NorthStar Regional Staff Training Schedule
Dates: 02.07.2022 - 02.11.2022

	Monday (2/7)	Tuesday (2/8)	Wednesday (2/9)	Thursday (2/10)	Friday (2/11)
7:00am					
7:30am					
8:00am	Arrive @ 8:00am	Arrive @ 8:00am	Arrive @ 8:00am	Arrive @ 8:00am	Arrive @ 8:00am
8:30am	Flash Mtg @ 8:30am Front Lobby Fireplace	Flash Mtg @ 8:30am Front Lobby Fireplace	Flash Mtg @ 8:30am Front Lobby Fireplace	Flash Mtg @ 8:30am Front Lobby Fireplace	Flash Mtg @ 8:30am Front Lobby Fireplace
9:00am	Deescalation Recording 9:00am-11:00am	Gratitude Jar Activity 9:00am-9:45am	Communication Skills 9:00am-9:45am	ASAM Training 9:00am-11:00am	Team building activity 9:00am-11:00am
9:30am		15 minute break	15 minute break		
10:00am	15 minute break	Sara UA Training 10:00am-11:00am	Coordinated/Elevate Training 10:00am-11:00am	15 minute break	15 minute break
10:30am	Deescalation Recording 9:00am-11:00am			ASAM Training 9:00am-11:00am	Team building activity 9:00am-11:00am
11:00am					
11:30am	Lunch Break 11:30am-12:00pm	Lunch Break 11:30am-12:00pm	Lunch Break 11:30am-12:00pm	Lunch Break 11:30am-12:00pm	Lunch Break 11:30am-12:00pm
12:00pm					
12:30pm	Review of dress code 12:00pm-1:00pm	Nurse Training 12:00pm-2:15pm	Tech Training 12:00pm-2:15pm	Day-to-day tasks 12:00pm-1:30pm	Staff Role play Lockdown situation 12:00pm-1:00pm
1:00pm	Insperity (Clock in/out) 1:00pm-1:30pm				ALL STAFF Meeting @ 1:00pm Front Lobby Fireplace
1:30pm	Review of Boundaries 1:30pm-3:00pm			Clinical staff duties 1:30pm-2:15pm	
2:00pm					
2:15pm	15 minute break	15 minute break	15 minute break	15 minute break	15 minute break
2:30pm	Review of Boundaries 1:30pm-3:00pm	Nurse Training - Role playing activities 2:30pm-5:00pm	Tech Training (Searching client items/Room search) 2:30pm-5:00pm	Tech duties 2:30pm-3:30pm	Team building activities 2:30pm-5:00pm
3:00pm					
3:30pm	Role playing activities 2:30pm-5:00pm			Learn about me Activity 4:00pm-5:00pm	
4:00pm					
4:30pm					
5:00pm					

De-escalation techniques

1. Move to a private area.
If it seems safe to do so, it may be helpful to move the patient away from public spaces and into a private area to talk.

2. Be empathetic and non-judgmental.
"Focus on understanding the person's feelings. Whether or not you think those feelings are justified, they're real to the other person."
Possible response: "I'm sure other patients have felt this way too."

3. Respect personal space.
"If possible, stand 1.5 to three feet away from the person . . . Allowing personal space tends to decrease a person's anxiety and can help prevent acting-out behavior. Do not block exits."

4. Keep your tone and body language neutral.
"The more a person loses control, the less they hear your words — and the more they react to your nonverbal communication. Relax your body and keep your hands in front of you, palms facing outward."

5. Avoid over-reacting.
"Remain calm, rational, and professional. While you cannot control the person's behavior, how you respond to their behavior can affect whether the situation escalates or defuses. Empathize with feelings, not behavior."
Possible response: "I understand you are _____, but it's not okay to yell at staff."

6. Focus on the thoughts behind the feelings.

"Some people have trouble identifying how they feel about what's happening to them."
Possible response: "Help me understand what you need."
Possible response: "What has helped you in the past?"
Possible response: "Tell me if I have this right."
Not: "Tell me how you feel."

7. Ignore challenging questions.

"Answering challenging questions often results in a power struggle. If a person challenges your authority, redirect their attention to the issue at hand. Ignore the challenge, not the person."
Patient: "Why is that other doctor such a _____?"
You: "Please tell me again when your symptoms started?"

8. Set boundaries.

"If the person's behavior is belligerent, defensive, or disruptive, give them clear, simple, and enforceable limits. Offer concise and respectful choices and consequences."
Possible response: "It's important for you to be calm in order for us to be able to talk. How can that be accomplished?"

9. Choose boundaries wisely.

"Carefully consider which rules are negotiable and which rules are not. If you can offer a person options and flexibility, you may be able to avoid unnecessary altercations."
Possible response: "I understand it's confusing when rules change, but federal law says we have to check your ID."

10. Allow silence.

By letting silence occur, you are giving the person a chance to reflect on what's happening and how to proceed.

11. Allow time for decisions.

"When a person is upset, they may not be able to think clearly. Give them a few moments to think through what you've said."
Sample response: "I've just shared a lot of information with you. I'll come back in about 10 minutes after you've had time to think about it."

Understanding the Violent Behavior Cycle: Know the 5 Phases

The next step in de-escalating a situation is to understand five phases of the Violent Behavior Cycle. There is no standard timeline for this cycle. It is difficult to know when a person will shift from one phase to the next. Recognizing the indicators of each phase can help you understand the appropriate intervention approach.

Triggering Phase	**Escalation Phase**	**Crisis Phase**	**Recovery Phase**	**Post Crisis Depression Phase**
The early warning phase. Something happens that makes the person afraid or frustrated. They can manage this state without hostility or aggressive behavior, but may be uncomfortable, angry or agitated.	The person will indicate movement toward a loss of control. Mentally and physically, they are preparing for a fight.	The person loses control and reacts to the environment. There may be outbursts or violent behavior. Others may be threatened or harmed.	After the outburst occurs, the person may: • **Express remorse, guilt** • **Blame others** • **Bargain with self, others, God** • **Run away**	After the event, the person may feel/express: • **Increased guilt** • **Low self-esteem & self worth** • **Loss of hope** • **Feelings of, "This can't be helped"** • **Fatigue** They may isolate themselves or disconnect from others.

De-Escalation Techniques

There is no single response to the Violent Behavior Cycle that will be appropriate for all situations. There is also no situation that calls for only one response. This is why it's important to continuously add to your own "De-Escalation" toolbox. Having a range of options will help you feel confident and maintain your calm when faced with crisis situations.

In a crisis situation, you'll need to do your escalation assessment, determine what phase the person is in, then choose an intervention that matches the circumstances. Think about the following suggestions as possibilities. Practice them in a safe place (e.g., with colleagues, in a training, in the mirror). Make the techniques your own so you'll be comfortable using them when they're needed.

- *Align with the person*. **Find a point of agreement—get to a yes. *Yes*, you can understand they're frustrated. *Yes*, what they're going through sounds scary. Even *yes*, it's a mighty hot day out there.**
- *Give them space*. **Stand 2-3 feet away if possible. If you need to move closer to provide care, explain what you're doing so they are less likely to feel threatened.**
- *Engage supportively*. **Listen to their story with full attention. Don't change the subject or interrupt. Give them the chance to say what they need to say.**
- *Monitor your voice tone*. **Keep your tone measured and calm. You might slow your pace a bit. Remember to breathe.**
- *Project a supportive attitude*. **In your voice, manner and behavior, communicate, "I have time for you. You are an important person."**
- *Protect yourself at all times*. **You may need to set limits—calling for assistance or moving out of the area, for example. Let the person know what you're doing. Don't respond to challenging questions or insults. Avoid power struggles.**
- *Know how to retreat*. **Sometimes a change in listeners can help. ("It seems we are not understanding each other, so let me have Ms. Evans talk with you. Maybe she can help us both.")**

Setting Boundaries

Personal boundaries are the limits and rules we set for ourselves within relationships. A person with healthy boundaries can say "no" to others when they want to, but they are also comfortable opening themselves up to intimacy and close relationships.

Know Your Boundaries

Boundaries should be based on your values, or the things that are important to you. For example, if you value spending time with family, set firm boundaries about working late.

Your boundaries are yours, and yours alone. Many of your boundaries might align with those who are close to you, but others will be unique.

Know your boundaries *before* entering a situation. This will make it less likely you'll do something you're not comfortable with.

What to Say

You always have the right to say "no". When doing so, express yourself clearly and without ambiguity so there is no doubt about what you want.

"I'm not comfortable with this"	"Please don't do that"	"Not at this time"
"I can't do that for you"	"This doesn't work for me"	"I've decided not to"
"This is not acceptable"	"I'm drawing the line at ___"	"I don't want to do that"

What to Do

Use Confident Body Language
Face the other person, make eye contact, and use a steady tone of voice at an appropriate volume (not too quiet, and not too loud).

Be Respectful
Avoid yelling, using put-downs, or giving the silent treatment. It's okay to be firm, but your message will be better received if you are respectful.

Plan Ahead
Think about what you want to say, and how you will say it, before entering a difficult discussion. This can help you feel more confident about your position.

Compromise
When appropriate, listen and consider the needs of the other person. You never *have* to compromise, but give-and-take is part of any healthy relationship.

Setting Boundaries

Instructions: Respond to the following practice questions as if you were really in each situation. Think about the language *you* would use to firmly state your boundary.

✔ Examples

Situation: You notice your roommate has been eating your food in the fridge. You never discussed plans to share food, and don't want them eating what you bought.

Response: "I'd like to keep our food separate. If there's something of mine that you want, please ask me before taking it."

Situation: Your friend calls you at 11 pm to discuss issues she is having with her boyfriend. You need to wake up at 6 am.

Response: "I can tell you're upset. I want to talk to you, but I need to go to bed. Maybe we can talk tomorrow afternoon."

Practice

Situation: You invited a friend over for the evening, but now it's getting late. You would like to get ready for bed, but your friend seems unaware of how late it is.

Response:

Situation: A good friend asks you out on a date. You are not interested in being more than friends. You would like to let them down clearly, but gently.

Response:

Setting Boundaries

Situation: You missed several days of work due to a medical condition. When you get back, a coworker asks what happened. You feel this information is personal, and do not want to share.

Response:

Situation: Your brother asks if you can watch his two young children on Saturday morning. You already have plans.

Response:

Situation: Your coworker is upset about their recent performance review. They start yelling and slamming their fist on their desk. This is making you very uncomfortable.

Response:

Situation: A salesperson comes to your door during dinner. You try to politely show disinterest, but they keep giving their sales pitch. You want to get back to dinner.

Response:

Boundaries in addiction treatment are an essential part of the client counselor relationship. In fact, they protect both the client and the counselor and they remain intact even during the inevitable ups and downs of addiction counseling. Boundaries are important because they:

- Reduce the chance of the exploitation (intentional or unintentional) of a client
- Create a definitive role for both the client and the counselor
- Create a framework of rules under which counseling can continue
- Offer a role-model for the client

Boundaries are set at the very beginning of treatment and it is the counselor's responsibility to make sure they are adhered to. Boundaries need to work in the best interests of the client and can be negotiated – sometimes based on cultural and/or personal preferences or differences.

While it may seem unfair that the counselor is ultimately responsible for maintaining boundaries, it is clear why this is. A) The counselor is the professional, B) the client may not understand the need and importance of having boundaries and C) there is a power imbalance between counselor and client. In other words the counselor is often perceived as being dominant party.

Blurred and broken boundaries can come with significant ramifications that include disciplinary action in an ethical and legal sense. The counselor can incur significant punishment for crossing the line. However not all boundaries are black and white nor defined very easily. Often, counselors have to make a split second decision on what to say or do. Some examples of blurred boundaries include:

- Self-disclosure
- Offering or accepting gifts
- Dual relationships
- Becoming friends
- Physical contact

Ultimately, it is part of a counselor's job to fully understand the depth of their relationship with a client. This is what we do and our jobs depend on our ability to make the best decisions for ourselves and our clients in mind.

Boundaries

In all our relationships we set limits. Each of us has a boundary around us that defines who we are as individuals. The strength of our boundary depends on our relationship with the other person and on the context of that relationship. One of the key issues for workers is to be able to recognize when we may be crossing the invisible line which separates a client from a worker and which defines our relationship as professional and therefore workable.

Example scenarios

Example: A welfare worker worked with a young person for two years. They built up a good working relationship after some initial hostility and distrust. The young person moved to another area and the case was transferred to another office and another caseworker. It has been six months since the first worker and the young person have had contact.

The first worker decides that they would like to see how that young person is doing. They use the client information system from their service to look up recent case notes and find out how that young person is.

Question - Is this professional/unprofessional? Why?

Note – You may wish to extend the discussion by asking learners to outline some strategies whereby the worker could make appropriate enquiries about the progress of a young person.

Question - Would it ever be appropriate to contact the young person directly? If not, why not?

Question - What are the implications for the worker to continue checking on the progress of ex-clients?

Question - What are the implications for the young person?

Example: Two teachers are in a tea room at the local primary school and they teach kindergarten and second class. They have two little girls that are sisters, one in each of their classes. They both find it difficult to interact with the mother of these children who is often hostile and yells at them at times. This morning the mother attended the school and grabbed one of the teachers by the arm, threatening to slap her if she didn't teach her child more effectively. Both the teachers were distressed by this incident, and are in the tea room 'debriefing' and talking about the family and what they should do. There are other teachers in the tearoom on their break.

Question - Is this professional/unprofessional? Why?

Note – You may wish to discuss ways in which the incident could be debriefed more appropriately. Should other staff be involved in the process in any way?

Personal reflection

Task - writing exercise/group activity

Consider the following questions and write down your ideas. Discuss your answers with other learners.

Question - Young people often ask you about your personal life or your drug use. How do you deal with these types of

questions?

Question - You are talking with a client in a designated smoking area at your workplace. Your client knows you are a smoker and offers you a cigarette. Is it appropriate to accept?

Question - You are working in a residential rehabilitation center. A young client of the same sex embraces you in a non-sexual hug. What should you do?

Answer - It is a good idea to avoid self-disclosure unless you are confident that this will be helpful to the young person. For example, if a client asks you if you have ever had a drug problem they might be trying to find out if you can really understand their situation. Whatever you decide to tell them, it is important to focus on the need behind the question. You should avoid revealing irrelevant information about your personal life and try to keep the focus on the young person.

Many workers feel that it is important to provide positive role models for young people and that this can be best achieved by not smoking with clients. Even if a client knows that you smoke you can usually show restraint without offending. However, there is quite a lot of debate about this issue. What is the view of your fellow learners or fellow workers?

Some people say that physical contact with young people is never appropriate because it might be misinterpreted. Other workers say that young people are vulnerable and therefore it is appropriate to touch them in a non-sexual way. Keep in mind that young people who have suffered sexual or physical abuse may regard physical contact as intrusive and unwelcome. Ideally the client should always initiate physical contact. Physical contact of a sexual nature is **never** appropriate.

Additional discussion questions

Workplace learning activity

Take some time to reflect on your own work experience.

Question - Have there been any situations where physical contact with a young person has been an issue for you or for another member of your team? *(For example, some young female clients are especially prone to hugging or showing affection and this can sometimes be inappropriate, but rejecting and alienating young people is also not desirable.)* How did you deal with the situation?

Question - Could you have handled the situation more effectively? How?

Question - Does your organization have a policy in regard to physical contact?

Question - Is it possible to regulate physical and emotional relationships between clients and workers?

Question - Does the current climate of litigation mean that workers need legal protection in their day-to-day work?

Question - In what ways can workers protect themselves from accusations of misconduct?

In your work with young people your goal should be to establish and maintain a professional and effective working relationship. The boundaries between you and your clients should be clear to both parties. Sometimes we need to be very explicit when we work with young people, especially if they are vulnerable or very manipulative. The question for

workers is how to recognize when these boundaries might be shifting or breaking down.

Maintaining professional boundaries

Task - writing exercise/group activity

Consider the following questions and write down your ideas. Discuss your answers with other learners.

Question - Suggest some signs that might indicate that boundaries are shifting?

Answer - You might consider that your relationship is drifting into something less than professional if you find yourself:

- setting aside a lot of time for one particular client
- staying back after hours with a particular client on a regular basis
- meeting a client socially on a regular basis
- finding yourself giving personal or irrelevant details about your own life
- becoming aware that a client will do whatever you suggest, without question
- becoming aware of sexual attraction to a client
- becoming aware of strong attachment to a client
- becoming aware of strong feelings of dislike for a client.

Question - If you recognize that your relationship with a client is becoming too intimate or that you have too much power and control over a young person, what can you do?

Answer

- Review your relationship with the young person
- Re-establish boundaries with the young person by clarifying your role
- Discuss the issue during your supervision session
- Alter workplace arrangements so that the client is moved to a new worker
- Arrange to share the case with another worker.
- Take time to reflect on the quality of relationships outside of work. Do you have time to develop and nurture these relationships?
- Think carefully about the best interests of the client. Are they being served?

Additional discussion questions

Task - brainstorm/writing exercise

You may know of situations where you or other workers have been concerned that boundaries were shifting or breaking down.

Question - How were you able to identify that this was occurring?

Question - How did you respond to this awareness?

Question - What could you have done differently?

Question - What would you do next time you sense that this is an issue for you or one of your team?

Question - In some work environments, it is possible that the general topic of boundary crossing can be raised at team meetings so that all workers can be sensitive to the issue and can deal with any problems before they develop into major issues. Is this a possibility at your workplace? If not, why not?

Active Listening

Communication Skill

Active Listening: Treating listening as an active process, rather than a passive one. This means participating in conversation, rather than acting as an audience. Active listeners show they are listening, encourage sharing, and strive to understand the speaker.

Show You're Listening

Put away distractions. Watching TV, using your phone, or doing other things while listening sends the message that the speaker's words are not important. Putting away distractions allows you to focus on the conversation and help the speaker feel heard.

Use verbal and nonverbal communication. Body language and short verbal cues that match the speaker's affect (e.g. responding excitedly if the speaker is excited) show interest and empathy.

Verbal:	*"mm-hmm" / "uh-huh"*	*"that's interesting"*	*"that makes sense"*	*"I understand"*
Nonverbal:	*nodding in agreement*	*reacting to emotional content (e.g. smiling)*		*eye contact*

Encourage Sharing

Ask open-ended questions. These are questions that encourage elaboration, rather than "yes" or "no" responses. Open-ended questions tell the speaker you are listening, and you want to learn more.

"What is it like to ____?"	*"How did you feel when ____?"*	*"Can you tell me more about ____?"*
"How do you ____?"	*"What do you like about ____?"*	*"What are your thoughts about ____?"*

Use reflections. In your own words, summarize the speaker's most important points. Be sure to include emotional content, even if it was only communicated through tone or body language.

Speaker: I've been having a hard time at work. There's way too much to do and I can't keep up. My boss is frustrated that everything isn't done, but I can't help it.

Listener: It sounds like you're doing your best to keep up, but there's too much work. That sounds stressful!

Strive to Understand

Be present. Listening means paying attention to body language, tone, and verbal content. Focus your attention on listening, instead of other mental distractions, such as what you want to say next. When possible, save sensitive conversations for a quiet time with few distractions.

Listen with an open mind. Your job is to understand the speaker's point of view, even if you don't agree. Avoid forming opinions and making judgments until you fully understand their perspective.

Non-verbal Communication Brainstorming Activity

Consider the many non-verbal ways in which people communicate. As a group, brainstorm and list all of the different non-verbal ways you communicate thoughts and feelings. (Example: crossed arms)

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

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14.

15.

16.

17.

18.

19.

20.

Consider how your non-verbal communication may be perceived in a workplace setting. What messages could you be sending to coworkers with your body language? Write a brief statement of how each of the following could be perceived by a coworker. (Example: Slouched posture may show you are not interested. Or minimal eye contact may signal lack of confidence)

Eye contact:

Facial expression:

Posture:

Handshake:

Personal space:

Vocal tone:

Review: The Importance of Clear Communication on the Job

10 minutes

Purpose:

The purpose of this discussion is to have participants examine how they communicate differently when the setting or group of people change. Everyone needs to learn to adjust their communication appropriately.

Materials:

- *None*

Facilitation Steps:

1. Ask participants to consider how they communicate with their friends. Then ask how they communicate with family members. Finally, ask how they are likely to communicate with an employer at a job interview. Ask for volunteers to describe each way of communicating and interacting.

2. Discuss the differences and similarities in the students' responses. Ask:

   • Why is each situation different?

   • What are the expectations of each person?

   • What would happen if you greeted your friends in the way you greeted an interviewer?

   • What would happen if you greeted an interviewer the same way you greet your friends?

3. Knowing how to communicate with people in the right context for a given situation is an important skill, as there are often unspoken rules and standards that are just expected.

How to Improve Communication in Relationships: 7 Essential Skills

1. Four Ears of a Message

There are "four ears" in every message:

- Fact: What I inform about (data, facts, statements)
- Self-revealing: What I reveal about myself (information about the sender)
- Relationship: What I think about you (information about how we get along)
- Appeal: What I want to make you do (an attempt to influence the receiver)

There is never the same emphasis put on each of the four facets, and the emphasis can be meant or understood differently. Try to focus on the fact of the message rather than guessing what the message was meant to say about yourself or the relationship between you and the sender.

2. Active Listening

Active listening is more than waiting for your turn to speak. Stop thinking about what to say next. Stop judging what the other person is saying. Instead, be present in the moment and truly listen to the other person. And remember:

- Show your attention (nonverbal involvement)
- Pay attention to your vis-à-vis, not your own thoughts
- Do not judge what they say
- Tolerate silence

3. Active Constructive Responding

Appreciative feedback in its nature needs to be supportive, inspiring and dealing from the strengths of the situation. Say your friend tells you she just got promoted. There are four ways you can respond to her:

- Nurturing (active constructive) "That is great! I'm so happy for you! Tell me more about it!"
- Cold (passive constructive) "Oh, that is good"
- Ignorant (passive destructive) "Sorry I don't have time to listen to you right now"
- Hurtful (active destructive) "Really? I don't think you do not deserve that"

Respond in a nurturing way: be enthusiastic and show genuine interest. Ask questions to allow her to relive the great moment and experience positive emotions.

4. Communication Climate

A destructive communication climate can have a negative impact on the conversation. The following six behaviors can help maintain a supportive communication climate: description (rather than evaluation), problem orientation (rather than control), equality (rather than superiority), empathy (rather than neutrality), provisionalism (rather than certainty) and spontaneity (rather than strategy).

5. Non-violent Communication

Nonviolent communication is the willingness and the ability to approach and perceive issues in a non-judgmental way. Here are the four steps:

1. Observation ≠ Interpretation/Evaluation
   Communicate your observations without interpreting them

2. Feelings ≠ Thoughts
   Understand your emotions and express them in a non-judgmental way

3. Need ≠ Strategy
   Express your needs

4. Request ≠ Demand
   Make a clear request

6. Transactional Theory, Thoughts and Perception

Good communication is an art which begins with your thoughts. The way you think of the other person may shape your conversation. Also, remember the three ego states we communicate from:

- Child State (feelings)
- Parent State (moral)
- Adult State (rational)

In complementary transactions communication flows effortlessly while crossed transactions lead to negative tension and misunderstandings.

7. Avoid Thinking Traps with Mindfulness

A thinking trap is an automatic way of thinking or responding to an event or stimuli that causes distress. So be aware of your thoughts and try to avoid awfulising/catastrophizing ("the plane must have crashed"), black and white thinking ("if he does not call today I will never visit him again") and emotional reasoning (using your emotional reaction to prove facts). Stay in the present moment and focus on what is good in your life and your relationship.

Gratitude Jar

Introduction

Gratitude Jars are a fun, artistic, and hands-on way for children to practice gratitude. In this activity, each child will create a special jar where they save gratitude statements at the end of the day.

Materials

- Clear Jar (glass or plastic)
- Art Supplies (ribbons, stickers, magazine cutouts, etc.)
- Gratitude Slips (blank strips of paper, or slips with gratitude prompts)

Instructions

Begin by helping each child personalize their jar with decorations. Use ribbons, stickers, magazine cut-outs, items found in nature, or anything else you can imagine.

After decorating the jars, it's time to add the first three gratitude statements. A gratitude statement acknowledges something that a person appreciates or is thankful for. Participants can use the prompts on the slips provided, or they can write their own gratitudes on blank slips. Here are some examples:

"I am grateful for my cat because she makes me laugh."

"I am thankful for the dinner I had tonight. It was my favorite: pizza!"

"I appreciate my grandma because she visited me when I was sick."

Once the participants have written down three gratitude statements—one per slip of paper—spend a moment discussing each one. Finally, fold the gratitude statements, and add them to the jar.

Plan for children to write three gratitude statements, and add them to their jars, each day. Encourage parents to make the gratitude jar part of their daily routine, including a brief discussion about each of their child's gratitudes. This activity works great as part of a bedtime routine.

Gratitude Jar

Today was special because...

I appreciate (person), because...

Something I accomplished today...

Something I'm looking forward to...

Something I am thankful for...

Something I like about my family...

Three people who make me happy are...

I felt happy today when...

Something little that makes me smile...

Today I had fun when...

Gratitude Jar

Something about today that I'll always want to remember...

I am proud of (person), because...

Something I appreciate about my past...

My friend (name) is important to me because...

Something good that happened today...

I was proud of myself today because...

Something interesting that I recently saw...

Something special about my family...

Something funny that happened today...

Something I like about myself...

Gratitude Jar

My favorite family tradition...

My favorite part of today...

Something I am grateful for...

Three friends who I appreciate...

A special memory I have of my family...

Something I look forward to every day...

Today, I felt happy when...

This week has been good because...

Something I like about myself...

Something that made me smile today...

The following are the six dimensions of ASAM, and how they are defined by the American Society of Addiction Medicine, (ASAM PPC-2R, ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, 2nd Edition – Revised, David Mee Lee, M.D. Editor, 2001).

ASAM Dimension 1.) Acute Intoxication and Withdrawal

1. What risk is associated with the patient's current level of acute intoxication?
2. Is there significant risk of severe withdrawal symptoms or seizures, based on the patients previous withdrawal history, amount, frequency, chronicity and recency of discontinuation or significant reduction of alcohol or other drug use.
3. Are there current signs of withdrawal?
4. Does the patient have supports to assist in ambulatory detoxification, if medically safe?

Dimension 2.) Bio-Medical Conditions and Complications

1. Are there current physical illnesses, other than withdrawal, that need to be addressed or that may complicate treatment?
2. Are there chronic conditions that affect treatment?

Dimension 3.) Cognitive, Behavioral, and Emotional Conditions

1. Are there current psychiatric illnesses or psychological, behavioral, emotional or cognitive problems that need to be addressed because they create risk or complicate treatment?
2. Are there chronic conditions that affect treatment?
3. Do any emotional, behavioral or cognitive problems appear to be an expected part of addictive disorder or do they appear to be autonomous?
4. Even if connected to the addiction, are they severe enough to warrant specific mental health treatment?
5. Is the patient able to manage the activities of daily living?
6. Can he or she cope with any emotional, behavioral or cognitive problems?

Dimension 4.) Readiness / Motivation

1. What is the individual's emotional and cognitive awareness of the need to change?
2. What is his or her level of commitment to and readiness for change?
3. What is or has been his or her degree of cooperation with treatment?
4. What is his or her awareness of the relationship of alcohol of other drug use to negative consequences?

Dimension 5.) Relapse, Continued Use, Continued Problem

1. Is the patient in immediate danger of continued severe mental health distress and or alcohol or drug use?
2. Does the patient have any recognition of, understanding of, or skills with which to cope with his or her addictive or mental disorder in order to prevent relapse, continued use or continued problems such as suicidal behavior?

How severe are the problems and further distress that may continue or reappear if the patient is not successfully engaged in treatment at this time?

3. How aware is the patient of relapse triggers, ways to cope with cravings to use, and skills to control impulses to use or impulses to harm self or others?

Dimension 6.) Recovery Environment

1. Do any family members, significant others, living situations or school or work situations pose a threat to the patients safety or engagement in treatment?
2. Does the patient have supportive friendships, financial resources, or educational/ vocational resources that can increase the likelihood of successful treatment?
3. Are there legal, vocational, social service agency or criminal justice mandates that may enhance the patient's motivation for engagement in treatment?
4. Are there transportation, child care, housing or employment issues that need to be clarified and addressed?

(ASAM PPC-2R, ASAM Patient Placement Criteria for the Treatment of Substance Related Disorders, 2nd Edition – Revised, David Mee Lee, M.D. Editor, 2001).

Weekly ASAM Staff Meeting Guide

Procedure Guidelines

- Every client will be reviewed each week following the ASAM dimensions.

Items to quickly highlight and discuss in each dimension. We will most likely only have 5-7 minutes to dedicate to each client.

Dimension	Things to discuss	Examples
1	-Intoxication or withdrawal -Under the influence at Tx -Relapse/s -Last UA	*No signs of intoxication or withdrawal reported or observed.* *Client reported experiencing irritability due to quitting marijuana, but is able to cope* *Client reported relapse on: 6/26, 10/13*
2	-Medical concerns -Medications -If they are out sick -Sleep patterns -Eating habits -Personal hygiene	*Client reports taking Cymbalta 60 mgs a day and Adderall 30mgs a day.* *Client reported that she attends monthly appointments with her psychiatrist and routine appointments with her medical provider for her ADHD medications.* *Client denied experiencing any physical concerns this week and reported that she was getting 8-10 hours of sleep per night this week.* *Client reports eating regularly, but not showering as much as they would like to.*
3	-Behavior -Impulsivity -Decision making ability -Aggression -Suicidal Ideation (SI) -Self Injurious Behaviors (SIB)	*Client has been diagnosed with Depression, ADHD, and PTSD.* *Client appeared to struggle with her impulsivity this week and reported that they stole a pack of cigarettes from their mother's friend's house. Client stated that they were able to address the issue and sent them back via mail and called to apologize.* *Client reported being able to use behavioral antidepressants and coping skills at home which were helpful. Client does appear to continue to have difficulty with their impulse control which impacts their home and treatment environment.*
4	-Motivation for sobriety/ MH -Motivation for Tx -Progress in Tx/Phase applications -Attendance and Participation -Goodbye letter assignment -Ability to recognize relapse pattern	*Client attended treatment but struggled to participate in groups. Client reported they do not want to work on their sobriety because "treatment is useless anyway"* *Client struggled to take responsibility for their actions and is unable to recognize their relapse pattern.* *Client identified they wanted to work on their impulsivity and how it affects them during phase 2.*
5 MH	-Insight to MH diagnoses -Overall symptoms for the week -Triggers experienced this week for MH -Suicidal ideation/self-harm tracker if applicable -Ability to use coping skills -Relapse potential	*Client denied a mental health relapse this week.* *Client reported that they have been using breathing as a healthy coping skills to aide in managing mental health symptoms.* *Client appears to display moderate vulnerability for further mental health problems and is not effectively using skills to manage impulsivity.* *Client reported self-harm/SI on: 5/8 no plan-created safety plan, 6/13 with plan-hospital* pull Jeremy's notes

Weekly ASAM Staff Meeting Guide

		Client appears to have insight into his mental health symptoms, but seems to struggle with using coping skills at home.
5 CD	-Insight to CD diagnoses -Triggers/urges experienced this week for CD -Ability to use coping skills -Relapse potential -Using behavior -Healthy activities, friendships, other relapse prevention activities -No use contract assignment	*Client reported they are experiencing cravings and is struggling to manage them* *Client reports he is doing well with triggers, but is still associating with using peers which increases chance for relapse.* *Client denied a chemical health relapse this week and reports that they have been talking to people who are still using but denied being around use this week. Client stated that they are "not worried" about their chemical health at this time and "knows" that they will not relapse.* *Relapse Log: 10/7/2016 THC 93ngs* *Client reports that they have been attending NA meetings in the community once a week.*
6	-Family involvement and support -Parenting skills -Family therapy -Respect for rules and structure -Conflict at home -Legal concerns -Accountability letter assignments	*Client's mother had consistent communication with the treatment team this week.* *Client reported they are following rules at home, but dad reported that there is a lack of structure.* *Client's parents attended both sessions of the parenting skills program this week.* *Client is not engaged in any structured activities outside of treatment at this time which places them at high risk for relapse.* *Client's parents have attended a family therapy session as discussed.*

NORTHSTAR
REGIONAL

Observed UA Collection Training

By my signature below, I am legally attesting that I have received the following documents during training. I also attest that I have had the opportunity to ask questions and to receive answers that I understand the information given to me today.

I also attest that I agree to abide by these protocols and understand that my position as a UA Collector is contingent on my following these protocols.

1. UA Collection Procedure: Observed Methodology
2. Urine Drug Testing Policy and Procedure

Name of UA Collector:_____

Signature and Date of UA Collector:_____

Name of Trainer:_____

Signature and Date of Trainer:_____

Compliance Department Signature: _____

UA Collection Procedure for Collectors: Observed Methodology

PRE-COLLECTION (Precision Diagnostics)

1. Print labels for the week (first name, last name, DOB, leave collection date blank)
2. Print Group lists for the week
3. Stock supplies in caddies

PRE-COLLECTION (Collectors)

1. Gather caddy, cups, gloves, labels, group lists, and pen
2. Ensure NSR Lab door is closed and locked
3. Conduct 1 collection at a time, all steps must be completed before starting another collection with a new client

COLLECTION

1. Confirm identity by asking client for their first name, last name, and date of birth
2. Inform client to stay with you until samples are sealed
3. Remove any unnecessary outer garments
4. Go to restroom and secure the restroom
5. Instruct client to wash and dry their hands prior to voiding process, begin voiding (urinating into cup)
6. Listen and look for signs of tampering with the specimen
7. Keep the specimen container in view at all times until sealed
8. If a client cannot void due to anxiety, leave the area and mark the sample as "unobserved"
9. If a client refuses to wash their hands or void, mark the paperwork as "refusal to test"
10. Never combine urine collected from separate voids to create a specimen
11. Take container from client while in restroom & go to workstation with client
12. Split specimen collection by pouring part into separate vial/cup
13. Record the date of the collection on the labels/seals
14. Place label/seal over each bottle cap
15. Have client initial the labels/seals on each specimen bottle
16. The collector seals the specimen in a biohazard bag and takes to NSR Lab
17. If the specimen is not immediately transported to the laboratory, they must remain under direct control of the collector or be appropriately secured under proper specimen storage conditions(not exposed to excessive heat or cold for more than 3 hours) until transported
18. Collectors are not to discuss test results, processes, or other clinical items with patients. Clients with questions are to be referred back to their primary CD counselor.

1.1 Drug Screening

Accountability is an important part of maintaining successful recovery and quality mental health. As participants in this program, clients are expected to comply with random drug screening as requested by the clinical treatment team. Clients are expected to disclose all prescribed medications and any changes to those medications to their individual therapist/case manager throughout the duration of this program and consent for care coordination with all prescribing physicians. Positive drug screens will be consulted with the treatment team and clinical decisions made with consideration of each individual client. If a client refuses to comply with a requested drug screen, this will be treated as a positive screen and may result in an incomplete discharge from treatment. Drug screening services are intended to provide clients with increased support in reaching a goal of sustained abstinence.

Drug screening services are provided and fees will be processed and managed both through NorthStar Regional Clinical Laboratory billings or independently through a third-party. With client consent, NorthStar Regional's staff will provide the third-party lab with billing information as outlined in the attached release form. NorthStar Regional's staff may offer assistance in obtaining funding resources, but clients are responsible for the cost of all laboratory services. Clients sign a Consent for Clinical Laboratory Services and Billing upon admission to the program.

Client Medical Record and Clinical Procedures

1. All clients are informed of NorthStar Regional's collaboration with the laboratories and will be expected to comply with random, observed, drug screening through the duration of their programs.
2. Primary CD Counselors, in collaboration with the treatment team, will request and manage appropriate drug screening under supervision of their Program Director.
    a. Group rosters will be attached to pre-printed labels for the Collectors to identify who gets tested on the designated day.
        i. When a group drug screen is scheduled for a treatment group and at the start of group, Primary CD Counselors and the Collector will confirm who is in attendance and who may be missing for the day.
        ii. Standing Lab Orders are uploaded and kept in each client medical record.
    b. Completed drug screens will be uploaded into the medical record, marked as positive or negative for the Primary CD Counselor. All positive drug screens will be discussed in case consultation in order to determine an appropriate treatment intervention.
        i. All results, from both the in-house lab and the confirmation lab, will be uploaded to client charts and documented by office staff in the medical record.
            - Positive screens will be noted in the medical record. The Primary CD Counselor will discuss these results with the treatment team. And/or Program Director, and determine next steps in the client's care.

Urine Specimen Collection Procedures

NorthStar Regional utilizes the direct observed methodology for specimen collection. This procedure for collection involves an individual who monitors the collection by checking for signs that the donor may be tampering with the specimen. Observers and collectors at NorthStar Regional are the same individual. A direct, observed collection includes the following steps:

1. All clients will confirm their identity with first name, last name, and date of birth for the collector.
2. The labels for the vials are then filled out with: Date, Client Name, DOB, and Signatures. If the donor refuses to complete paperwork, the collector notes the refusal and continues with the collection process.
3. The collector asks the donor to remove any unnecessary outer garments (e.g., coat, jacket) that might conceal items or substances that could be used to adulterate or substitute the urine specimen:
    a. The collector must ensure that all personal belongings (e.g., purse or briefcase) remain with the outer garments; the donor may retain the donor's wallet.

b. If an item is present that appears to have been brought to the collection site with the intent to adulterate, substitute, or dilute the specimen, this is considered a questionable sample. The collector will continue the collection process as normal then notify the primary CD counselor (if available), the MLT, or the Chief Compliance Officer. The primary CD counselor will be notified and the medical record will be documented with the observations. If the item appears to be inadvertently brought to the collection site, the collector must secure the item and continue the normal collection procedure.

4. The collector must be the same gender as the donor, unless the collector is a trained medical professional (e.g., nurse, doctor, physician's assistant, technologist or technician) who is licensed or certified to practice where the collection occurs, and:
   a. The collector accompanies the donor into the restroom.
   b. The collector shall instruct the donor to wash and dry the donor's hands prior to urination. After washing the donor's hands, the donor must remain in the presence of the collector and must not have access to any water fountain, faucet, soap dispenser, cleaning agent, or any other materials which could be used to adulterate or substitute the specimen.
   c. If the donor refuses to wash the donor's hands when instructed by the collector, this is considered a "refusal to test." The collector must stop the collection and report the refusal to test.
   d. The collector listens and looks for signs of tampering with the specimen.
   e. After the donor has completed urinating into the collection container: the collector shall receive the container from the donor while they are both in the restroom.
   f. In cases where a donor is unable to produce a sample due to anxiety or previous trauma, the collector will exit the area, communicate with the primary counselor, and notate the specimen as "Unobserved."
   g. Unobserved procedures are as follows:
      i. Ask the donor to turn out their pockets
      ii. Pat down the inner and outer thighs to determine no external objects are being hidden
      iii. Ask the donor to raise their arms and pat down the armpits.
      iv. Ask the donor to turn out or expose their beltline as many people hid objects along the beltline.
5. Integrity, Identity, and Control of a Specimen
   a. The collector must inform the donor that, once the collection procedure has begun, the donor must remain at the collection site (i.e., in an area designated by the collector) until the collection process is complete, specimen sealed and verified by the client. Both the donor and the collector must keep the specimen container in view at all times until the collector seals the specimen bottles.
   b. After the donor has given the specimen to the collector, whenever practical, the donor shall be allowed to wash the donor's hands and the donor may flush the toilet.
   c. When there is any reason to believe that a donor may have adulterated or substituted the specimen, another specimen must be obtained as soon as possible under direct observation.
   d. The collector must determine the volume of urine in the specimen container. The collector must never combine urine collected from separate voids to create a specimen.
   e. If the donor fails to remain present through the completion of the collection, declines to have a direct observed collection as required, refuses to provide a second specimen as required, or refuses to provide an alternate specimen, the collector stops the collection and reports the refusal to test.
6. Specimen Custody Management and Preparation for Testing
   a. All collections are to be split specimen collections: one for NorthStar Regional Clinical Laboratory and one for a confirmation testing by a third-party vendor.
   b. The collector, in the presence of the donor, places the vacuum suction vial into the sample/donation cup to collect the urine from the collection container into two specimen vials.
   c. In the presence of the donor, the collector places the tamper-resistant label/seal over each specimen bottle cap.

d. The collector places one vial in a bag labels for the In-House lab; the collector places the vial in another bag labeled for the third-party lab.
e. The collector seals the specimens in a package and, within 24 hours or during the next business day, sends them to the main on-site laboratory that will be testing the urine specimen.
f. If the specimen is not immediately transported to the laboratory, they must remain under direct control of the collector or be appropriately secured under proper specimen storage conditions until transported.

7. Collectors are not to discuss test results, processes, or other clinical items with patients. Clients with questions are to be referred back to their primary Chemical Dependency (CD) counselor.

PRINTED PATIENT NAME ____________ CLIENT DOB ____________ CLIENT INITIALS ____________

COLLECTION DATE ___/___/___ COLLECTOR'S INITIALS ____________

PRINTED PATIENT NAME ____________ CLIENT DOB ____________ CLIENT INITIALS ____________

COLLECTION DATE ___/___/___ COLLECTOR'S INITIALS ____________

PRINTED PATIENT NAME ____________ CLIENT DOB ____________ CLIENT INITIALS ____________

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COLLECTION DATE ___/___/___ COLLECTOR'S INITIALS ____________