by instructions for conducting each specific session. These instructions include

- The goals of the session
- A list of client handouts
- Notes to the counselor about anything to keep in mind during the session
- Topics for group discussion, including key points to cover
- Guidelines for helping clients recognize their progress, manage their time, and address any concerns they have about time management
- Homework assignments for clients

Copies of the handouts that make up the *Client's Handbook* are located at the end of each section's instructions for easy reference. The counselor should review thoroughly the session instructions before conducting each group or individual session.

Readers who are interested in learning more about the Matrix approach to treatment for stimulant use disorders will find a list of articles for further reading in Appendix E.

II. The Role of Drug and Breath-Alcohol Testing in Matrix IOP

Philosophy

In the Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders (IOP) model, drug and breath-alcohol testing is viewed and presented to clients as a valuable tool to help clients become abstinent and enter recovery, not as a punitive monitoring measure. Its use should not be presented or perceived as an indication of mistrust of a client's honesty. Instead, the counselor should help clients accept that people in outpatient treatment for substance use disorders need as many tools as possible to recover. To regain control of their lives, clients need ways to impose structure on their behavior.

Urine or saliva drug and breath-alcohol test results can provide invaluable clinical data when a lapse or relapse has occurred and the client is unable to talk about it. The occurrence of relapse and, often, denial of use make testing for substances an essential component of outpatient substance abuse treatment programs.

The goals of testing for substances in treatment include

- Deterring a client from resuming substance use
- Providing a counselor with objective information about a client's substance use
- Providing a client who is denying use with objective evidence of use
- Identifying a substance use problem severe enough to warrant residential or hospital-based treatment

Procedure

This section assumes that the counselor's program has established procedures for collecting, identifying, storing, ensuring chain of custody for collecting, and transporting specimens. If drug screens are required (e.g., if they have been ordered by the court), clients should be so informed.

Testing Schedule

In the Matrix IOP approach, all clients are asked to provide a urine or saliva specimen for drug analysis and to take a breath-alcohol test once each week. Occasionally, the testing day should be random but should be on a day that most closely follows a period of high risk (e.g., weekends, payday). Unexplained missed appointments, unusual behavior in sessions or groups, or family reports of unusual behavior may indicate a need for immediate testing. The counselor should be sensitive to possible client embarrassment and avoid any unnecessary public discussion or joking about the tests.

A program can screen for a client's substance of choice or for a broad range of substances. The program may want to use Breathalyzer™ screening every time or only when alcohol use is suspected. Full drug screens should be done when the counselor suspects other substance use.

Addressing Tampering

Occasionally a client may attempt to conceal drug use by tampering with a urine specimen. At the time the suspect specimen is submitted,

the client should be taken into a private setting and told that there is some uncertainty about the specimen. Staff members should not be accusatory and should attempt to make the client comfortable. However, staff persons should avoid tension-relieving jokes that might communicate the wrong message about the purpose or importance of urine specimen collection and testing.

Tampered urine specimens usually indicate substance use. Clients who alter their specimens rarely admit it. Specimen tampering is a critical concern in treatment and may signal a relapse. Drug use combined with denial may reflect a breakdown of the therapeutic process. If a client attempts to alter more than one specimen sample, it may be necessary to observe the client giving another sample immediately and on subsequent testing occasions until the client's abstinence is reasonably verified. Doing so should be viewed as a last resort to establish the client's drug use and to encourage truthfulness.

If a situation warrants observing urine collection, the counselor should consult with a supervisor for approval and direction. The counselor should follow the agency's policy and procedures for observing urine collection. Observing urine specimen collection is uncomfortable for staff members and may be humiliating for the client. Urine collection procedures should be explained to the client at the first individual session including the possibility that urine collections may be observed occasionally.

An observed urine collection procedure is a last resort for clients who are having difficulties in the recovery process. It is important to view this procedure as a therapeutic activity. In many cases, drug testing can move clients back on track and prompt them to tell the truth about drug use.

Addressing a Positive Urine Test

A positive drug test is a significant event in treatment. It might mean one use, or it might indicate a return to chronic use. In response to a positive result, the counselor should take the following steps:

- Reevaluate the period surrounding the test. Were there other indications of a problem such as missed appointments, unusual behavior, discussions in treatment sessions or groups, or family reports of unusual activity?
- Give the client an opportunity to explain the result, for example, by stating, "I received a positive result from the lab on your urine test from last Monday. Did anything happen that weekend you forgot to tell me about?"
- Avoid discussion about the validity of the results (e.g., the lab could have made an error; the bottle might have been mixed up with another client's).
- Consider temporarily increasing the frequency of testing to determine the extent of use.
- Reinforce a client's honesty if he or she admits to use, and stress the therapeutic importance of the admission. This interaction may result in admissions of other instances of substance use that had gone undetected.
- Collaborate with corrections or court staff as appropriate.

Sometimes a client responds to the news of a positive urine test with a partial confession of drug involvement, for instance, that he or she

was at a party and was offered drugs but did not use them. These partial confessions are often the closest the client can get to actually admitting drug use.

Occasionally a client reacts angrily to notification of positive test results. Typically, the client may accuse the counselor of lack of trust and display indignation at the suggestion of drug use. These reactions can be convincing and may cause a counselor initially to react defensively. However, the counselor calmly should inform the client that discussing a positive test result is necessary for treatment and that the counselor's questioning is in the client's best interest. If the client is unresponsive to these explanations, the counselor should attempt to move on to other issues. At some other time, the topic of truthfulness may be revisited and the client given another opportunity to discuss the urine test result.

A client should not be discharged from the Matrix IOP intervention because of positive drug test or Breathalyzer results. If there are repeated positive test results, however, it may be necessary for the counselor to stress that abstinence is the goal of the Matrix IOP approach and to consider

increasing the frequency of a client's visits. For example, the counselor could place a client back into the Early Recovery Skills group if the client has already completed those group sessions but has had repeated positive test results, or more individual sessions could be scheduled for a client who is at an earlier stage in the treatment process. If a client continues to have positive drug tests, the counselor may be required to refer the client to a higher level of care.

Even if the client denies drug or alcohol use, the counselor must proceed as if there were use. Lapses should be analyzed with the client (possibly in an individual session), and a plan for avoiding relapse reformulated. It may become necessary to assess the need for inpatient or residential treatment. The counselor's confidence in and certainty of the test results are critical at this point and may be instrumental in inducing an honest explanation from the client of what has been happening. If the urine testing process succeeds in documenting out-of-control drug use and establishes the need for increasing the intensity of outpatient treatment or considering residential or hospital-based treatment, it has served a valuable function.



III. Individual/Conjoint Sessions

Introduction

Goals of Individual/Conjoint Sessions

- Provide clients and their families with an opportunity to establish an individualized connection with the counselor and learn about treatment.
- Provide a setting where clients and their families can, with the counselor's guidance, work out crises, discuss issues, and determine the continuing course of treatment.
- Allow clients to discuss their addiction openly in a nonjudgmental context with the full attention of the counselor.
- Provide clients with reinforcement and encouragement for positive changes.

Session Guidelines

Three individual sessions are scheduled in the Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders (IOP) model. These sessions are 50 minutes long. The initial session orients the client to treatment, and the final session helps the client plan for post-treatment recovery; these are the first and last sessions of the client's Matrix IOP experience. The remaining session should be scheduled 5 or 6 weeks into treatment or when a client has relapsed or is experiencing a crisis. This session focuses on assessing the client's progress, supporting successes, and providing resources to keep recovery strong. Whenever possible, the counselor should involve the client's family or other significant and supportive persons in the individual sessions; these are called conjoint sessions. Substance abuse can place a family in

crisis. The counselor should be mindful that violence can erupt in this kind of environment. A concern for the safety of the client and the family members involved in treatment should be foremost in the counselor's mind.

Starting individual sessions on time is important. The client should feel that the visit is an important part of the counselor's day. The counselor should try to accommodate the client by scheduling individual sessions at convenient times.

Generally, the counselor sees each client alone for the first half of the session and then invites family members to join the client for the second half. This arrangement should be communicated to the client and family members before they arrive for the sessions so that family members can bring along something to occupy them for the first 25 minutes of the session.

Session Format and Counseling Approach

The connection between the client and counselor is the most important bond that develops in treatment. The counselor should use common sense, courtesy, compassion, and respect in interacting with the client and family members.

Session 1: Orientation

The client's family members may be included for the orientation portion of the first session. Family members are informed of how the Matrix IOP approach works and what is expected of the client. The counselor also explains how family members can support the client's recovery and answers questions the client or family members have.

Session 2: Client Progress/Crisis Intervention

During the second session, the counselor ensures that the client and family members have an opportunity to describe urgent issues and to discuss emotionally charged topics. During the first portion of the session, when the counselor meets alone with the client, the counselor determines whether urgent issues, such as strong cravings or a relapse, need to be addressed immediately. If a crisis needs to be addressed, the counselor may want to bring the family members into the session earlier than the halfway point.

If the client's recovery is going well, the counselor introduces the scheduled material for the session. Any positive changes in the client's behavior or attitude need to be strongly reinforced. For example, a client who has done a good job of stopping drug and alcohol use, scheduling, and attending group sessions, but who has

not exercised, needs to be given unqualified reinforcement for the accomplishments. The counselor should mention that the client would benefit from exercise, but the counselor should not engage in a struggle over one area of resistance.

Session 3: Continuing Treatment Planning

The final Individual/Conjoint session is also one of the final sessions of Matrix intensive outpatient treatment. The counselor reviews the client's treatment experience and underscores the importance of recovery activities (e.g., scheduling, exercise, regularly attending a 12-Step program) that help prevent relapse. The counselor works through a goal-setting exercise with the client and helps the client plan steps that will make the goals attainable. The client is encouraged to work on issues that may have been put on hold during treatment, such as couples or family therapy.



Session 1: Orientation

Goals of Session

- Help clients understand what is expected of them during treatment.
- Orient clients and their family members to the Matrix IOP approach.
- Help clients make a treatment schedule.
- Enlist family members' help in supporting clients' recovery.

Handout

- IC 1—Sample Service Agreement and Consent

Session Content

This session is conducted before the first group session and gives the client and family members an opportunity to meet the counselor and learn about the program. The counselor also uses this session to ensure that the client and family members are oriented properly to treatment. At this session, the counselor gives each client a copy of the *Client's Treatment Companion*. Programs should not distribute the *Client's Handbook* during the orientation session. Clients receive the *Client's Handbook* during the first group session. Clients have their own copies and make personal use of them but should not take them home. Programs collect and store the handbooks in a secure location until clients return for the next group session. (Programs may choose to give clients photocopies of the handouts from the *Client's Handbook*, rather than provide an individual copy of the book to each client.)

After greeting the client and family members, the counselor gives them a brief overview of the Matrix IOP model. This overview takes about 10 minutes and includes the following:

- A general introduction to the principles on which the Matrix IOP model is based
- A description of the various components of the Matrix IOP model
 - Individual/Conjoint group sessions
 - Early Recovery Skills group sessions
 - Relapse Prevention group sessions
 - Social Support group sessions
 - Urine and breath tests
 - 12-Step or mutual-help group attendance
- A program schedule that shows the client and family members what a typical week of the Matrix IOP intervention looks like and how sessions change as the client moves through treatment

The counselor brings to the session a list of the program's Matrix IOP meetings and times. With the counselor's help, each client selects a schedule. The counselor then provides a copy of this schedule to the client. The goal is for the client to leave the session with a copy of the schedule and a clear idea of what the next steps are.

The counselor gives the client a copy of the program's service agreement and consent form. (Handout IC 1—Sample Service Agreement and Consent is provided as an example of such a form; programs are free to use or adapt this form if they do not have service agreement and consent forms of their own.) The counselor reads aloud while the client and family members follow along. It is important for the counselor to take time going over this document; the counselor should pause after each numbered item on the form to be sure the client understands what he or she is initialing. The counselor should ensure that the client understands the consequences for not abiding by the agreement.

The counselor allows ample time for questions during and at the end of the session. It is imperative that the client and family members feel knowledgeable about and comfortable with the Matrix IOP approach.



Session 2: Client Progress/Crisis Intervention

Goals of Session

- Help clients assess progress.
- Help clients address any crises they may be experiencing.
- Reinforce recovery principles clients have learned in treatment.

Handouts

- IC 2A—Recovery Checklist
- IC 2B—Relapse Analysis Chart

Session Content

The second Individual/Conjoint session is conducted about 5 or 6 weeks after a client enters treatment. The counselor begins the session by briefly discussing with the client how the recovery is progressing. At this point, the session can take one of two different directions, depending on the client's response:

- If the client's recovery is on track, this session is used to assess progress, review relapse prevention skills, give positive reinforcement for the client's successes, and identify areas in which the client can improve. The client completes handout IC 2A—Recovery Checklist. The counselor either reads the handout with the client or gives the client a few minutes to complete it.

The counselor reviews the client's answers with the client. It is important that the counselor praise the client's progress before moving on to the final two questions on the handout, which address relapse prevention activities the client may be struggling to implement. The counselor may wish to make reference to Early Recovery Skills and Relapse Prevention session descriptions or handouts when reviewing recovery skills with the client. Useful session descriptions and handouts include

- Early Recovery Skills sessions 1, 2, 3, 6, and 7 (in Section IV)
 - Handout IC 2B (in this section)
 - Handouts ERS 3B, 5, 6A, 6B, and 7B (in Section IV)
 - Handout SCH 1 (in Section IV)
 - Relapse Prevention sessions 3, 7, 11, 13, 16, 18, and 21 (in Section V)
 - Handouts RP 3A, 3B, 4, 8, 12, 13, 17, 19, and 22 (in Section V)
- If the client has been struggling with recovery or is experiencing a personal crisis, the counselor spends the session addressing these issues, allowing time for the client to talk about what is going on and, when appropriate, developing a plan to help the client maintain or get back to recovery. If a client recently has had a relapse or feels that a relapse is imminent, the client

completes handout IC 2B—Relapse Analysis Chart. The counselor can read the handout with the client or give the client a few minutes to complete it. The goal of completing this sheet and discussing it is to sensitize the client to the events and feelings that precede a relapse. The counselor may wish to refer to the notion of “mooring lines” that keep recovery anchored, as discussed in Relapse Prevention session 3 (Avoiding Relapse Drift) and its accompanying handouts, RP 3A and 3B. The session descriptions and handouts listed above also may make the client aware of the subtle ways in which behavior can imperil recovery.

Relapse does not occur suddenly or unpredictably, although it often feels that way to the client. The counselor needs to help the client understand the context of the relapse. Handout IC 2B—Relapse Analysis Chart helps the client see relapse as an event that both has antecedents and can be avoided. Many people who successfully complete outpatient treatment experience a relapse at some point in the process. The critical issue is whether the client continues the recovery process following the relapse. The counselor should stress to the client that relapse does not indicate failure; it should be viewed as an indication that the treatment plan needs adjusting.



Session 3: Continuing Treatment Planning

Goals of Session

- Help clients evaluate their progress in recovery.
- Help clients set continuing treatment goals.
- Help clients draft a continuing treatment plan.

Handouts

- Handout IC 3A—Treatment Evaluation
- Handout IC 3B—Continuing Treatment Plan

Session Content

The final Individual/Conjoint session is scheduled when the client is about to complete or after he or she has completed 16 weeks of the Matrix IOP intervention (i.e., after clients have completed Family Education and Relapse Prevention sessions). The counselor begins the discussion by asking the client general questions about the treatment experience:

- What aspects of treatment have been most helpful?
- Were there parts of treatment that have not been helpful? What were they?
- What would you change about treatment, if you could?
- How are you a different person now than you were when you entered treatment?
- Have you started attending Social Support group sessions? How have they helped you?

The counselor then works with the client to complete handout IC 3A—Treatment Evaluation, addressing the eight categories listed on the left side of the handout and helping the client evaluate behavioral changes, current status, and hoped-for progress. Examining the discrepancy between the client's current situations and the goals often generates motivation for the client to formulate steps to reach the desired goals. The counselor encourages the client to make the goals realistic and helps the client set realistic timetables for achieving the goals.

After the client has identified goals and established timetables, the counselor goes over handout IC 3B—Continuing Treatment Plan, stressing the importance of ongoing therapy and attending Social Support group sessions and 12-Step or mutual-help meetings. The counselor should think of this session as the final opportunity for case management. Earlier group sessions underscored the importance of continuing with 12-Step or mutual-help meetings after the end of treatment. During those sessions, the counselor provided the client with a list of local meetings and discussed ways to facilitate the client's attendance. The counselor should provide the client with another copy of the list of meetings and discuss in detail the client's plans for attending meetings.

The client uses items from handout IC 3A—Treatment Evaluation to draft a continuing recovery plan at the end of handout IC 3B—Continuing Treatment Plan. The counselor assists the client in writing this plan. The counselor helps the client finish treatment with a clear understanding of how to maintain recovery, with short- and long-term recovery goals and with a realistic plan for accomplishing those goals.

Handouts for Individual/Conjoint Sessions

The handouts that follow are to be used by the client and the counselor to make the most of the three Individual/Conjoint sessions.



Sample Service Agreement and Consent

[Each program uses an agreement and consent form that it has developed to meet its particular needs. This form is provided as a sample.]

It is important that you understand the kinds of services you will be provided and the terms and conditions under which these services will be offered.

I, _____, am requesting treatment from the staff of _____ . As a condition of that treatment, I acknowledge the following items and agree to them. (Please initial each item.)

I understand:

- _____ 1. The staff believes that the outpatient treatment strategies the program uses provide a useful intervention for chemical dependence problems; however, no specific outcome can be guaranteed.
- _____ 2. Treatment participation requires some basic ground rules. These conditions are essential for a successful treatment experience. Violation of these rules can result in treatment termination.

I agree to the following:

- a. It is necessary to arrive on time for appointments. At each visit I will be prepared to take urine and breath-alcohol tests.
- b. Conditions of treatment require *abstinence from all drug and alcohol use for the entire duration of the treatment program*. If I am unable to make this commitment, I will discuss other treatment options with the program staff.
- c. I will discuss any drug or alcohol use with the staff and group while in treatment.
- d. Treatment consists of individual and group sessions. Individual appointments can be rescheduled, if necessary. *I understand that group appointments cannot be rescheduled and attendance is extremely important*. I will notify the counselor in advance if I am going to miss a group session. Telephone notification may be made for last-minute absence or lateness.
- e. Treatment will be terminated if I attempt to sell drugs or encourage drug use by other clients.
- f. I understand that graphic stories of drug or alcohol use will not be allowed.

Sample Service Agreement and Consent

- g. I agree not to become involved romantically or sexually with other clients.
- h. I understand that it is not advisable to be involved in any business transactions with other clients.
- i. I understand that all matters discussed in group sessions and the identity of all group members are absolutely confidential. I will not share this information with nonmembers.
- j. All treatment is voluntary. If I decide to terminate treatment, I will discuss this decision with the staff.

_____ 3. Staff: Services are provided by psychologists, licensed marriage and family counselors, master's-level counselors-in-training, or other certified addiction staff people. All nonlicensed counselors are supervised by a licensed counselor trained in the treatment of addictions.

_____ 4. Consent to Videotape/Audiotape: To help ensure the high quality of services provided by the program, therapy sessions may be audiotaped or videotaped for training purposes. The client and, if applicable, the client's family consent to observation, audiotaping, and videotaping.

_____ 5. Confidentiality: All information disclosed in these sessions is strictly confidential and may not be revealed to anyone outside the program staff without the written permission of the client or the client's family. The only exceptions are when disclosures are required or permitted by law. Those situations typically involve substantial risk of physical harm to oneself or to others or suspected abuse of children or the elderly.

_____ 6. Accomplishing treatment goals requires the cooperation and active participation of clients and their families. Very rarely, lack of cooperation by a client may interfere substantially with the program's ability to render services effectively to the client or to others. Under such circumstances, the program may discontinue services to the client.

I certify that I have read, understand, and accept this Service Agreement and Consent. This agreement and consent covers the length of time I am involved in treatment activities at this facility.

Client's Signature: _____ Date: _____



Outpatient treatment requires a great deal of motivation and commitment. To get the most from treatment, it is necessary for you to replace many old habits with new behaviors.

Check all the things that you do regularly or have done since entering treatment:

- Schedule activities daily
- Visit physician for checkup
- Destroy all drug paraphernalia
- Avoid people who use alcohol
- Avoid people who use drugs
- Avoid bars and clubs
- Stop using alcohol
- Stop using all drugs
- Pay financial obligations promptly
- Identify addictive behaviors
- Avoid triggers (when possible)
- Use thought stopping for cravings
- Attend Individual/Conjoint sessions
- Attend Early Recovery Skills and Relapse Prevention sessions
- Attend 12-Step or mutual-help meetings
- Get a sponsor
- Exercise daily
- Discuss thoughts, feelings, and behaviors honestly with your counselor

What other behaviors have you decided to start since you entered treatment?

Which behaviors have been easy for you to do?

Which behaviors take the most effort for you to do?

Which behavior have you not begun yet? What might need to change for you to begin this behavior?

Behavior Not Begun

Change Needed

Relapse Analysis Chart

Name: _____ **Date of Relapse:** _____

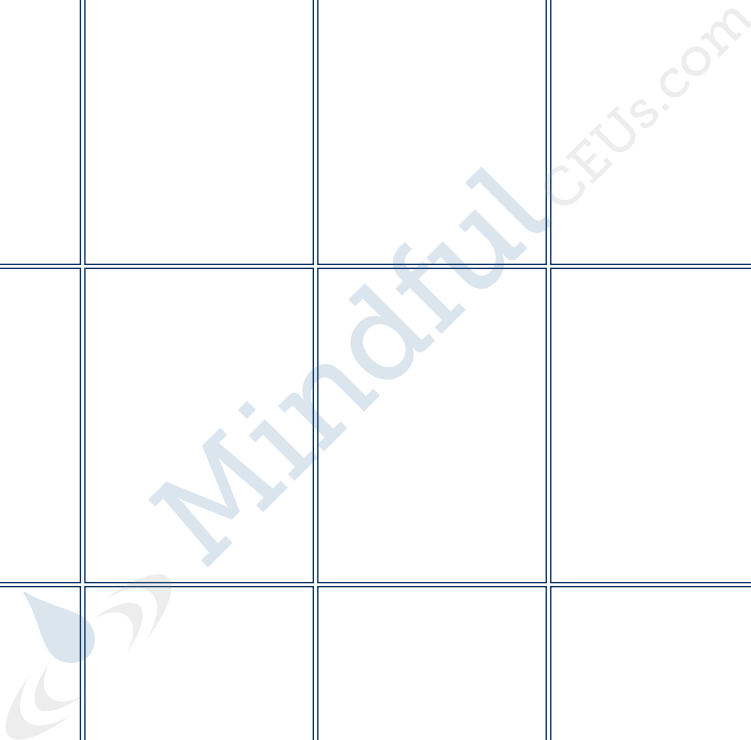
A relapse episode does not begin when you take a drug. Often, things that happen *before* you use indicate the beginning of a relapse. Identifying your patterns of behavior will help you recognize and interrupt the relapse. Using the chart below, note events that occurred during the week immediately before the relapse.

Career Events	Personal Events	Treatment Events	Drug-Related Behaviors	Behavioral Patterns	Relapse Thoughts	Health Status
Feelings about the above events						

Recovery requires specific actions and behavioral changes in many areas of life. Before you end your treatment, it is important to set new goals and plan for a different lifestyle. This guide will help you develop a plan and identify the steps necessary for reaching your goals. Write your current status and goals for the areas of life listed in the left column.

Subject	Where are you now?	Where would you like to be?	What steps do you need to take?	When?
Family				
Work/Career				
Friendships				
Financial, Legal Obligations				

Subject	Where are you now?	Where would you like to be?	What steps do you need to take?	When?
Education				
Exercise				
Leisure Activities				
12-Step or Mutual-Help Meetings				



Client's Signature _____

Date _____

Counselor's Signature _____

Date _____

IC 3B

Continuing Treatment Plan



Recovery is a lifelong process. You can stop drug and alcohol use and begin a new lifestyle during the first 4 months of treatment. Developing an awareness of what anchors your recovery is an important part of that process. But this is only the beginning of your recovery. As you move forward with your recovery after treatment, you will need a lot of support. And you may need different kinds of support than you did during treatment. You and your counselor can use the information below to help you decide how best to support your recovery.



Group Work

You should participate in at least one regular recovery group every week after treatment. The program offers a Social Support group that meets once a week. Other recovery groups are often available in the community. Ask your counselor about local recovery groups.

Individual Therapy

Individual sessions with an addiction counselor might be helpful. When your current treatment ends, you have choices about continuing with therapy. You may choose this time to enter therapy with another professional. You may want to return to therapy with the professional who referred you for the Matrix IOP method. Or you may choose to continue to see your current Matrix IOP counselor.

Couples Therapy

It is often a good idea at this point for couples to begin seeing a marriage counselor together to work on relationship issues.

12-Step or Mutual-Help Meetings

Attendance at a 12-Step or mutual-help meeting is a critical part of the recovery process. It is essential to find a meeting that you will attend regularly.

IV. Early Recovery Skills Group

Introduction

Goals of Early Recovery Skills Group

- Provide a structured group meeting for new clients to learn about recovery skills and 12-Step and mutual-help programs.
- Introduce clients to the basic tools of recovery and aid clients in stopping drug and alcohol use.
- Introduce 12-Step or mutual-help involvement and create an expectation of participation as part of treatment.
- Help clients adjust to participation in a group setting such as Relapse Prevention (RP) or Social Support group sessions or 12-Step or mutual-help meetings.
- Allow the recovering co-leader to provide a model for strengthening initial abstinence.
- Provide the recovering co-leader with increased self-esteem and reinforce his or her progress.

Session Format and Counseling Approach

Counselor and Co-Leader

The Early Recovery Skills (ERS) group is led by a counselor and co-led by a recovering client. This co-leader is usually a current client with more than 8 weeks of abstinence. The client must be progressing successfully through the program, abstaining from using drugs and drinking, and actively participating in an outside recovery group. The counselor should invite clients from the program's RP group who meet these criteria to fill the role of recovering co-leader. The co-leader should be paired up with the same counselor for 3 months.

The counselor and co-leader should meet for 15 minutes before the start of each group session to go over the session's topic and new issues about individual clients. *No confidential information can be given to the client co-leader. He or she is a volunteer and a client, not an employee.* The co-leader should be instructed to share experiences about the topic and not attempt to be a counselor. After each group session, the counselor should debrief the co-leader to ensure that the co-leader is refocused and stabilized, if necessary.

Group and Session Characteristics

The ERS component comprises eight group sessions that are held twice per week during the first month of intensive treatment. A typical ERS group is small (6–10 people), and sessions are relatively short (approximately 50 minutes). ERS sessions cover a substantial amount of material in a short time; counselors may need to move briskly from topic to topic. This group must stay structured and on track. The counselor and co-leader should be serious and focused and not contribute to the high-energy, out-of-control feeling that may characterize clients in early recovery.

The counselor begins every session by stating that the group's objective is to teach basic abstinence skills. All clients are introduced and asked to state how far they have progressed in treatment. First-time participants should be given several minutes to give a brief history. Clients giving detailed drug or alcohol histories can be interrupted politely and asked to discuss issues that prompted treatment. Any time a new client joins the ERS group, the counselor should explain the importance of scheduling and marking progress, regardless of which ERS session is the client's first. The instructions for session 1 in ERS go into detail about scheduling. The instructions

for session 2 in ERS discuss marking progress in detail. The recovering co-leader is introduced as someone who is currently going through the recovery process and who can give a personal account of how the program is working for him or her.

The ERS sessions should begin on a positive note by emphasizing benefits that each client derives from recovery and the length of time clients have remained abstinent. Five minutes is set aside after introductions so clients can place a mark on their calendar handout for each day of abstinence, share positive stories with the group, and encourage other members.

Following the marking of progress, the counselor introduces the new topic, tells participants which handouts from their *Client's Handbook* they will use for the current session, gives an overview of why this topic is important to clients' recovery and abstinence, and discusses the topic with clients in the group. The session outlines that follow have specific questions and suggestions to structure and enrich discussions. The counselor should use these questions but may find that clients have other concerns that the questions do not address. The counselor should feel free to take the discussion in directions that will be most helpful to the group. The recovering co-leader can relate how each topic was useful during the early stages of his or her recovery. The counselor should ask all participants to describe how they can use the skills being discussed. If clients are having problems, the counselor can solicit advice from other group members, and the counselor and recovering co-leader can offer suggestions. About 35 minutes is spent on group topics.

The remaining part of each ERS group session is devoted to scheduling and to following up on the previous session's homework assignment.

All clients must have a plan for the time between the current session and the next session. The more rigorously clients can plan, the more likely it is that they will abide by their schedules and avoid relapse. The goal is to map every day until the next ERS group meeting. After scheduling is explained in the first ERS session, 5 minutes is set aside in each session for this activity. The counselor should use part of this time to allow clients to discuss successes and challenges with scheduling. Specific Alcoholics Anonymous (AA), Cocaine Anonymous, Narcotics Anonymous, or mutual-help meetings can be suggested. Clients should be discouraged from planning activities with one another or other clients in early recovery, except for meeting one another at 12-Step or mutual-help meetings. Following up on clients' homework also should take the form of a brief discussion. The counselor should strive to involve all clients, fostering in them an interest in completing the homework and an understanding that working on recovery takes full-time commitment.

At the end of group sessions, any clients who will be moving on can be given several minutes to discuss what benefits the ERS group has provided in their first month of abstinence. Any clients who are struggling should be able to meet briefly with their counselor or schedule a time to do so. The recovering co-leader is not to engage in one-on-one counseling. There is a 15-minute break between the ERS group session and the RP group session.

Special Considerations

Clients in the ERS group probably have achieved only brief periods of abstinence. Their behavior may require that the counselor sometimes intervene and assert control in a strong, yet tactful fashion. The examples below illustrate how to handle some common situations.

Clients Who Spend Too Much Time Describing Episodes of Substance Use

Failing to interrupt and redirect a client who is going into detail about episodes of use can turn the session into an unstable experience that might trigger some clients to relapse. The counselor should

- Make it clear to clients new to the group that it is inappropriate for anyone to go into detail about episodes of substance use or feelings that led to using
- Interrupt a client who begins to talk in detail about using
- Remind the group that such talk can lead to relapse
- Pose a new question or topic for discussion

Clients Who Resist Participation in 12-Step, Mutual-Help, or Other Spiritual Groups

In discussions about 12-Step or mutual-help program involvement, clients frequently express dissenting opinions about the value of participation. Resistance to 12-Step or mutual-help group involvement is an important issue. To address client concerns, the counselor should

- State clearly that the treatment outcome for people who attend 12-Step or mutual-help programs is better than for people who do not. The Matrix Institute has conducted several surveys on treatment outcomes and 12-Step or mutual-help program involvement and consistently has found a strong positive relationship. However, clients may state that they do not find meetings helpful and are not going to attend.
- Acknowledge that it is not uncommon for people initially to find participating in such programs uncomfortable.

- Avoid arguing with reluctant clients or trying to compel them to attend 12-Step meetings.
- Provide clients with a list of local meetings and encourage clients to attend different meetings until they find one that feels comfortable.
- Encourage clients who are resistant to the spiritual aspects of 12-Step or mutual-help programs to attend for the fellowship and support. Social activities, coffee after the meetings, and the availability of others to call in times of trouble are encouraging aspects of participation for ambivalent members.

Those who feel uncomfortable going to unfamiliar meetings in the community may want to attend them with the recovering co-leader or other group members. Program graduates may want to start a 12-Step meeting at the treatment center, providing clients with a way to become familiar with 12-Step or mutual-help group philosophies and meeting structures while in a familiar environment.

Some clients may be willing to attend 12-Step meetings but resist getting a sponsor and working the steps. It is important to allow clients to engage in 12-Step activities on their schedules, when they are ready. The more involved clients are in a 12-Step or mutual-help program, the stronger their recovery is likely to be. Clients should choose a sponsor who is accepting of concurrent involvement in professional treatment.

Clients who are looking for an alternative to traditional 12-Step programs should be encouraged to explore the following groups:

- Women for Sobriety (<http://www.womenforsobriety.org>) helps women overcome alcohol dependence through emotional and spiritual growth.

- Jewish Alcoholics, Chemically Dependent Persons and Significant Others (JACS) (<http://www.jbfc.org/JACS>) helps people explore recovery in a nurturing Jewish environment.
- Self-Management and Recovery Training (SMART) (<http://www.smartrecovery.org>) is a cognitive–behavioral group approach that focuses on self-reliance, problemsolving, coping strategies, and a balanced lifestyle.
- Secular Organizations for Sobriety (<http://www.secularhumanism.org>) maintains that sobriety is a separate issue from religion or spirituality and credits the individual for achieving and maintaining sobriety.
- Community-based spiritual fellowships, which take place in churches, synagogues, mosques, temples, and other spiritually focused meeting sites, often form the basis for support, lifestyle change, and clarification of values in peoples' lives.

The counselor should consult local directories for these groups and be prepared to provide contact information, if clients request.

Note: The list of alternatives to 12-Step programs is referred to in session 4 and session 8 of ERS and in session 30 of RP. The counselor should take a copy of this list to every session, in case a client requests information.

Clients Who Provide Inaccurate or Dangerous Suggestions to Other Clients

Clients sometimes may provide suggestions during group meetings that are inaccurate or possibly dangerous. When a client makes a potentially harmful recommendation to another client, the counselor

- Maintains a polite and respectful attitude toward all members of the group while remaining clearly in control
- Redirects the conversation as in the example that follows

Client A states that her prescribed antidepressants are not helping with her depression and are making her tired. Client B says, “You should really just stop taking your antidepressants. If you’re tired, you may end up relapsing to meth because you can’t stay awake during the day. You’ve worked so hard to quit using meth and remain abstinent.” The counselor should step in at this point to address the situation. “Client B, although I know you have good intentions, Client A needs to discuss her medication with her doctor. But you raise an important point: being tired can be a trigger for relapse. Let’s talk about how thought stopping can help you cope with triggers when they arise.”

Clients Who Cannot Take Direction or Limit Their Input

Sometimes, unstable clients are unable to take subtle direction or appropriately limit their input. In situations such as these, the counselor should

- Defuse the situation by saying something like, “You have a lot of energy tonight. Let’s make sure everyone has a chance to talk. Just listen for a while.”
- Address the client directly and ask the client to cease the disruptive behavior, if the counselor’s attempt to defuse the situation does not succeed.
- Ask the client to leave the group for that session, if the disruptive behavior continues.

- Speak with the client alone after the group meeting about his or her specific problem, if possible.

A client who is disruptive or out of control may be experiencing an attention deficit disorder or a more serious mental disorder. Counselors should be alert to the possibility of co-occurring substance use and mental disorders and make referrals to appropriate psychiatric care when necessary.

Clients Who Appear Intoxicated

If a client seems intoxicated, the counselor should

- Ask the client to step outside the session room with the counselor. The recovering co-leader can continue the group while the counselor attempts to evaluate the client's condition and discusses the circumstances leading to the drug or alcohol use, if no other counselor is available or the client is not capable of engaging in treatment.
- Help the client find another counselor on site who can work with the client, if the client is capable of engaging productively in one-on-one treatment.
- Ensure that the client has safe transportation home and forgo any discussion of the matter until the next treatment appointment, depending on the degree of the client's intoxication.
- Avoid confrontation.

Clients Who Relapse

Clients who are beyond the first month of treatment but have relapsed and are struggling to impose structure on their recovery may benefit from repeating the ERS group while

they attend RP sessions. Once the counselor determines that these clients have stabilized, they may stop attending ERS sessions and attend only RP sessions.

Rational Brain Versus Addicted Brain

The ERS group session descriptions use the metaphorical struggle between a client's rational brain and addicted brain as a way to talk about recovery. The terms *rational brain* and *addicted brain* do not correspond to physiological regions of the brain, but they give clients a way to conceptualize the struggle between the desire to stay committed to recovery and the desire to begin using stimulants again.

Adapting Client Handouts

Client handouts are written in simpler language than the session descriptions for counselors. The client materials should be understandable for someone with an eighth grade reading level. Difficult words (e.g., *abstinence*, *justification*) are occasionally used. Counselors should be prepared to help clients who struggle with the material. Counselors should be aware that handouts will need to be adapted for clients with reading difficulties.

Session Descriptions

Pages 37–56 provide structured guidance to the counselor for organizing and conducting the eight ERS group sessions in the intensive outpatient program. The handouts indicated in the session guidance are provided after the session descriptions for the counselor's use and are duplicated in the *Client's Handbook*. Figure IV-1 provides an overview of the eight ERS sessions.

Figure IV-1. Early Recovery Skills Sessions Overview

Session Number	Topic	Content	Pages
1	Stop the Cycle	Clients learn about triggers and cravings and how they are related to substance use. Clients learn to use thought-stopping techniques to disrupt relapse and scheduling to organize their recovery.	37–39
2	Identifying External Triggers	Clients learn to identify their external triggers and that charting their external triggers can help prevent relapse.	40–42
3	Identifying Internal Triggers	Clients learn to identify their internal triggers and that charting their internal triggers can help prevent relapse.	43–44
4	Introducing 12-Step or Mutual-Help Activities	Clients learn about the format, benefits, and challenges of 12-Step programs and about 12-Step meetings in their area. Clients also learn about alternatives to 12-Step meetings, such as mutual-help groups.	45–47
5	Body Chemistry in Recovery	Clients learn that their bodies must adjust to recovery as they work through the stages of recovery. Clients identify ways to overcome the physical challenges posed by recovery.	48–49
6	Common Challenges in Early Recovery	Clients learn new coping techniques that do not involve substance use. Clients identify challenging situations and ways to address them that help maintain abstinence.	50–51
7	Thinking, Feeling, and Doing	Clients learn how thoughts and emotions contribute to behavior and that responses to thoughts and emotions can be controlled. Clients identify behaviors that are related to substance use.	52–54
8	12-Step Wisdom	Clients learn 12-Step sayings and identify situations in which they will use them. Clients also learn to recognize when they are most vulnerable to relapse.	55–56

Session 1: Stop the Cycle

Goals of Session

- Help clients understand what triggers and cravings are.
- Help clients identify individual triggers.
- Help clients understand how triggers and cravings can lead to use.
- Help clients learn techniques for stopping thoughts that can lead to use.
- Help clients learn the importance of scheduling time.

Handouts

- ERS 1A—Triggers
- ERS 1B—Trigger—Thought—Craving—Use
- ERS 1C—Thought-Stopping Techniques
- SCH 1—The Importance of Scheduling
- SCH 2—Daily/Hourly Schedule

Topics for Group Discussion (35 minutes)

1. *Discussing the Concept of Triggers*

Over time certain people, places, things, situations, and even emotions become linked with substance use in the mind of the person who abuses substances. Being around those triggers can bring on a craving for the substance, which can lead to use.

- Go over handout ERS 1A—Triggers.
- Ask clients to identify their triggers on the handout.
- Discuss specific things that have acted as triggers for clients.
- Ask clients to think about possible triggers they will face when they leave the program.
- Introduce the importance of scheduling to avoid triggers; the last 15 minutes of this session (and the last 5 minutes of every other ERS session) is devoted to clients' scheduling their time from the end of one session to the beginning of the next.

2. *Discussing Cravings*

Cravings are impulsive urges to use that have a physiological basis. Cravings will not stop just because clients have decided not to use. Clients will need to alter their behavior to avoid the triggers that can lead to cravings. Planning for behavior changes will accomplish much more than mere good intentions and strong commitment will.

- Discuss how clients will have to change their behaviors to avoid triggering cravings.
- Discuss the importance of removing paraphernalia associated with substance use.
- Ask what changes clients already have made to reduce cravings. What effect have these changes had?
- Have the recovering co-leader discuss how the intensity of cravings has changed over time as a result of behavior changes. It is important for clients to know that cravings will subside eventually.

3. *Discussing the Principle of Thought Stopping*

In addition to changing behaviors to avoid triggers, clients can interrupt the sequence that leads from trigger to thinking about using to craving and then to using. Even though the triggering of cravings seems like an automatic process, clients still can avoid using by stopping their thoughts about using.

- Go over handout ERS 1B—Trigger—Thought—Craving—Use.
- Help clients understand that cravings do not have to overwhelm them; they can block the thoughts that lead to cravings.
- Have clients discuss the images that will help them stop their thoughts of using.

4. *Discussing and Practicing Thought-Stopping Techniques*

Thought stopping is a useful skill if clients practice it. When they encounter a trigger to use, clients must be able to use thought-stopping techniques to break the link between thinking of using and cravings. Clients should know that triggers do not *automatically* lead to using; by stopping their thoughts, clients can choose not to use.

- Go over handout ERS 1C—Thought-Stopping Techniques.
- Discuss with clients which of the four techniques (visualization, snapping, relaxation, calling someone) they think will be most helpful to them.
- Solicit suggestions for concrete applications of the techniques. What will clients visualize? What will they do to relax? Whom will they call?
- Make it clear to clients that thought-stopping techniques will hold cravings at bay, buying clients time until they can take action (e.g., go to a meeting, work out at the gym).
- Have clients suggest other techniques that might help them stop their thoughts about using (e.g., taking a walk, going to a movie, taking a bath).
- Emphasize to clients that cravings will pass; most only last 30 to 90 seconds.
- Have the co-leader discuss thought-stopping techniques that work for him or her.

Scheduling (15 minutes)

One of the main goals of scheduling is to ensure that the rational part of clients' brains takes charge of their behavior rather than the emotional addicted part of their brains where cravings start. When clients make a schedule and stick to it, they put their rational brains in charge. People in outpatient treatment need to structure their time if they are serious about recovery. It is important for clients to plan their activities and to write them down in their schedules. Schedules that exist only in one's head are too easy to revise or abandon. Clients need to schedule every hour of the day and stick to the schedule. When clients are making their schedules, special attention should be paid to weekends and any other times clients feel they are particularly vulnerable to substance use.

- Go over handout SCH 1—The Importance of Scheduling.
- Help clients understand that scheduling their time rigorously and sticking to the schedule are part of the recovery process. Scheduling will help clients' rational brains govern their behavior and aid them in making good decisions.
- Have clients complete handout SCH 2—Daily/Hourly Schedule; encourage them to be thorough in their scheduling, leaving no holes in their schedules.

Clients will undertake this scheduling exercise at the close of all eight sessions in the ERS portion of treatment. Fifteen minutes is allotted to this activity in session 1 so that the counselor can introduce it. In sessions 2 through 8, 5 minutes is devoted to scheduling, and a new activity—marking progress—is added to the beginning of each session.



Session 2: Identifying External Triggers

Goals of Session

- Help clients understand what external triggers are.
- Help clients identify individual external triggers.
- Help clients understand how external triggers can lead to use.
- Help clients review the need for scheduling to avoid external triggers.
- Help clients learn the importance of marking recovery progress.

Handouts

- CAL 1—Marking Progress
- CAL 2—Calendar
- ERS 2A—External Trigger Questionnaire
- ERS 2B—External Trigger Chart
- SCH 2—Daily/Hourly Schedule

Marking Progress (5 minutes)

Keeping a daily record of abstinence keeps clients mindful that their recovery is a day-to-day process. Marking progress also allows clients to take pride in how far they have come. Clients who are newly abstinent may experience a distortion in which time seems to pass more slowly than when they were using substances. Charting their progress in short units may make the daunting process of recovery seem more manageable. The first 5 minutes of each session in the ERS portion of treatment is devoted to this activity.

- Go over handout CAL 1—Marking Progress.
- Have clients place a checkmark on each day on handout CAL 2—Calendar for which they have not used substances.

Topics for Group Discussion (35 minutes)

1. Discussing the Concept of External Triggers

In session 1, clients learned what triggers are and identified and discussed specific triggers. Now they undertake a more detailed examination of situations and circumstances that are linked to using substances. The counselor helps clients understand that external triggers are aspects of their lifestyle and the choices they make that are under their control. These are things that they can change.

- Go over handout ERS 2A—External Trigger Questionnaire.
- Have clients place a checkmark next to all external triggers that apply to them and a zero next to those that do not.

- Encourage clients to think of external triggers that are not on the handout and list these separately.
- Have clients list situations and people who are not linked with substance use for them (i.e., who are “safe”).
- Discuss clients’ external triggers.
- Review the method for responding to triggers discussed in session 1 (ERS 1C—Thought-Stopping Techniques).
- Review the importance of scheduling to avoid triggers.

2. Charting External Triggers

Now that clients have made lists of their external triggers and of those people, places, and situations that are “safe,” clients can classify them according to the strength of their association with substance use. Completing the External Trigger Chart (ERS 2B) helps clients realize that an episode of using substances is not set off by random events. Clients also realize that they have the knowledge to help themselves avoid substance use. By altering their behavior, clients can exercise control and reduce the chances of using substances. The counselor can encourage clients to bring this chart (and ERS 3B—Internal Trigger Chart [discussed in session 3]) to their individual counseling sessions to help address issues with triggers. Clients should keep this chart handy and add triggers to it, if new triggers arise (see Homework below).

- Go over handout ERS 2B—External Trigger Chart.
- Have clients list people, things, and situations on the chart, rating them for their potential as triggers.
- Encourage clients to share those items that are particularly troublesome and those that they feel are “safe.”
- Have the recovering co-leader discuss how using the External Trigger Chart has helped him or her understand and gain control of triggers.

Scheduling (5 minutes)

The counselor should remind clients that scheduling their time rigorously and sticking to the schedule are part of the recovery process. People who abuse substances are not accountable to schedules; taking responsibility for sticking to a schedule helps clients stop using. Following through on decisions made during scheduling helps keep clients’ rational brains in charge of behavior.

- Ask clients how the schedule they made at the end of the previous session helped them remain drug free.
- Ask clients what they learned about scheduling that will affect how they make future schedules.
- Have clients complete handout SCH 2—Daily/Hourly Schedule for the time between this session and session 3.

Homework (5 minutes)

Ask clients to share briefly their experience of doing the homework from the previous session. The counselor can decide how detailed the followup on homework should be. The goal of asking is not to discover which clients have not done the homework but to encourage clients to work on their recovery between sessions and to share that work with the group.

Encourage clients to update their list of external triggers on handout ERS 2B—External Trigger Chart as their recovery continues.



Session 3: Identifying Internal Triggers

Goals of Session

- Help clients understand what internal triggers are.
- Help clients identify individual internal triggers.
- Help clients understand how internal triggers can lead to use.
- Help clients understand the individual thoughts and emotions that act as triggers.
- Help clients review the importance of scheduling and marking progress.

Handouts

- CAL 2—Calendar
- ERS 3A—Internal Trigger Questionnaire
- ERS 3B—Internal Trigger Chart
- SCH 2—Daily/Hourly Schedule

Marking Progress (5 minutes)

Before introducing the session topics, the counselor gives clients time to chart their progress on CAL 2—Calendar and encourages clients to share positive events they have experienced since the last session.

Topics for Group Discussion (35 minutes)

1. *Discussing the Concept of Internal Triggers*

In session 1 clients learned what triggers are and identified and discussed specific triggers. Now they undertake a more detailed examination of thoughts and emotions that are linked with using substances. Early recovery can be a chaotic time, especially emotionally. Many clients may feel depression, shame, fear, confusion, or self-doubt. Although clients may feel that their thoughts and emotions are not under their control during this time, the counselor can help clients understand that how they respond to those internal triggers *is* under their control.

- Go over handout ERS 3A—Internal Trigger Questionnaire.
- Have clients place a checkmark next to all internal triggers that apply to them and a zero next to those that do not. Clients also should include thoughts or emotions that once acted as triggers, even if they no longer do.
- Have clients complete the rest of the handout, with special attention to thoughts or emotions that have triggered recent use.
- Discuss clients' internal triggers. As clients describe their internal states, reflect back what they say and ask whether it is accurate.
- Review the method for responding to triggers discussed in session 1 (ERS 1C—Thought-Stopping Techniques).

- Discuss other ways that clients can cope with triggers. If a certain internal state is no longer a problem for a client, have that client share how he or she got control over the internal trigger.

2. *Charting Internal Triggers*

Now that clients have listed their internal triggers, they should classify the triggers according to the strength of their association with substance use, just as they did for their external triggers. Charting their internal triggers allows clients to identify particularly safe and unsafe emotional states, which, in turn, should help them anticipate and head off problems. Completing the Internal Trigger Chart (ERS 3B) helps clients visualize the choices they make and the consequences of those choices. By seeking to avoid situations that provoke dangerous emotions, clients can exercise control over their recovery. The counselor can encourage clients to bring this chart (and ERS 2B—External Trigger Chart) to their individual counseling sessions to help address issues with triggers. Clients should keep the Internal Trigger Chart handy and add triggers to it, if new triggers arise (see Homework below).

- Go over handout ERS 3B—Internal Trigger Chart.
- Have clients list thoughts and emotions on the chart, rating them for their potential as triggers.
- Encourage clients to share the items that are particularly troublesome and those that they feel are “safe.”
- Have the recovering co-leader discuss how using the Internal Trigger Chart has helped him or her understand and gain control of triggers.

Scheduling (5 minutes)

The counselor should remind clients that scheduling their time rigorously and sticking to the schedule are part of the recovery process. People who abuse substances are not accountable to schedules; taking responsibility for sticking to a schedule helps clients stop using. Following through on decisions made during scheduling helps keep clients’ rational brains in charge of behavior.

- Ask clients how the schedule they made at the end of the previous session helped them remain drug free.
- Ask clients what they learned about scheduling that will affect how they make future schedules.
- Have clients complete handout SCH 2—Daily/Hourly Schedule for the time between this session and session 4.

Homework (5 minutes)

Ask clients to share briefly their experience of doing the homework from the previous session. The counselor can decide how detailed the followup on homework should be. The goal of asking is not to discover which clients have not done the homework but to encourage clients to work on their recovery between sessions and to share that work with the group.

Encourage clients to update their list of internal triggers on handout ERS 3B—Internal Trigger Chart as their recovery continues.

Session 4: Introducing 12-Step or Mutual-Help Activities

Goals of Session

- Help clients understand the structure and format of 12-Step programs.
- Help clients identify the challenges and benefits of participating in 12-Step programs.
- Help familiarize clients with options for local 12-Step meetings.
- Help clients recognize that participation in 12-Step or mutual-help programs is integral to recovery.
- Help clients review the importance of scheduling and marking progress.

Handouts

- CAL 2—Calendar
- ERS 4A—12-Step Introduction
- ERS 4B—The Serenity Prayer and the 12 Steps of Alcoholics Anonymous
- SCH 2—Daily/Hourly Schedule

Marking Progress (5 minutes)

Before introducing the session topics, the counselor gives clients time to chart their progress on CAL 2—Calendar and encourages clients to share positive events they have experienced since the last session.

Topics for Group Discussion (35 minutes)

1. *Discussing Clients' Prior Participation in 12-Step or Mutual-Help Programs*

Participation in a 12-Step or mutual-help program during and after treatment is central to recovery. Clients should view 12-Step or mutual-help group participation as important to their recovery as attending treatment sessions. Research shows that a combination of professional substance abuse treatment and participation in 12-Step support groups is often the most effective route to recovery. The most important aspect of 12-Step or mutual-help group participation is that it surrounds clients with supportive people who are going through the same struggles. Participation in a 12-Step or mutual-help group also reinforces the message that recovery is not an individual process. The client must do the work of quitting substance use, but the knowledge and support of others who have remained abstinent are essential to recovery.

- Ask how many clients have participated in 12-Step or mutual-help programs.
- Ask those who have participated to share *briefly* their negative experiences with meetings. The recovering co-leader can start this discussion, if clients are reticent. Negative experiences might include the following:
 - Some people in meetings are not interested in change.
 - It is hard to reveal problems, even (or especially) in front of strangers.

- The structure is too rigid.
 - Meetings are too time consuming.
 - The spiritual elements are intrusive.
 - Going to meetings can make one feel like using again.
- Ask clients who have *not* attended meetings to express their concerns about 12-Step or mutual-help group participation.
 - Ask clients who have participated in 12-Step or mutual-help programs to share their positive experiences. Again, the recovering co-leader can initiate this discussion.

2. *Discussing Clients' Knowledge of 12-Step Programs*

The preceding discussion gives the counselor a good idea of clients' understanding of the structure and processes of 12-Step meetings. Meetings can have different characteristics. If clients do not feel that the first meeting they try suits them, they should try to find one with which they are more comfortable. It is important for clients to know that many different types of meetings are available, especially in metropolitan areas, including language-specific meetings, gender-specific meetings, open meetings, meetings based on participants' sexual orientation, and meetings for people who also have a mental disorder ("double trouble" or Dual Recovery Anonymous meetings).

- Go over handout ERS 4A—12-Step Introduction.
- Go over handout ERS 4B—Serenity Prayer and the 12 Steps of Alcoholics Anonymous.
- Emphasize that meetings are not *religious* but spiritual. Clients decide for themselves what the higher power of the 12 Steps refers to. Metropolitan areas may have special secular 12-Step meetings. Crystal Meth Anonymous (CMA) is a 12-Step program for people who are in recovery from methamphetamine dependence. CMA meetings can be found in many large cities and some smaller communities, especially in the West, Midwest, and South.
- Early in recovery, encourage clients to find a home meeting and attend as many meetings as their schedule permits.
- Stress the importance of finding and working with a sponsor.
- Have the recovering co-leader tell his or her story of finding a 12-Step meeting to attend and how doing so has helped him or her.
- Share with clients information about the 12-Step programs in the area. Ensure that you are knowledgeable about the characteristics of each group program. Provide a list of programs—with addresses, phone numbers, contacts, and a brief description—to each client.

3. Introducing Alternative Mutual-Help Groups

The counselor should research local options to 12-Step programs and expose clients to other types of recovery support in addition to 12-Step programs. Many clients find help from the organizations listed on pages 33 and 34.

Scheduling (5 minutes)

The counselor should remind clients that scheduling their time rigorously and sticking to the schedule are part of the recovery process. People who abuse substances are not accountable to schedules; taking responsibility for sticking to a schedule helps clients stop using. Following through on decisions made during scheduling helps keep clients' rational brains in charge of behavior.

- Ask clients how the schedule they made at the end of the previous session helped them remain drug free.
- Ask clients what they learned about scheduling that will affect how they make future schedules.
- Have clients complete handout SCH 2—Daily/Hourly Schedule for the time between this session and session 5.

Homework (5 minutes)

Ask clients to share briefly their experience of doing the homework from the previous session. The counselor can decide how detailed the followup on homework should be. The goal of asking is not to discover which clients have not done the homework but to encourage clients to work on their recovery between sessions and to share that work with the group.

Encourage clients to attend at least one 12-Step or mutual-help meeting before session 5.



Session 5: Body Chemistry in Recovery

Goals of Session

- Help clients understand that recovery is a physical process that requires the body to adjust.
- Help clients understand specific physical symptoms that may occur during recovery.
- Help clients identify the stages of recovery and the challenges associated with them.
- Help clients consider ways to overcome the physical challenges of early recovery.

Handouts

- CAL 2—Calendar
- ERS 5—Roadmap for Recovery
- SCH 2—Daily/Hourly Schedule

Marking Progress (5 minutes)

Before introducing the session topics, the counselor gives clients time to chart their progress on CAL 2—Calendar and encourages clients to share positive events they have experienced since the last session.

Topics for Group Discussion (35 minutes)

1. Discussing Recovery as a Physical Process

In addition to experiencing behavioral and emotional changes while in recovery, clients also experience physical changes. Clients' bodies also must adjust. The chemistry of the brain is altered by habitual substance use; clients can think of this adjustment period as a "healing" of the brain. During early recovery clients may experience symptoms such as depression, low energy, sleep disturbances, headaches, and anxiety. These symptoms are part of the body's healing process. If clients understand this, they are better able to focus on their recovery. Good nutrition, exercise, sufficient sleep, relaxation, and leisure activities to reduce stress may be beneficial, particularly during the early stages of recovery.

- Ask clients to share their experiences with prior attempts at recovery.
- Ask clients what physical symptoms they experienced during recovery. How long did these symptoms persist?
- Ask the recovering co-leader to share personal experiences of the physical difficulties of early recovery. What strategies or activities helped the recovering co-leader through the physical discomfort of early recovery?

2. Discussing the Stages of Recovery

Recovery from stimulant use can be divided into four stages: withdrawal, early abstinence (a.k.a. the Honeymoon), protracted abstinence (a.k.a. the Wall), and readjustment. These four stages were originally developed to describe recovery from cocaine addiction. The length of time for various stages

may vary for other stimulants. For example, because methamphetamine has a longer half-life in the body than cocaine, recovery from methamphetamine will lag behind the time periods listed on handout ERS 5—Roadmap for Recovery. The stages are a rough outline of the progress of recovery, and every client's experience is different. However, being familiar with the typical changes and challenges that come with recovery helps prepare clients for them.

- Go over handout ERS 5—Roadmap for Recovery. Explain to clients that the time periods listed provide a general outline of recovery and that their recovery may take slightly longer.
- For each stage, focus on the substances that people in the group had been using (e.g., if no one in the group used opioids, focus on stimulants and alcohol).
- Ask clients to discuss the symptoms they are experiencing.
- Caution clients about the intense cravings and risk of impulsive actions during the first 2 weeks of abstinence—the withdrawal stage. Also be certain that clients are aware of the challenges posed by the stage known as the Wall. Most relapses occur during one of these two stages.
- Remind clients of the need to continue attending treatment sessions and 12-Step or mutual-help meetings, even if, after several weeks of abstinence, they feel as if their substance use is behind them.

Scheduling (5 minutes)

The counselor should remind clients that scheduling their time rigorously and sticking to the schedule are part of the recovery process. People who abuse substances are not accountable to schedules; taking responsibility for sticking to a schedule helps clients stop using. Following through on decisions made during scheduling helps keep clients' rational brains in charge of behavior.

- Ask clients how the schedule they made at the end of the previous session helped them remain drug free.
- Ask clients what they learned about scheduling that will affect how they make future schedules.
- Have clients complete handout SCH 2—Daily/Hourly Schedule for the time between this session and session 6.

Homework (5 minutes)

Ask clients to share briefly their experience of doing the homework from the previous session. The counselor can decide how detailed the followup on homework should be. The goal of asking is not to discover which clients have not done the homework but to encourage clients to work on their recovery between sessions and to share that work with the group.

Encourage clients to try one new activity or strategy to combat the physical symptoms of early abstinence. Remind them to eat well, exercise, get enough sleep, and try new leisure activities.

Session 6: Common Challenges in Early Recovery

Goals of Session

- Help clients understand that it is necessary to find new coping techniques that do not involve substance use.
- Help clients identify challenges and new solutions that maintain abstinence.
- Help clients understand the importance of stopping alcohol use.

Handouts

- CAL 2—Calendar
- ERS 6A—Five Common Challenges in Early Recovery
- ERS 6B—Alcohol Arguments
- SCH 2—Daily/Hourly Schedule

Marking Progress (5 minutes)

Before introducing the session topics, the counselor gives clients time to chart their progress on CAL 2—Calendar and encourages clients to share positive events they have experienced since the last session.

Topics for Group Discussion (35 minutes)

1. *Discussing Challenges Clients Often Face in Early Recovery*

Many aspects of clients' lives require change if clients are to maintain abstinence. But certain areas and situations have proved to be particularly troublesome for people in recovery. Examining the five challenges listed on ERS 6A and discussing solutions help clients address these challenges more effectively. In the past, clients probably turned to substance use when they encountered one of these problem situations. Part of the recovery process is learning a new repertoire of responses to cope with these situations. Recovery consists of assembling new coping techniques one solution at a time. The wider the variety of coping techniques clients can call on, the better they are able to manage their problems.

- Go over handout ERS 6A—Five Common Challenges in Early Recovery with clients.
- Ask clients what solutions they think will be helpful to them when they face these scenarios. Do clients have suggested solutions that are not listed?
- Ask clients which challenges are particularly troublesome. How do they plan to address them?
- Ask the recovering co-leader to discuss how he or she handled these common early recovery challenges.
- Remind clients of the importance of scheduling. Many of the solutions on the handout involve planning abstinent outings or setting aside time for new activities. Rigorous scheduling helps clients maintain their abstinence.

2. Discussing the Importance of Stopping Alcohol Use

Some clients have problems giving up alcohol; some feel that giving up stimulants is enough work without making another major life adjustment. As discussed in session 5, when the Honeymoon stage ends after about 6 weeks of treatment, clients may experience intense cravings for stimulants. This also is the time when many clients return to alcohol use. Seeing no connection between alcohol and stimulants, clients may try to rationalize their return to alcohol use. It is important for clients to understand that it is necessary to abstain from alcohol to allow the brain to heal and that abstaining from alcohol will help them abstain from stimulants.

- Go over handout ERS 6B—Alcohol Arguments.
- Ask clients whether they have had some of these “arguments” with themselves. What other rationalizations for using alcohol have clients faced?
- Ask clients how they have responded to these rationalizations.
- Draw on the recovering co-leader’s experience to help clients address their rationalizations of a return to alcohol use. What strategies has the co-leader used to abstain from alcohol?

Scheduling (5 minutes)

The counselor should remind clients that scheduling their time rigorously and sticking to the schedule are part of the recovery process. People who abuse substances are not accountable to schedules; taking responsibility for sticking to a schedule helps clients stop using. Following through on decisions made during scheduling helps keep clients’ rational brains in charge of behavior.

- Ask clients how the schedule they made at the end of the previous session helped them remain drug free.
- Ask clients what they learned about scheduling that will affect how they make future schedules.
- Have clients complete handout SCH 2—Daily/Hourly Schedule for the time between this session and session 7.

Homework (5 minutes)

Ask clients to share briefly their experience of doing the homework from the previous session. The counselor can decide how detailed the followup on homework should be. The goal of asking is not to discover which clients have not done the homework but to encourage clients to work on their recovery between sessions and to share that work with the group.

When clients are confronted with a problem, encourage them to try one of the alternatives discussed on handout ERS 6A—Five Common Challenges in Early Recovery. In addition to the arguments listed on handout ERS 6B—Alcohol Arguments, have clients think of another argument for remaining abstinent from alcohol and record it in their *Client’s Treatment Companion*

Session 7: Thinking, Feeling, and Doing

Goals of Session

- Help clients understand the connections among thoughts, emotions, and behavior.
- Help clients understand how thoughts and emotions contribute to behavior.
- Help clients understand that responses to thoughts and emotions can be controlled.
- Help clients identify behaviors that are related to substance use.

Handouts

- CAL 2—Calendar
- ERS 7A—Thoughts, Emotions, and Behavior
- ERS 7B—Addictive Behavior
- SCH 2—Daily/Hourly Schedule

Marking Progress (5 minutes)

Before introducing the session topics, the counselor gives clients time to chart their progress on CAL 2—Calendar and encourages clients to share positive events they have experienced since the last session.

Topics for Group Discussion (35 minutes)

1. Discussing Connections Among Thoughts, Emotions, and Behavior

Many people assume that thoughts and emotions happen outside their control. Because they feel that they cannot influence or change their thoughts and emotions, these people may not consider the effects that their thoughts and emotions can have on behavior. In session 1, the group discussed how emotions can act as triggers for substance use and how thoughts, if not stopped, can lead to cravings. It is important for clients to become aware of thoughts and emotions, to be able to observe and analyze them. Clients can look for patterns in their thoughts and emotions. They also can pay attention to how their thoughts and feelings are expressed in body language, physical changes, and behavior. Attuned to their thoughts and feelings, clients are better able to recognize which thoughts and emotions are connected to substance use. This recognition helps clients exercise control over their responses.

- Go over handout ERS 7A—Thoughts, Emotions, and Behavior.
- Ask clients about the differences between thoughts and emotions. How do clients respond to each?
- Review thought-stopping techniques, and ask clients to share the visualizations they use to stop thoughts of using.
- State that usually positive emotions (e.g., excitement, joy, gratitude) are considered good things. What are some positive emotions that can lead to substance use?
- Ask the recovering co-leader to discuss how he or she controls thoughts and emotions.

- Ask clients what connections they can make between thoughts and behavior and between emotions and behavior.
- Remind clients of the importance of scheduling. Planning time thoroughly is one way of gaining control of behavior. Attending 12-Step or mutual-help meetings, finding new activities, and resuming old hobbies also are good ways of steering behavior in productive directions.

2. Discussing the Importance of Recognizing Early Movement Toward Addictive Behaviors

People who abuse substances often feel that their behavior is out of their control because they experience uncontrollable urges to use substances. By breaking down a behavior into the steps that precede it, clients are able to control how they respond to urges. In session 1, clients learned about thought-stopping techniques (handout ERS 1C) that can interrupt the sequence of events that leads to craving and then to using substances. Another way to prevent the reemergence of addictive behaviors is for clients to recognize the early warning signs of substance abuse: behaviors that clients know are linked to substance abuse for them. Clients cannot maintain a successful recovery from substance abuse if they continue to engage in the behaviors that accompanied substance abuse.

- Go over handout ERS 7B—Addictive Behavior.
- Ask clients to assess honestly which behaviors from the list on the handout are related to their substance abuse.
- Ask clients what behaviors that place them at risk for relapse are not listed.
- Ask clients to think about how they can monitor their behavior (e.g., regular 12-Step attendance, keeping a diary, staying in touch with their sponsors).
- Ask clients what they will do to avoid returning to substance use if they recognize that they have slipped into one of these addictive behaviors.
- Ask the recovering co-leader to share experiences with addictive behaviors and how he or she avoided relapsing to substance use.
- Ask the recovering co-leader to describe the benefits of being vigilant about addictive behaviors.

Scheduling (5 minutes)

The counselor should remind clients that scheduling their time rigorously and sticking to the schedule are part of the recovery process. People who abuse substances are not accountable to schedules; taking responsibility for sticking to a schedule helps clients stop using. Following through on decisions made during scheduling helps keep clients' rational brains in charge of behavior.

- Ask clients how the schedule they made at the end of the previous session helped them remain drug free.
- Ask clients what they learned about scheduling that will affect how they make future schedules.
- Have clients complete handout SCH 2—Daily/Hourly Schedule for the time between this session and session 8.

Homework (5 minutes)

Ask clients to share briefly their experience of doing the homework from the previous session. The counselor can decide how detailed the followup on homework should be. The goal of asking is not to discover which clients have not done the homework but to encourage clients to work on their recovery between sessions and to share that work with the group.



Session 8: 12-Step Wisdom

Goals of Session

- Help clients identify 12-Step sayings that are helpful in recovery.
- Help clients identify situations in which 12-Step sayings are helpful.
- Help clients understand that people are more vulnerable to relapse when they are hungry, angry, lonely, or tired.

Handouts

- CAL 2—Calendar
- ERS 8—12-Step Sayings
- SCH 2—Daily/Hourly Schedule

Marking Progress (5 minutes)

Before introducing the session topics, the counselor gives clients time to chart their progress on CAL 2—Calendar and encourages clients to share positive events they have experienced since the last session.

Topics for Group Discussion (35 minutes)

1. *Discussing the Usefulness of 12-Step Sayings*

Many sayings that originated in Alcoholics Anonymous and became part of other 12-Step programs have taken root in popular discourse, too. Such phrases as “One day at a time” and “Keep it simple” may be familiar even to clients who have not participated in a 12-Step program. Because the phrases are familiar, clients may take them for granted. The counselor should present these sayings in the context of 12-Step programs so that clients can understand their value. The direct approach to recovery that these sayings convey can be used to support the usefulness of 12-Step participation.

- Go over handout ERS 8—12-Step Sayings (up to discussion of the HALT acronym).
- Ask clients which 12-Step sayings they find useful. Why?
- Ask clients to imagine situations in which they would call on these phrases for strength or encouragement.
- Ask the recovering co-leader to discuss what 12-Step wisdom means and how it has helped him or her in recovery.

2. *Using 12-Step Wisdom To Avoid Relapse*

The counselor explains the acronym, HALT. Clients who have participated in 12-Step programs before will be familiar with it and should be called on to help explain its importance. Recovery is a process of returning the body to a normal, healthy state. Controlling *hunger* by eating regularly is an important part of recovery. *Anger* is a frequent cause of relapse; it can drag clients down, making them feel bitter and resentful. It is important for clients to learn how to recognize and control anger. *Loneliness* is a common experience for clients in recovery; clients may feel isolated from friends and loved ones. The supportive fellowship of others in recovery helps combat loneliness. Feeling *tired* is often a warning sign of a relapse. Along with eating well, regular exercise and rest mitigate fatigue.

- Go over the HALT acronym presented in handout ERS 8—12-Step Sayings.
- Ask clients to share their answers to the questions at the end of the handout.
- Ask clients which of the HALT states poses the greatest relapse risk for them. What strategies will help them avoid the relapse pitfalls mentioned in HALT?
- Ask clients what other relapse risks exist for them. List these and perhaps make an acronym that represents them.
- Ask the recovering co-leader to explain how HALT has helped him or her avoid relapse.

3. *Offering an Alternative Approach*

The counselor should research local options to 12-Step programs and expose clients to other types of recovery support in addition to 12-Step programs.

Scheduling (5 minutes)

The counselor should remind clients that scheduling their time rigorously and sticking to the schedule are part of the recovery process. People who abuse substances are not accountable to schedules; taking responsibility for sticking to a schedule helps clients stop using. Following through on decisions made during scheduling helps keep clients' rational brains in charge of behavior.

- Ask clients how the schedule they made at the end of the previous session helped them remain drug free.
- Ask clients what they learned about scheduling that will affect how they make future schedules.
- Have clients complete handout SCH 2—Daily/Hourly Schedule for the time between this session and their next treatment group session.

Homework (5 minutes)

Ask clients to share briefly their experience of doing the homework from the previous session. The counselor can decide how detailed the followup on homework should be. The goal of asking is not to discover which clients have not done the homework but to encourage clients to work on their recovery between sessions and to share that work with the group.

This is the final session of the Early Recovery Skills portion of treatment. Have clients take some time to reflect on what they have learned.

Handouts for Early Recovery Skills Group Sessions

The handouts that follow are to be used by clients with the counselor's guidance. The handouts will help clients make the most of the eight ERS sessions.

SCH 1

The Importance of Scheduling



Scheduling may be a difficult and boring task if you're not used to it. It is, however, an important part of the recovery process. People with substance use disorders do not schedule their time. Scheduling your time will help you achieve and maintain abstinence.

Why Is Scheduling Necessary?

If you began your recovery in a hospital, you would have the structure of the program and the building to help you stop using. As a person in outpatient treatment, you have to build that structure to help support you as you continue functioning in the world. Your schedule is your structure.

Do I Need To Write Down My Schedule?

Absolutely. Schedules that are in your head are too easily revised. If you write down your schedule while your rational brain is in control and then follow the schedule, you will be doing what you *think* you should be doing instead of what you *feel like* doing.

What if I Am Not an Organized Person?

Learn to be organized. Buy a schedule book and work with your counselor. Thorough scheduling of your activities is very important to treating your substance use disorder. Remember, your rational brain plans the schedule. If you follow the schedule, you won't use. Your addicted brain wants to be out of control. If you go off the schedule, your addicted brain may be taking you back to using drugs or drinking.

Who Decides What I Schedule?

You do! You may consider suggestions made by your counselor or family members, but the final decision is yours. Just be sure you do what you wrote down. Follow your schedule; try not to make any changes.

Most people can schedule a 24-hour period and follow it. If you can, you are on your way to gaining control of your life. If you cannot, you may need to consider a higher level of care as a start.

Date:

7:00 AM

How many hours will you sleep? _____

8:00 AM

From _____ To _____

9:00 AM



Notes:

10:00 AM

11:00 AM

12:00 PM

1:00 PM

2:00 PM

3:00 PM

4:00 PM



Reminders:

5:00 PM

6:00 PM

7:00 PM

8:00 PM

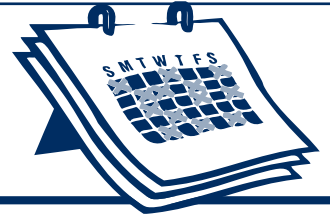
9:00 PM

10:00 PM

11:00 PM

CAL 1

Marking Progress



It is useful for both you and your counselor to know where you are in the recovery process at all times. Marking a calendar as you go helps in several ways:

- It's a reminder of how far you've come in your recovery.
- A feeling of pride often results from seeing the number of days you have been abstinent.
- Recovery can seem very long unless you can measure your progress in short units of time.

Make a mark to record on the calendar pages every day of abstinence you achieve. You may decide to continue the exercise following the program.

If you record your abstinent days regularly, this simple procedure will help you and your counselor see your progress.

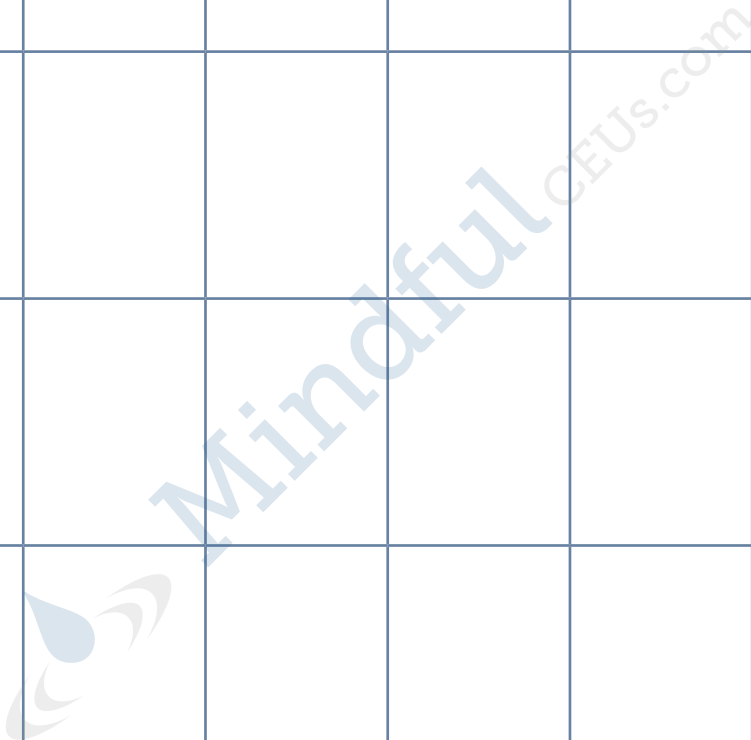


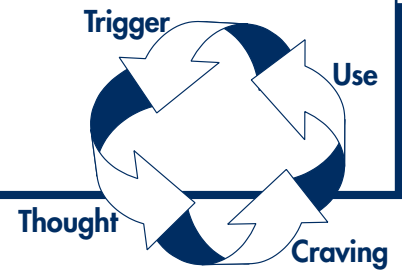
CAL 2

Calendar

Month:

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY





Triggers are people, places, objects, feelings, and times that cause cravings. For example, if every Friday night someone cashes a paycheck, goes out with friends, and uses stimulants, the triggers might be

- Friday night
- After work
- Money
- Friends who use
- A bar or club

Your brain associates the triggers with substance use. As a result of constant triggering and using, one trigger can cause you to move toward substance use. The trigger–thought–craving–use cycle feels overwhelming.

Stopping the craving process is an important part of treatment. The best way to do that is to do the following:

1. Identify triggers.
2. Prevent exposure to triggers whenever possible (for example, do not handle large amounts of cash).
3. Cope with triggers differently than in the past (for example, schedule exercise and a 12-Step or mutual-help meeting for Friday nights).

Remember, triggers affect your brain and cause cravings even though you have decided to stop substance use. Your intentions to stop must translate into behavior changes, which keep you away from possible triggers.

What are some of the strongest triggers for you?

What particular triggers might be a problem in the near future?

The Losing Argument

If you decide to stop drinking or using but at some point end up moving toward using substances, your brain has given you permission by using a process called relapse justification. Thoughts about using start an argument inside your head—your rational self versus your substance-dependent self. You feel as though you are in a fight, and you must come up with many reasons to stay abstinent. Your mind is looking for an excuse to use again. You are looking for a relapse justification. The argument inside you is part of a series of events leading to substance use. How often in the past has your substance dependence lost this argument?

Thoughts Become Cravings

Craving does not always occur in a straightforward, easily recognized form. Often the thought of using passes through your head with little or no effect. But it's important to identify these thoughts and try to eliminate them. It takes effort to identify and stop a thought. However, allowing yourself to continue thinking about substance use is choosing to relapse. The further the thoughts are allowed to go, the more likely you are to relapse.

The “Automatic” Process

During addiction, triggers, thoughts, cravings, and use seem to run together. However, the usual sequence goes like this:

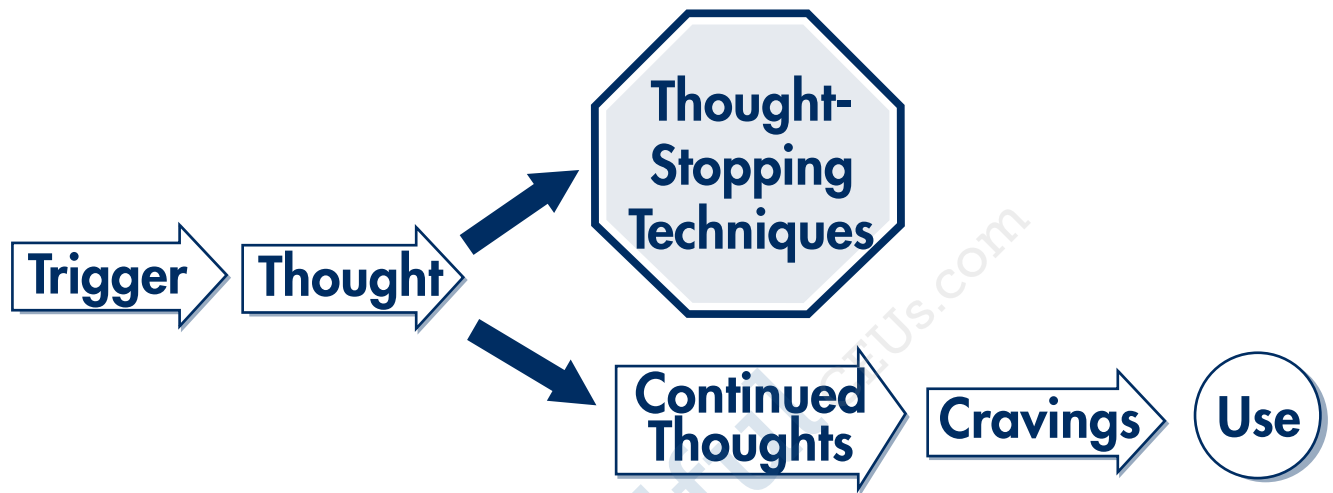
TRIGGER ⇒ THOUGHT ⇒ CRAVING ⇒ USE

Thought Stopping

The only way to ensure that a thought won't lead to a relapse is to stop the thought before it leads to craving. Stopping the thought when it first begins prevents it from building into an overpowering craving. It is important to do it as soon as you realize you are thinking about using.

A New Sequence

To start recovery, it is necessary to interrupt the trigger–thought–craving–use sequence. Thought stopping provides a tool for disrupting the process.



This process is not automatic. You make a choice either to continue thinking about using (and start on the path toward relapse) or to stop those thoughts.

Thought-Stopping Techniques

Try the techniques described below, and use those that work best for you:



Visualization. Imagine a scene in which you deny the power of thoughts of use. For example, picture a switch or a lever in your mind. Imagine yourself actually moving it from ON to OFF to stop the using thoughts. Have another picture ready to think about in place of those thoughts.

ERS 1C

Thought-Stopping Techniques

STOP



Snapping. Wear a rubber-band loosely on your wrist. Each time you become aware of thoughts of using, snap the rubberband and say, “No!” to the thoughts as you make yourself think about another subject. Have a subject ready that is meaningful and interesting to you.

Relaxation. Feelings of hollowness, heaviness, and cramping in the stomach are cravings. These often can be relieved by breathing in deeply (filling lungs with air) and breathing out slowly. Do this three times. You should be able to feel the tightness leaving your body. Repeat this whenever the feeling returns.

Call someone. Talking to another person provides an outlet for your feelings and allows you to hear your thinking process. Have phone numbers of supportive, available people with you always, so you can use them when you need them.

ALLOWING THE THOUGHTS TO DEVELOP INTO CRAVINGS IS MAKING A CHOICE TO REMAIN DEPENDENT ON SUBSTANCES.



Place a checkmark next to activities, situations, or settings in which you frequently used substances; place a zero next to activities, situations, or settings in which you never have used substances.

- | | | |
|---|--|--|
| <input type="checkbox"/> Home alone | <input type="checkbox"/> During a date | <input type="checkbox"/> Before going out to dinner |
| <input type="checkbox"/> Home with friends | <input type="checkbox"/> Before sexual activities | <input type="checkbox"/> Before breakfast |
| <input type="checkbox"/> Friend's home | <input type="checkbox"/> During sexual activities | <input type="checkbox"/> At lunch break |
| <input type="checkbox"/> Parties | <input type="checkbox"/> After sexual activities | <input type="checkbox"/> While at dinner |
| <input type="checkbox"/> Sporting events | <input type="checkbox"/> Before work | <input type="checkbox"/> After work |
| <input type="checkbox"/> Movies | <input type="checkbox"/> When carrying money | <input type="checkbox"/> After passing a particular street or exit |
| <input type="checkbox"/> Bars/clubs | <input type="checkbox"/> After going past dealer's residence | <input type="checkbox"/> School |
| <input type="checkbox"/> Beach | <input type="checkbox"/> Driving | <input type="checkbox"/> The park |
| <input type="checkbox"/> Concerts | <input type="checkbox"/> Liquor store | <input type="checkbox"/> In the neighborhood |
| <input type="checkbox"/> With friends who use drugs | <input type="checkbox"/> During work | <input type="checkbox"/> Weekends |
| <input type="checkbox"/> When gaining weight | <input type="checkbox"/> Talking on the phone | <input type="checkbox"/> With family members |
| <input type="checkbox"/> Vacations/holidays | <input type="checkbox"/> Recovery groups | <input type="checkbox"/> When in pain |
| <input type="checkbox"/> When it's raining | <input type="checkbox"/> After payday | |
| <input type="checkbox"/> Before a date | | |

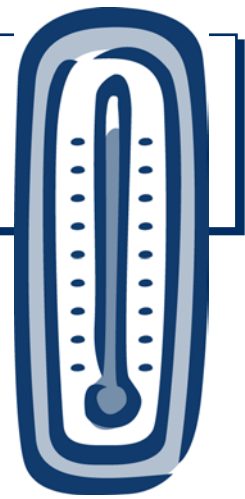
List any other activities, situations, or settings where you frequently have used.

List activities, situations, or settings in which you would not use.

List people you could be with and not use.

ERS 2B

External Trigger Chart



Name: _____ Date: _____

Instructions: List people, places, objects, or situations below according to their degree of association with substance use.

0% **Chance of Using** 100% **Chance of Using**

Never Use

Almost Never Use

Almost Always Use

Always Use

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



These situations are "safe."

These situations are low risk, but caution is needed.

These situations are high risk. Staying in these situations is extremely dangerous.

Involvement in these situations is deciding to stay addicted. Avoid totally.



During recovery certain feelings or emotions often trigger the brain to think about using substances. Read the following list of feelings and emotions, and place a check mark next to those that might trigger thoughts of using for you. Place a zero next to those that are not connected with using.

- | | | | |
|-------------------------------------|--------------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Afraid | <input type="checkbox"/> Criticized | <input type="checkbox"/> Excited | <input type="checkbox"/> Aroused |
| <input type="checkbox"/> Frustrated | <input type="checkbox"/> Inadequate | <input type="checkbox"/> Jealous | <input type="checkbox"/> Revengeful |
| <input type="checkbox"/> Neglected | <input type="checkbox"/> Pressured | <input type="checkbox"/> Bored | <input type="checkbox"/> Worried |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Depressed | <input type="checkbox"/> Exhausted | <input type="checkbox"/> Grieving |
| <input type="checkbox"/> Guilty | <input type="checkbox"/> Insecure | <input type="checkbox"/> Lonely | <input type="checkbox"/> Resentful |
| <input type="checkbox"/> Nervous | <input type="checkbox"/> Relaxed | <input type="checkbox"/> Envious | <input type="checkbox"/> Overwhelmed |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Embarrassed | <input type="checkbox"/> Deprived | <input type="checkbox"/> Misunderstood |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Irritated | <input type="checkbox"/> Humiliated | <input type="checkbox"/> Paranoid |
| <input type="checkbox"/> Passionate | <input type="checkbox"/> Sad | <input type="checkbox"/> Anxious | <input type="checkbox"/> Hungry |

What emotional states that are not listed above have triggered you to use substances?

Was your use in the weeks before entering treatment

_____ Tied primarily to emotional conditions?

_____ Routine and automatic without much emotional triggering?

Were there times in the recent past when you were not using and a specific change in your mood clearly resulted in your wanting to use (for example, you got in a fight with someone and wanted to use in response to getting angry)? Yes _____ No _____ **If yes, describe:**

Internal Trigger Chart



Name: _____ Date: _____

Instructions: List emotional states below according to their degree of association with substance use.

0%
Chance of Using

100%
Chance of Using

Never Use

Almost Never Use

Almost Always Use

Always Use

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



These emotions are "safe."

These emotions are low risk, but caution is needed.

These emotions are high risk.

Persisting in these emotions is deciding to stay addicted. Avoid totally.



Meetings

What Is a 12-Step Program?

In the 1930s, Alcoholics Anonymous (AA) was founded by two men who could not cope with their own alcoholism through psychiatry or medicine. They found a number of specific principles helped people overcome their alcohol dependence. They formed AA to introduce people who were dependent on alcohol to these self-help principles. The AA concepts have been adapted to stimulant and other drug addictions (for example, Crystal Meth Anonymous, Narcotics Anonymous [NA], and Cocaine Anonymous) and to compulsive behaviors such as gambling and overeating.

People dependent on drugs or alcohol have found that others who also are dependent can provide enormous support and help to one another. For this reason, these groups are called fellowships, where participants show concern and support for one another through sharing and understanding.

Do I Need To Attend 12-Step Meetings?

If treatment in this program is going to work for you, it is essential to establish a network of support for your recovery. Attending treatment sessions without going to 12-Step meetings may produce a temporary effect. But without involvement in self-help programs, it is very unlikely that you will successfully recover. Clients in these programs should attend three 12-Step meetings per week during their treatment involvement. Many successfully abstinent people go to 90 meetings in 90 days. The more you participate in treatment and 12-Step meetings, the greater your chance for recovery.

Are All Meetings the Same?

No. There are different types of meetings:

- Speaker meetings feature a person in recovery telling his or her story of drug and alcohol use and recovery.

12-Step Introduction



- Topic meetings have a discussion on a specific topic such as fellowship, honesty, acceptance, or patience. Everyone is given a chance to talk, but no one is forced.
- Step/Tradition meetings are special meetings where the 12 Steps and 12 Traditions are discussed.
- Book study meetings focus on reading a chapter from the main text of the 12-Step group. (For AA, this is the Big Book; for NA, the Basic Text.) Book study meetings often focus on someone's experience or a recovery-related topic.
- Depending on where you live, there may be language-specific meetings, gender-specific meetings, open meetings, meetings based on participants' sexual orientation, and meetings for people who also have a mental disorder ("double trouble" Dual Recovery Anonymous meetings).

Are the 12-Step Programs Religious?

No. None of the 12-Step programs are religious, but spiritual growth is considered a part of recovery. Spiritual choices are very personal and individual. Each person decides for himself or herself what the term "higher power" means. Both nonreligious and religious people can find value and support in 12-Step programs.

How Do I Find a Meeting?

You can call directory assistance or check the phonebook for Alcoholics Anonymous, Cocaine Anonymous, or Narcotics Anonymous. Listings for Crystal Meth Anonymous meetings can be found at <http://www.crystalmeth.org>. You can call the numbers available from the Web site and speak to someone who can tell you when and where meetings are scheduled. At meetings, directories are available that list meetings by city, street address, and meeting time and include information about the meeting (for



example, speaker, step study, nonsmoking, men's, or women's). Another way to find a good meeting is to ask someone who goes to 12-Step meetings.

Sponsors

The first few weeks and months of recovery are frustrating. Many things happen that are confusing and frightening. During this difficult period, there are many times when people in recovery need to talk about problems and fears. A sponsor helps guide a newcomer through this process.

What Do Sponsors Do?

- Sponsors help the newcomer by answering questions and explaining the 12-Step recovery process.
- Sponsors agree to be available to listen to their sponsees' difficulties and frustrations and to share their insights and solutions.
- Sponsors provide guidance and help address problems their sponsees are having. This advice comes from their personal experiences with long-term abstinence.
- Sponsors are people with whom addiction-related secrets and guilt feelings can be shared easily. They agree to keep these secrets confidential and to protect the newcomer's anonymity.
- Sponsors warn their sponsees when they get off the path of recovery. Sponsors often are the first people to know when their sponsees experience a slip or relapse. So, sponsors often push their sponsees to attend more meetings or get help for problems.
- Sponsors help their sponsees work through the 12 Steps.



How Do I Pick a Sponsor?

The process of choosing a sponsor is easy. The newcomer simply asks someone to be his or her sponsor. But you need to think carefully about whom you will ask to sponsor you. Most people select a sponsor who seems to be living a healthy and responsible life, the kind of life a person in recovery would want to lead.

Some general guidelines for selecting a sponsor include the following:

- A sponsor should have several years of abstinence from all mood-altering drugs.
- A sponsor should have a healthful lifestyle and not be struggling with major problems or addiction.
- A sponsor should be an active and regular participant in 12-Step meetings. Also, a sponsor should be someone who actively “works” the 12 Steps.
- A sponsor should be someone to whom you can relate. You may not always agree with your sponsor, but you need to be able to respect your sponsor.
- A sponsor should be someone you would not become romantically interested in.

Alternatives to 12-Step Programs

There are alternatives to 12-Step groups, many of which are not based on the concept of a higher power. Although the philosophies of these groups differ, most offer a mutual-help approach that focuses on personal responsibility, personal empowerment, and strength through an abstinent social network. Here are a few notable alternatives to 12-Step groups:



- Women for Sobriety (<http://www.womenforsobriety.org>) helps women overcome alcohol dependence through emotional and spiritual growth.
- Jewish Alcoholics, Chemically Dependent Persons and Significant Others (JACS) (<http://www.jbfcs.org/JACS>) helps people explore recovery in a nurturing Jewish environment.
- Self-Management and Recovery Training (SMART) (<http://www.smartrecovery.org>) is a cognitive-behavioral group approach that focuses on self-reliance, problem solving, coping strategies, and a balanced lifestyle.
- Secular Organizations for Sobriety (<http://www.secularhumanism.org>) maintains that sobriety is a separate issue from religion or spirituality and credits the individual for achieving and maintaining sobriety.
- Community-based spiritual fellowships, which take place in churches, synagogues, mosques, temples, and other spiritually focused settings, often help people clarify their values and change their lives.

Questions To Consider

- Have you ever been to a 12-Step meeting? If so, what was your experience?
- Have you attended any other types of recovery meetings (such as those listed above)?
- Do you plan to attend any 12-Step meetings? Where? When?
- How might you make use of 12-Step meetings to stop using?
- Are there alternatives to 12-Step meetings that you might consider attending?

The Serenity Prayer and the 12 Steps of Alcoholics Anonymous

The Serenity Prayer

God grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.

The 12 Steps of Alcoholics Anonymous*

1 We admitted that we were powerless over alcohol—that our lives had become unmanageable.

2 Came to believe that a Power greater than ourselves could restore us to sanity.

3 Made a decision to turn our will and our lives over to the care of God as we understood Him.

4 Made a searching and fearless moral inventory of ourselves.

5 Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6 Were entirely ready to have God remove all these defects of character.

7 Humbly asked Him to remove our shortcomings.

8 Made a list of all persons we had harmed and became willing to make amends to them all.

9 Made direct amends to such people wherever possible, except when to do so would injure them or others.

10 Continued to take personal inventory, and when we were wrong, promptly admitted it.

11 Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.

12 Having had a spiritual awakening as a result of the steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

*The Twelve Steps are reprinted with permission of Alcoholics Anonymous World Services, Inc. (A.A.W.S.). Permission to reprint the Twelve Steps does not mean that A.A.W.S. has reviewed or approved the contents of this publication, or that A.A.W.S. necessarily agrees with the views expressed herein. A.A. is a program of recovery from alcoholism only—use of the Twelve Steps in connection with programs and activities which are patterned after A.A., but which address other problems, or in any other non-A.A. context, does not imply otherwise.

ERS 5

Roadmap for Recovery

RECOVERY



Recovery from a substance use disorder is not a mysterious process. After the use of substances is stopped, the brain goes through a biological readjustment. This readjustment process is essentially a “healing” of the chemical changes that were produced in the brain by substance use. It is important for people in the beginning stages of recovery to understand why they may experience some physical and emotional difficulties. The durations of the stages listed below are a rough guide of recovery, not a schedule. The length of stages will vary from person to person. The substance used will affect the client’s progress through the stages, too. Clients who had been using methamphetamine will tend to spend more time in each stage than clients who were using cocaine or other stimulants.

The Stages

Withdrawal Stage (1 to 2 weeks)

During the first days after substance use is stopped, some people experience difficult symptoms. The extent of the symptoms often is related to the amount, frequency, and type of their previous substance use.

For people who use stimulants, withdrawal can be accompanied by drug craving, depression, low energy, difficulty sleeping or excessive sleep, increased appetite, and difficulty concentrating. Although people who use stimulants do not experience the same degree of physical symptoms as do people who use alcohol, the psychological symptoms of craving and depression can be quite severe. Clients may have trouble coping with stress and may be irritable.

ERS 5

Roadmap for Recovery



People who drank alcohol in large amounts may have the most severe symptoms. The symptoms can include nausea, low energy, anxiety, shakiness, depression, intense emotions, insomnia, irritability, difficulty concentrating, and memory problems. These symptoms typically last 3 to 5 days but can last up to several weeks. Some people must be hospitalized to detox safely.

For people who used opioids or prescription drugs, the 7- to 10-day withdrawal period (or longer for people who use benzodiazepines) can be physically uncomfortable and may require hospitalization and medication. It is essential to have a physician closely monitor withdrawal in people dependent on these substances. Along with the physical discomfort, many people experience nervousness, trouble sleeping, depression, and difficulty concentrating. Successfully completing withdrawal from these substances is a major achievement in early recovery.

Early Abstinence (4 weeks; follows Withdrawal)

For people who used stimulants, this 4-week period is called the Honeymoon. Most people feel quite good during this period and often feel “cured.” As a result, clients may want to drop out of treatment or stop attending 12-Step meetings during the Honeymoon period. Early abstinence should be used as an opportunity to establish a good foundation for recovery. If clients can direct the energy, enthusiasm, and optimism felt during this period into recovery activities, they can lay the foundation for future success.

For people who used alcohol, this 4-week period is marked by the brain’s recovery. Although the physical withdrawal symptoms have ended, clients still are getting used to the absence of substances. Thinking may be unclear, concentration may be poor, nervousness and anxiety may be troubling, sleep is often irregular, and, in many ways, life feels too intense.

ERS 5

Roadmap for Recovery



For those who used opioids or prescription drugs, there is essentially a gradual normalization during this period. In many ways the process is similar to the alcohol recovery timetable. Slow, gradual improvement in symptoms is evidence that the recovery is progressing.

Protracted Abstinence (3.5 months; follows Early Abstinence)

From 6 weeks to 5 months after clients stop using, they may experience a variety of annoying and troublesome symptoms. These symptoms—difficulties with thoughts and feelings—are caused by the continuing healing process in the brain. This period is called the Wall. It is important for clients to be aware that some of the feelings during this period are the result of changes in brain chemistry. If clients remain abstinent, the feelings will pass. The most common symptoms are depression, irritability, difficulty concentrating, low energy, and a general lack of enthusiasm. Clients also may experience strong cravings during protracted abstinence. Relapse risk goes up during this period. Clients must stay focused on remaining abstinent one day at a time. Exercise helps tremendously during this period. For most clients, completing this phase in recovery is a major achievement.

Readjustment (2 months; follows Protracted Abstinence)

After 5 months, the brain has recovered substantially. Now, the client's main task is developing a life that has fulfilling activities that support continued recovery. Although a difficult part of recovery is over, hard work is needed to improve the quality of life. Because cravings occur less often and feel less intense 6 months into recovery, clients may be less aware of relapse risk and put themselves in high-risk situations and increase their relapse risk.

Five Common Challenges in Early Recovery



Everyone who attempts to stop using substances runs into situations that make it difficult to maintain abstinence. Listed below are five of the most common situations that are encountered during the first few weeks of treatment. Next to these problems are some suggested alternatives for handling these situations.

Challenges

New Approaches



Friends and associates

who use: You want to continue associations with old friends or friends who use.

- Try to make new friends at 12-Step or mutual-help meetings.
- Participate in new activities or hobbies that will increase your chances of meeting abstinent people.
- Plan activities with abstinent friends or family members.



Anger, irritability:

Small events can create feelings of anger that seem to preoccupy your thoughts and can lead to relapse.

- Remind yourself that recovery involves a healing of brain chemistry. Strong, unpredictable emotions are a natural part of recovery.
- Engage in exercise.
- Talk to a counselor or a supportive friend.



Substances in the home:

You have decided to stop using, but others in your house may still be using.

- Get rid of all drugs and alcohol.
- Ask others to refrain from using and drinking at home.
- If you continue to have a problem, think about moving out for a while.

Five Common Challenges in Early Recovery

Challenges



Boredom, loneliness:

Stopping substance use often means that activities you did for fun and the people with whom you did them must be avoided.



Special occasions:

Parties, dinners, business meetings, and holidays without substance use can be difficult.

New Approaches

- Put new activities in your schedule.
- Go back to activities you enjoyed before your addiction took over.
- Develop new friends at 12-Step or mutual-help meetings.

- Have a plan for answering questions about not using substances.
- Start your own abstinent celebrations and traditions.
- Have your own transportation to and from events.
- Leave if you get uncomfortable or start feeling deprived.

Are some of these issues likely to be problems for you in the next few weeks? Which ones?

How will you handle them?



Have you been able to stop using alcohol completely? At about 6 weeks into the recovery process, many people return to alcohol use. Has your addicted brain played with the idea? These are some of the most common arguments against stopping the use of alcohol and answers to the arguments.

I came here to stop using speed, not to stop drinking. Part of stopping methamphetamine use is stopping all substance use, including alcohol use.

I've had drinks and not used, so it doesn't make any difference. Drinking over time greatly increases the risk of relapse. A single drink does not necessarily cause relapse anymore than a single cigarette causes lung cancer. However, with continued drinking, the risks of relapse greatly increase.

Drinking actually helps. When I have a craving, a drink calms me down, and the craving goes away. Alcohol interferes with the brain's chemical healing process. Continued alcohol use eventually intensifies cravings, even if one drink seems to reduce cravings.

I'm not an alcoholic, so why do I need to stop drinking. If you're not an alcoholic, you should have no problem stopping alcohol use. If you can't stop, maybe alcohol is more of a problem than you realize.

I'm never going to use drugs again, but I'm not sure I'll never drink again. Make a 6-month commitment to total abstinence. Give yourself the chance to make a decision about alcohol with a drug-free brain. If you reject alcohol abstinence because "forever" scares you, then you're justifying drinking now and risking relapse to substance use.

Has your addicted brain presented you with other justifications? If so, what are they?

How are you planning to handle alcohol use in the future?

Thoughts, Emotions, and Behavior

Habitual substance use changes the way people think, how they feel, and how they behave. How do these changes affect the recovery process?

Thoughts

Thoughts happen in the rational part of the brain. They are like pictures on the TV screen of the mind. Thoughts can be controlled. As you become aware of your thoughts, you can learn to change channels in your brain. Learning to turn off thoughts of substance use is a very important part of the recovery process. It is not easy to become aware of your thinking and to learn to control the process. With practice it gets easier.

Emotions

Emotions are feelings. Happiness, sadness, anger, and fear are some basic emotions. Feelings are the mind's response to things that happen to you. Feelings cannot be controlled; they are neither good nor bad. It is important to be aware of your feelings. Talking to family members, friends, or a counselor can help you recognize how you feel. People normally feel a range of emotions. Drugs can change your emotions by changing the way your brain works. During recovery, emotions are often still mixed up. Sometimes you feel irritated for no reason or great even though nothing wonderful has happened. You cannot control or choose your feelings, but you can control what you do about them.

Behavior

What you do is behavior. Work is behavior. Play is behavior. Going to treatment is behavior, and substance use is behavior. Behavior can result from an emotion, from a thought, or from a combination of both. Repeated use of a substance changes your thoughts and pushes your emotions toward substance use. This powerful, automatic process has to be brought back under control for recovery to occur. Structuring time, attending 12-Step or mutual-help meetings, and engaging in new activities are all ways of regaining control. The goal in recovery is to learn to combine your thinking and feeling self and behave in ways that are best for you and your life.

Addictive Behavior

People who abuse substances often feel that their lives are out of control. Maintaining control becomes harder and harder the longer they have been abusing substances. People do desperate things to continue to appear normal. These desperate behaviors are called addictive behaviors—behaviors related to substance use. Sometimes these addictive behaviors occur only when people are using or moving toward using. Recognize when you begin to engage in these behaviors. That's when you know to start fighting extra hard to move away from relapse.

Which of these behaviors do you think are related to your drug or alcohol use?

- Lying
- Stealing
- Being irresponsible (for example, not meeting family or work commitments)
- Being unreliable (for example, being late for appointments, breaking promises)
- Being careless about health and grooming (for example, wearing "using" clothes, avoiding exercise, eating poorly, having a messy appearance)
- Getting sloppy in housekeeping
- Behaving impulsively (without thinking)
- Behaving compulsively (for example, too much eating, working, sex)
- Changing work habits (for example, working more, less, not at all, new job, change in hours)
- Losing interest in things (for example, recreational activities, family life)
- Isolating (staying by yourself much of the time)
- Missing or being late for treatment
- Using other drugs or alcohol
- Stopping prescribed medication (for example, disulfiram, naltrexone)

The program of Alcoholics Anonymous has developed some short sayings that help people in their day-to-day efforts at staying sober. These concepts are often useful tools in learning how to establish sobriety.

One day at a time. This is a key concept in staying abstinent. Don't obsess about staying abstinent forever. Just focus on today.

Turn it over. Sometimes people with addictions jeopardize their recovery by tackling problems that cannot be solved. Finding a way to let go of issues so that you can focus on staying abstinent is a very important skill.

Keep it simple. Learning to stay abstinent can get complicated and seem overwhelming if you let it. In fact, there are some simple concepts involved. Don't make this process difficult: keep it simple.

Take what you need and leave the rest. Not everyone benefits from every part of 12-Step meetings. It is not a perfect program. However, if you focus on the parts you find useful, rather than the ones that bother you, the program has something for you.

Bring your body, the mind will follow. The most important aspect of 12-Step programs is attending the meetings. It takes a while to feel completely comfortable. Try different meetings, try to meet people, and read the materials. Just go and keep going.

HALT

This acronym is familiar to people in the 12-Step programs. It is a shorthand way of reminding people in recovery that they are especially vulnerable to relapse when they are too hungry, angry, lonely, or tired.

Hungry: When people are using, they often ignore their nutritional needs. People in recovery need to relearn the importance of eating regularly. Being hungry can cause changes in body chemistry that make people less able to control themselves or avoid cravings. Often the person feels anxious and upset but doesn't associate the feelings with hunger. Eating regularly increases emotional stability.



Angry: This emotional state is probably the most common cause of relapse to drug use. Learning to cope with anger in a healthy way is difficult for many people. It is not healthy to act in anger without thinking about the consequences. Nor is it healthy to hold anger in and try to pretend it doesn't exist. Talking about anger-producing situations and how to handle them is an important part of recovery.

Lonely: Recovery is often a lonely process. People lose relationships because of their substance use. As part of staying abstinent, people in recovery may have to give up friends who still use. The feelings of loneliness are real and painful. They make people more vulnerable to relapse.

Tired: Sleep disorders are often a part of early recovery. People in recovery frequently have to give up chemical aids to sleep that they used in the past. Being tired is often a trigger for relapse. Feeling exhausted and low on energy leaves people vulnerable and unable to function in a healthy way.

How often do you find yourself in one or more of these emotional states?

What could you do differently to avoid being so vulnerable?

Appendix A.

The Methamphetamine Treatment Project

Overview

Conducted over 18 months between 1999 and 2001, the Methamphetamine Treatment Project (MTP) is (to date) the largest randomized clinical trial of treatment approaches for methamphetamine dependence; 978 individuals participated in the study (Rawson et al. 2004). MTP researchers randomly assigned participants at each treatment site into either the Matrix model treatment or the program's treatment as usual (TAU). The study design did not standardize TAU across sites, so each program offered different outpatient treatment models (including lengths of treatment ranging from 4 to 16 weeks). All TAU models,

along with the Matrix model, either required or recommended that participants attend 12-Step or mutual-help groups during their treatment, and all treatment models encouraged participation in continuing care activities after primary treatment.

The characteristics of a cross-section of participants in MTP (both TAU and Matrix participants) were found to be consistent with those of the clinical populations who participated in similar studies of treatment for methamphetamine abuse (Huber et al. 1997; Rawson et al. 2000). Figure A-1 lists specific client characteristics.

Figure A-1. Characteristics of MTP Participants			
Male	45%	Average education	12.2 years
Female	55%		
Caucasian	60%	Employed	69%
Hispanic/Latino	18%		
Asian/Pacific Islander	17%		
Other*	5%		
Average age	32.8 years	Average lifetime methamphetamine use	7.54 years
		Average days of methamphetamine use in the past 30 days	11.53 days
Married and not separated	16%	Preferred route of methamphetamine administration	
		Smoking	65%
		Intravenous	24%
		Intranasal	11%

*Two percent of participants in the Other category were African American (personal correspondence with Jeanne Obert, Matrix Institute, November 2004).

Source: Rawson et al. 2004, p. 711.

Participants' histories indicated multiple substance use. During the study, participant self-reports and drug and breath-alcohol tests confirmed that some clients had used marijuana or alcohol, as well as methamphetamines, but no other substances of abuse were identified.

All MTP participants completed baseline assessments including the methamphetamine-dependence checklist in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (American Psychiatric Association 1994), and the Addiction Severity Index (McLellan et al. 1992). The assessments were repeated at several points during participants' active treatment, at discharge from treatment, and at 6 and 12 months after their dates of discharge from the program. Urine drug testing was conducted weekly throughout active treatment.

Results

No significant differences in substance use and functioning were found between TAU and Matrix groups at discharge and at 6-month followup. However, the MTP study found that the Matrix model participants (Rawson et al. 2004)

- Had consistently better treatment retention rates than did TAU participants
- Were 27 percent more likely than TAU participants to complete treatment
- Were 31 percent more likely than TAU participants to have methamphetamine-free urine test results while in treatment

At 6-month followup, more than 65 percent of both Matrix and TAU participants had negative urine tests for methamphetamine and other drugs (Rawson et al. 2004).



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Appendix B.

Notes on Group Facilitation

All clients in a group develop individual relationships with their counselor. The degree to which the counselor can instigate positive change in clients' lives is related directly to the credibility that the counselor establishes. The counselor must be perceived as a highly credible source of information about substance use. Two keys to establishing credibility with clients are the degree to which the counselor engages and maintains control over a group and the counselor's ability to make all participants perceive the group as a safe place.

These two elements are highly interrelated. For a group to feel safe, the members need to view the counselor as competent and in control. Sometimes, group members enter the group with a lot of energy and are talkative and boisterous. Frequently this situation occurs during holidays, particularly if several members have relapsed. The counselor should use verbal and nonverbal methods of calming the group and focusing the group on the session topic. Conversely, there may be times when group members are lethargic, sluggish, and depressed. During these times, the counselor should infuse energy and enthusiasm. He or she needs to be aware of the emotional tone of the group and respond accordingly.

In a similar manner, the members of a group need to feel that the counselor is keeping the group moving in a useful and healthful direction. The counselor must be willing to interrupt private conversations in the group, terminate a graphic drug use story, or redirect a lengthy tangential diversion. He or she must be perceived as clearly in control of the time in the group. Each member must be given an opportunity to

have input. The counselor should ensure that a few members do not monopolize the group's time. Clients must feel that the counselor is interested in their participation in the group as it relates to abstinence. The counselor must be clearly, actively, unquestionably in control of the group.

The counselor needs to be sensitive to emotional and practical issues that arise in group. At times it also may be necessary to be directive and confrontational or to characterize input from group members as a reflection of addictive thinking. In these instances the counselor should focus on the addiction as opposed to the person. In other words, care should be taken to avoid directing negative feedback toward the client, focusing instead on the addiction-based aspects of the client's behavior or thinking.

The counselor is preferably the professional who also sees the members of the group for the prescribed Individual/Conjoint sessions. The advantage of this dual role (group leader and individual counselor) is that the counselor can coordinate more effectively and guide the progressive recovery of each individual. The frequency of contact also strengthens the therapeutic bond that can hold the client in treatment. A potential disadvantage of the dual role is the possible danger that the counselor may inadvertently expose confidential client information to the group before the client chooses to do so. It is a violation of boundaries for the counselor even to imply that information exists and to attempt to coerce a client into sharing that information if the client has not planned to do so in the group.

Another danger to be avoided is the counselor's being perceived as showing preference to some clients. It is important that the counselor be equally supportive of all group members and not allow them to engage in competition for attention.

The counselor can find discussions of group development, leadership, concepts, techniques,

and other helpful information for conducting group therapy in Treatment Improvement Protocol 41, *Substance Abuse Treatment: Group Therapy* (CSAT 2005b), a free publication from the Center for Substance Abuse Treatment.



Appendix C.

Sample Agreement for Co-Leaders and Client-Facilitators

All clients serving as group co-leaders or client-facilitators are required to read and agree to abide by the conditions below, as indicated by initialing each item and signing at the bottom of the form.

As a co-leader or client-facilitator I agree to the following:

- _____ To commit to participating in _____ group sessions per week for at least 3 months (for co-leaders) or 6 months (for client-facilitators).
- _____ To participate in regular pregroup and postgroup meetings with my assigned group counselor.
- _____ To be on time for scheduled groups. If I am unable to attend a scheduled group, I will call and notify the program 24 hours in advance.
- _____ To abstain from using illicit drugs or alcohol and from abusing prescription drugs.
- _____ To respect and maintain client confidentiality with respect to information disclosed in group sessions.
- _____ Not to become involved socially, sexually, or economically with group members or with other program clients.
- _____ To abide by the program's statement of ethical conduct.
- _____ That I am entering this agreement on a strictly volunteer basis; I understand that I will not be paid for my time.
- _____ To actively participate in some form of ongoing recovery support or treatment.
- _____ That any departure from the above conditions could result in my termination from the co-leader or client-facilitator position.

Co-Leader's Signature

Date

Client-Facilitator's Signature

Date

Counselor's Signature

Date

Program Director's Signature

Date

Appendix D.

Acronyms and Abbreviations List

AA	Alcoholics Anonymous
ACoA	Adult Children of Alcoholics
Al-Anon	A support group for families and loved ones of people who are addicted to alcohol
Alateen	A support group for young family members and loved ones of people who are addicted to alcohol
ASI	Addiction Severity Index
CA	Cocaine Anonymous
CAL	Calendar (for worksheets used during scheduling)
CMA	Crystal Meth Anonymous
CoDA	Co-Dependents Anonymous
CSAT	Center for Substance Abuse Treatment
EA	Emotions Anonymous
ERS	Early Recovery Skills
GA	Gamblers Anonymous
HALT	Hungry Angry Lonely Tired
IC	Individual/Conjoint
IOP	Intensive Outpatient Treatment for People With Stimulant Use Disorders
JACS	Jewish Alcoholics, Chemically Dependent Persons and Significant Others
MA	Marijuana Anonymous
meth	Methamphetamine
MTP	Methamphetamine Treatment Project
NA	Narcotics Anonymous
Nar-Anon	A support group for families and loved ones of people who are addicted to narcotics
OA	Overeaters Anonymous
PA	Pills Anonymous
RP	Relapse Prevention
SAMHSA	Substance Abuse and Mental Health Services Administration
SCH	Schedule (for worksheets used during scheduling)
SMART	Self-Management and Recovery Training
SS	Social Support
TAU	Treatment as Usual



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