

FCC BEHAVIORAL HEALTH ADOLESCENT CSTAR – KENNETT

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Your Child's Counselor will be: _____

PARENT/GUARDIAN HANDBOOK

Revised: November 14, 2016
Previous Revision: 7/24/2016

CSTAR STAFF

CLINICAL STAFF

CARE COORDINATOR – VACANT (EXT: 1307)

NURSE – MICHELLE BURKS (EXT: 1312)

DIAGNOSTICIAN – ROBIN VICKERY (EXT: 953)

FAMILY THERAPIST – PEGGY BRIDGES (EXT: 1310)

RESIDENTIAL COUNSELOR – LARRY HAMPTON (EXT: 1305)

RESIDENTIAL COUNSELOR – JESSICA WILSON (EXT: 1309)

EDUCATION COORDINATOR – CHRISTINA MEZO (EXT: 1302)

RECREATION COORDINATOR – BRANDON VANVICKLE

OFFICE MANAGER – JIMINEZ JIMINEZ (EXT: 1301)

RESIDENTIAL MANAGER – JOSH GATTIS (EXT: 1302)

CLINICAL MANAGER – JOANNE WILLIAMS (EXT: 1308)

PROGRAM DIRECTOR – STEPHANIE MOBLEY (EXT: 1310)

RECOVERY SUPPORT AIDE STAFF

FEMALE GROUP HOME

MS. HANNAH WILLIAMS

MRS. MARY DOGAN

MS. ELISHA THOMASON

MS. SARAH DAILY

OPEN POSITION

MALE GROUP HOME

MR. BOB ROBERTSON

MR. NICK SMALL

MR. BERLEY BECK

MR. BRANDON KULIN

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ADOLESCENT CSTAR PROGRAM VISION

Collaboratively engaging adolescents to achieve their unique goals and dreams.

ADOLESCENT CSTAR PROGRAM MISSION

Collaboratively engage adolescents to learn new skills, strengthen positive relationships, make good decisions, and enhance confidence in order to empower them to accomplish their dreams.

ADOLESCENT CSTAR PROGRAM CORE VALUES

- Substance use problems can effectively be treated in the community.
- Treatment services should be individualized to meet the unique needs of each adolescent served in order to improve overall wellness.
- Treatment services will be provided in the least restrictive environment.
- Staff will assist in identifying and developing individualized treatment goals and will provide person-centered treatment through the utilization of various evidence-based practices such as Motivational Interviewing, Cognitive Behavioral Therapy, Moral Reconciliation Therapy, Staying Quit, 12 Step Group and the Matrix Model.
- Education and services will be provided to help the adolescent served effectively manage their symptoms and problem areas in order to live productive lives in the community.
- Program staff will evaluate services to help improve their overall effectiveness and improve the ability to empower the recovery efforts of adolescent served.
- Family involvement will be encouraged through all aspects of treatment.
- Co-occurring services will be integrated into the program to enhance treatment to those struggling with both mental health and substance use issues.

ADOLESCENT CSTAR PROGRAM KEY OUTCOMES

- Adolescents will demonstrate improved academic performance as evidenced by an increase in GPA during the current episode of care.
- Adolescents will demonstrate an improvement in daily living activities as evidenced by an increase in DLA-20 scores from the time of admission to the time of discharge.
- Adolescents with symptoms of anxiety will demonstrate decreased levels of anxiety as evidenced by the Generalized Anxiety Disorder 7 (GAD-7) scores obtained at time of admission compared to GAD-7 scores obtained at time of discharge.
- Adolescents with symptoms of depression will demonstrate decreased levels of depression as evidenced by the Patient Health Questionnaire (PHQ-9) scores obtained at time of admission compared to PHQ-9 scores obtained at time of discharge.

SCOPE OF SERVICES

KENNETT, BLOOMFIELD, CAPE GIRARDEAU AND POPLAR BLUFF ADOLESCENT COMPREHENSIVE SUBSTANCE TREATMENT AND REHABILITATION (CSTAR)

The Adolescent CSTAR Program provides substance use treatment services to male and female adolescents specifically 12-17 years of age. Individuals are accepted without regard to race, creed, national origin, gender, disability, or sexual orientation. To qualify for services, adolescents must have a substance use diagnosis as determined by a licensed diagnostician. Adolescents in the level 1 residential treatment component must also be certified for services by a physician.

The **Kennett Adolescent CSTAR** treatment center is located off Highway VV in Kennett, MO at 1109 Jones Street. The Kennett Adolescent CSTAR program has two (2) residential group homes which are located on the same campus as the business office/treatment center.

The group homes provide separate living quarters for male and female adolescents. Both group homes provide a relaxing, comfortable home like environment. Activities in the group homes include structured therapeutic group sessions, relaxing positive leisure time activities and life skills lessons.

The Kennett Adolescent CSTAR programs offer level I residential treatment, level I day treatment, intensive outpatient treatment and outpatient supported recovery treatment services. The business office at both locations is open Monday through Friday from 8:00am to 5:00pm.

All levels of treatment include intake screening, comprehensive assessment, community support, group education, drug screen services, academic education, group counseling, nursing services, recreation, family therapy, individual counseling and co-occurring counseling services.

The **Level I Residential Treatment** component provides 24-hour supervision, with up to 60-hours of structured therapeutic activities per week. Clinical Services are provided seven (7) days a week.

The **Level 1 Day Treatment** program is provided Monday through Friday from 8:00am to 4:30pm.

Intensive Outpatient Treatment and **Outpatient Treatment Services** are offered on Tuesdays and Thursdays from 4:00pm to 8:00pm. Adolescents attend based on their individualized needs. The length of each level of care is based on individualized needs.

Adolescent CSTAR also provides outpatient services at two (2) satellite locations; 20 South Sprigg Street in Cape Girardeau, MO and 3001 Warrior Lane in Poplar Bluff, MO. Both satellite locations provide: Intake screening, comprehensive assessment, community support, group counseling, group education, co-occurring counseling, individual counseling and drug screen services. Business hours for both satellite offices are Monday through Friday from 8:00am to 5:00pm.

Funding Sources for the Adolescent CSTAR programs include private healthcare insurance, POS funds, Medicaid and private fees. The ability to pay is based on the Department of Behavioral Health (DBH) sliding scale and the income of the adolescent and/or parent/guardian. The fees are determined by family income and number of dependents. If it is determined that adolescent and/or parent/guardian has a monthly fee from the sliding scale, that fee is collected upon admission and at the first of each month thereafter as long as the adolescent remains active in treatment services.

Adolescents are referred from a variety of sources to include, but not limited to, self and family referrals; juvenile office; court system; Division of Family Services (DFS); Division of Youth Services (DYS); attorneys; hospitals; physicians; community agencies; private practitioners; schools and community mental health centers.

Information regarding program structure and services is provided to all adolescents, family members and referral sources upon admission into the program. This information is provided in written form in the respective facility program handbook. The Scope of Service is also provided to payers and other relevant stakeholders as needed in order to help them understand what the program has to offer and determine whether it will meet the needs of the adolescents. Community relations activities also allow for the distribution of program information to the public through printed brochures, speaking engagements and at our website www.fccinc.org. The Scope of service is reviewed at least annually and updates are made to it as needed.

Clinical services are provided directly by program staff to include licensed social workers, licensed counselors, certified substance use professionals and nursing staff. Primary care needs are provided in cooperation with local medical providers. Mental health and psychiatric services are provided by on-site Qualified Mental Health Professionals (QMHP) through FCC Behavioral Health or in cooperation with our local community mental health center.



PROGRAM ORIENTATION ACTIVITIES

During the intake process, the Adolescent and his/her family receives an orientation to the Program and the services provided. The orientation process includes the following:

Located in this handbook:

- Rights and Responsibilities
- Grievance Policy and Appeal Procedures
- How to provide feedback about their treatment experience through the use of the facility suggestion box; satisfaction surveys and participation in program community meetings.
- Program Schedule
- Rules and Program Expectations
- Handling of personal belonging brought into the facility.
- Earning and Loss of Privileges/Level System/Behavior Marks and Merits/Behavior Write-ups
- Floor Plans and Emergency Evacuation Routes
- Policy Regarding Use of Seclusion and/or Restraint
- Program policy regarding use of tobacco products and gambling.
- Program policy regarding possession of illegal drugs brought into the program.
- Program policy regarding the possession of weapons.
- Identification of the staff member responsible for service coordination, which is typically the Care Coordinator.
- Prescription Medication Policy
- Crisis or after hours emergencies
- Discharge criteria
- Relapse Policy
- Pass Policy
- Visitation Policy
- Family Therapy Agreement
- Video/Audio Surveillance Authorization
- Responsibility for Damaged Property
- Notice of Privacy Practice
- Financial Obligations and Responsibilities
- Consent to Treat
- Grievance Policy
- Notice of Ethical Practices

Other orientation activities which will occur during the first day of services:

- Tour of Facility
- Assessment purpose and process.
- Description of how the individualized recovery care plan will be developed and the expectations regarding participation in this process by the adolescent served.

PROGRAM SERVICES

Services are designed and delivered to support the recovery, health and well-being of the adolescent served; to enhance their quality of life, to reduce needs and build resiliency, improve functioning and support their integration back into the community.

Assessment

During the assessment process, a variety of assessment tools are utilized to obtain a comprehensive overview of the adolescent and their family. Each adolescent will meet face-to-face with a licensed clinician to establish person-centered care plan goals based on the individual's strengths, needs, abilities and preferences. Once the goals are established, the adolescent will work with various staff members to develop specific steps for meeting these goals.

Academic Education services provided appropriate to the developmental needs of each adolescent. The Academic Coordinator (AC) works with the local school settings to address all educational needs. The AC coordinates with the community schools to facilitate reintegration. Adolescent CSTAR utilizes the Edmentum Plato Learning Courseware system. Plato Courseware is a standards-based online curriculum that provides a wide range of core subjects, electives and some and advanced placement offerings. The Plato Courseware system also allows the students to work on credit recovery. The AC links the student with the Plato Courseware Program in order to establish the appropriate prescribed courses that are specifically centered on the individuals' needs and abilities.

Group Counseling is face-to-face, goal oriented therapeutic interaction among a counselor and two (2) or more adolescent's as specified in individual recovery care plans designed to promote the adolescent's functioning and recovery through personal disclosure and interpersonal interaction among group members. The usual and customary size of group counseling sessions is eight (8) adolescent's and shall not exceed twelve (12) adolescent's in order to promote full participation, disclosure and feedback. Specialized group counseling topics include, but are not limited to: Moral Reconciliation Therapy, Anger Management, Relapse Prevention, gender specific groups, trauma groups and co-occurring specific groups.

Individual Counseling is a structured, goal-oriented therapeutic process in which the adolescent interacts on a face-to-face basis with a counselor in accordance with the individual's rehabilitation plan in order to resolve problems related to substance use which interferes with the person(s)-served functioning. Various treatment modalities are provided by appropriately trained staff to include, but are not limited to: Motivational Interviewing, Cognitive Behavioral Therapy, Moral Reconciliation Therapy, Integrated Dual Disorders Treatment and Relapse Prevention Therapy.

Recreation/Healthy Living Activities are structured to promote development of positive leisure time activities to include the involvement in community, social, fitness, cultural, athletic and leisure activities offered as part of the program.

Nursing services are provided in order to monitor the overall health and wellness of person(s)-served to include medication education; medication efficacy; health education; TB, HIV, STD screenings and preventative education. Primary care needs can be obtained for the adolescents through referral and collaboration with community resources.

Medication Assisted Treatment (MAT) is an evidenced based practice that combines pharmacological interventions with substance use counseling and social support. All adolescents in services at CSTAR will be educated on available medication assisted treatment interventions. The program will provide staff that are trained and certified in the delivery of Medication Assisted Treatment services.

Community Support services, consist of specific activities in collaboration with, or on behalf of the person(s)-served, are delivered in accordance with the recovery care plan. Community Support services maximize adjustment and functioning within the community while achieving sobriety and sustaining recovery, maximizing the involvement of natural support systems, and promoting independence and responsibility. Care Coordinators assist the individual in identifying available community resources and services to help them achieve recovery care plan goals. Care Coordinators have a working knowledge of health care, social services, employment, safe housing, recreational opportunities, transportation, and other services and systems available in the community. Care Coordinators also provide educational services regarding various daily living skills such as budgeting, meal planning and personal care. Care Coordinator services are provided in any setting that allows the best access to services. Settings may include the treatment center, medical clinics, schools and/or community businesses.

Co-Occurring Counseling is a service that provides counseling to those identified as having both a substance use diagnosis and a mental health diagnosis. Co-occurring issues are integrated into the recovery care plan and are provided by qualified personnel. Co-occurring specific groups are also provided. If it is determined that a person(s)-served needs a psychiatric evaluation, this service can be coordinated through the agency telemedicine program. The program is equipped with telemedicine equipment that will allow us to access agency psychiatrists as needed for routine and/or crisis psychiatry services.

Family Therapy is strongly encouraged and is scheduled on a case-by-case basis in order to promote access to services. The Family Therapist works directly with the family to schedule appointments. Family Therapy is a planned, face-to-face, goal oriented therapeutic interaction with a qualified staff member in accordance with an individualized recovery care plan. The Family Therapist works with each family to identify family strengths, needs and preferences. The purpose of family therapy is to address and resolve problems in family interaction related to the substance use problem and recovery.

Drug Screens are completed upon intake and sent to Laboratory for confirmation. Follow-up testing may be conducted at any time during treatment which could include specimens being sent to the lab for confirmation and/or an on-site dip screening test. The urine samples are collected according to recognized practice standards by trained staff. Results from drug screens are addressed with persons-served once the results are available, in order to intervene with substance use behavior. Test results and actions taken shall be documented in the adolescent's record.

Alcohol and Drug Education consists of the presentation of general information regarding substances of use, and the application of the information to participants through group discussion designed to promote recovery.

Group Education consists of the presentation of general information and application of the information to participants through group discussion in accordance with individualized treatment plans which are designed to promote recovery and enhance social functioning. The usual and customary size of group educational sessions shall not exceed thirty (30) adolescents.

Examples of topics discussed in group education are, but not limited to:

- Anger management
- Communication
- Family issues
- PAWS symptoms
- Substance use and its effects
- Gender specific issues
- Life skills
- Domestic violence
- 12-Steps
- Parenting
- Study Skills
- Suicide Prevention
- Budgeting and Money Management Skills
- Critical Thinking
- Nutrition
- Social Skills
- Emergency Preparedness and Personal Safety
- Community Meetings with adolescents to discuss program operations, concerns, problems and plans.
- Self esteem
- Wellness/Health
- Coping skills
- Teen issues
- Sexual issues and sex education
- Relapse prevention strategies
- Early recovery
- Co-occurring issues
- Vocational Skills
- Peer Support Groups
- Criminal Thinking
- Self Harm Prevention
- Decision Making
- Problem Solving
- Community Living Skills
- Social Supports

LEVEL POLICY

Adolescents enter the program at a Level 1. At the time of admission, your child will be given individualized assignments and will participate in education and counseling activities. In order to move to a higher level within the program, they must complete the requirements of each level, complete assignments given by counselors and instructors, actively participate in groups and follow the rules. With each level move, they earn additional privileges as outlined below. They must ask staff to review their assignments and grade them in order for them to request a level move. Assignments will also be processed with their counselor prior to asking for a level move. It is highly recommended that they do not wait until the day of staffing to obtain needed signatures.

1. Criteria for entering each level are defined in writing and stated in behavioral terms.
2. Criteria are applied equally to all adolescents.
3. Residents requesting to be considered for a level change must have all paperwork filled out and completed before staffing on Thursdays at 1:00pm. Residents must have all the appropriate signatures from Treatment Staff and Treatment Technicians before staffing on Thursdays.
4. Residents with consistent rule violations can and will be recommended for an automatic loss of level.
5. All level forms must be filled out completely and neatly or they will be denied.

LEVEL I PRIVILEGES

- On the second Saturday of their stay, an on-site visit will be available with approved family members between the hours of 9:00am – 12:00pm for females and 1:00pm – 4:00pm for males.
- Send and receive mail. All incoming and outgoing mail will be read and screened for appropriate content.
- No telephone privileges are allowed for level I adolescents until after their first staffing as long as there has been no major behavior issues or incident reports issued. However, parents are encouraged to call clinical staff to inquire about their child.

NOTE: Clinical Staff are in the office Monday – Friday between the hours of 8:00am – 5:00pm.

CRITERIA FOR LEVEL II MOVES

- Cannot request level two (2) moves until second (2nd) Staffing Week. Normally after you have completed the initial two (2) weeks of treatment.
- Minimum of 15 Behavior Marks within week of going up for level move.
- Must maintain no more than 15 Behavior Marks each week thereafter in order to maintain level 2 or result will be the loss of level 2 status.
- Must be actively involved with structure and completion of duties.
- Must be actively participating in Groups. Includes the Day/Night time groups.
- **NO** room or bed violations. (Clean and Organized)
- Respect of Peers and staff.
- Must be in compliance of all assignments given by Treatment Staff.
- Must be in compliance with your Treatment Plan assignments.

LEVEL II PRIVILEGES

- Late night privileges on Friday evening only.
 - Two (2), five (5) minute outgoing phone calls per week.
 - Adolescents will be required to wait three (3) weeks after obtaining Level II before requesting Level III.
-

CRITERIA FOR LEVEL III MOVES

- Must be on level 2 for minimum of three (3) weeks.
- Must continue to meet all requirements of level 2.
- Minimum of 10 Behavior Marks within the week prior to going up for level move.
- Must maintain no more than 10 Behavior Marks each week thereafter in order to maintain level 3 or can/will result in loss of level.
- Must be actively helping to ensure participation of others in Groups.
- Must be actively involved with structure and completion of duties.
- Must exhibit leadership characteristics amongst peers and staff.
- **NO** room or bed violations. (Clean and Organized)
- Must have led at minimum (8) groups during the time receiving Level 2 status and requesting Level 3 status. (can be in either treatment center or cottage)
- Respect of Peers and staff.
- Must be in compliance of all assignments given by Treatment Staff.
- Must be in compliance with your Treatment Plan assignments.

LEVEL III PRIVILEGES

- Late night privileges on Friday and Saturday evening.
- Two (2), ten (10) outgoing phone calls per week.
- Level III is the requirement for a successful completion of the program.
- There will be additional packets and individualized assignments required to maintain this level until the time of discharge.

MP3 PLAYERS POLICY

1. I have reviewed all of the songs in the playlist, and deem them appropriate for my child to be listening to while in treatment. I understand that any trouble regarding the playlist will result in the consumer losing privileges with the MP3 player.
2. FCC and CSTAR will not be held liable for the loss, damage, or theft of the device.
3. I have reviewed the device's capacity to log in to the internet, and agree that the device is unable to obtain internet access.
4. I agree that the device cannot be used as a telephone, and is strictly an MP3 player.

NOTE:

These are only to be used during free-time. If caught using them during group activities, or if caught using another consumers MP3 player that does not belong to you (hygiene related issue and is for your protection) they will be confiscated and locked up until further notice. This is a privilege so do not abuse it.



SITE POLICY

1. FCC Behavioral Health's Adolescent CSTAR and its staff, is not responsible for damage to your personal property or loss due to theft, accident, or illness.
2. If you abscond (run away) from the treatment program, we will keep your belongings at the center for thirty (30) days. After 30 days, all belongings will be disposed.
3. In the event that you abscond (run away) from this treatment program, you do so with the understanding that FCC Behavioral Health's Adolescent CSTAR is not responsible for the safe keeping of your property and that you are not guaranteed its full return.
4. Drug screen testing can be conducted at any time during the course of treatment. You are expected to fully cooperate with drug screen requests.
5. It is expected that you participate in all meetings, counseling sessions, and activities except when you have an excuse from staff.
6. You must respect the confidentiality of all other adolescents and not disclose information, stories, or names with anyone outside of this facility.
7. All staff at the facility are mandated reporters and required by law to report any information related to child abuse and elder abuse. In addition, staff are also required by law to report an adolescent that makes a threat to harm themselves, or others.
8. Do not verbally, emotionally, or physically abuse another resident or staff members.
9. You are not to become sexually or romantically involved with another adolescent or staff member. This includes any attempt to initiate an intimate relationship with others by means of talking, physical contact, letter writing, etc. Focus should remain on treatment. If you are seeking an inappropriate relationship with another person, you are unable to focus completely on treatment. Consequences, to include loss of privileges and/or possible discharge, will be given for any inappropriate relationships.
10. Complaints are to be reported to your assigned Counselor and/or Clinical Manager. Do not share complaints with someone that has no authority to deal with the situation.
11. You are expected to maintain your assigned room, including your bed and closet space, in a neat and orderly manner. You will be assigned chores at the treatment center and group home as part of your treatment program.
12. The use of any and all tobacco products is prohibited. This also includes electronic cigarettes.
13. In the event that illegal drugs or unauthorized prescription medication is brought into the facility for the purpose of illegal use or distribution, local law enforcement will be contacted and possible charges filed.

14. Gambling is not allowed on the premises.
15. Weapons of any kind are not permitted. All weapons will be confiscated and the proper authorities contacted as necessary to ensure safety of others.
16. All of your belongings will be searched and inventoried on your first evening of treatment. All belongings will be labeled with your initials and a written description of them will be documented on an inventory sheet for you to sign. It is your responsibility to keep up with your belongings. Sharing or loaning your belongings is strongly discouraged. Neither FCC Behavioral Health nor the Adolescent CSTAR Program can be held responsible for any lost or stolen property.
17. All prescription medication will be collected at time of admission. The nurse will contact the prescribing physician and/or filling pharmacy to verify your medication dosage and schedule. Your medication will be made available to you at prescribed times for you to self-administer under staff supervision. All medication will be kept under two locks at all times.

THE JUDGMENT OF STAFF ON DUTY IS TO BE CONSIDERED THE FINAL AUTHORITY ON RULES!

GENERAL RULES

1. You are not permitted to touch and/or adjust any electronic equipment without staff permission and/or supervision.
2. You are not allowed to be in the kitchen area without permission and you are not allowed to eat meals at the kitchen counter.
3. MP3, iPod and personal radios with headphones are allowed. Parental approval is assumed. These devices are not allowed if they have photographic, internet capability, video or voice recording capabilities.
4. No personal softballs, frisbees, games, pool sticks, musical instruments, cards, dice, hacky sacks, sports equipment, etc.
5. Glass items, including, but not limited to, mirrors, picture frames, glass vases and glass figurines, etc. is not permitted while in treatment.
6. Pictures of family and friends are allowed as long as the content of the picture is appropriate. Staff will be the final judge of a picture's appropriateness. You are not allowed to give a picture of yourself to any other person for keeping.
7. Lip medication will be allowed, but must be approved by staff.
8. All reading material must be appropriate and approved by staff.
9. You are only allowed to use pencils unless you are in a supervised group in which staff is allowing use of a different writing utensil. This includes, but not limited to, highlighters, pens and/or markers.

10. No gang writing, symbols, satanic, black magic, demonology, witchcraft symbols or paraphernalia/graffiti allowed on books, clothing, journals, etc. Staff has the final say on whether a drawing is considered appropriate. Staff will confiscate any materials deemed inappropriate.
11. Vulgar and inappropriate language will not be used under any circumstances.
12. No racial or ethnic slurs will be tolerated.
13. You must ask permission before leaving the room, getting out of your seat, going to the restroom, or going outside the building or group home.
14. You are **NOT** allowed to borrow, exchange, loan, trade or give clothing, jewelry or any other personal items to another person. If you choose to violate this rule, staff is not responsible for broken, damaged, stolen or lost items.
15. Journals are to be carried at all times.
16. Staff has the right to search any room, journal, person, or personal property at any time.
17. Note passing is not allowed.
18. Food, candy and drink items are not allowed to be brought into the center unless approved by staff and there must be enough for everyone. There are sodas and snacks available on site for purchase in the CSTAR Store.
19. You are not allowed to view movies with a rating higher than PG-13. All movies are subject to staff approval.
20. You are not allowed to be in possession of any electronic equipment with photographic capabilities, including a camera. You cannot take a picture of, or be in possession of pictures, of any other resident due to confidentiality rules.
21. No ***shared*** listening on iPods, MP3 players, etc. You are not allowed to listen to music in the cafeteria until after the serenity prayer and everyone has been served their food. Staff always reserves the right to request that music be turned off. Music is not allowed during the class or any time staff is talking to the group as a whole. MP3 players can and will be confiscated if misused.
22. You are allowed to have one iPod/MP3 player in your possession.
23. No metal or spiral bound notebooks are allowed.
24. Aggressive and/or threatening behavior of any kind will NOT be tolerated under any circumstance.
25. Aerosol products of any kind are not permitted while in treatment.
26. Cell phones are not permitted on CSTAR property.
27. Disrespecting of other group members and/or staff will be not tolerated.
28. Horseplay of any kind will be not tolerated under any circumstance.
29. Plastic bags of any kind are not permitted.
30. **ALWAYS** use appropriate lines of communication between staff and peers.

GROUP HOME RULES

1. Must ask for staff permission before entering/exiting all rooms, getting out of seat, going to restroom or exiting the building. This is to ensure that staff members are aware of your whereabouts at all times and to ensure their personal safety.
2. Dirty clothes are to be kept in hampers with the lid kept closed at all times.
3. Closets will be kept neat, clean, and organized at all times.
4. Assigned chores must be completed on a daily basis. Beds must be neatly made each morning to the satisfaction of staff member on duty.
5. You are NOT to enter another adolescent's room under any circumstance and are ONLY allowed to enter your own with staff permission. Write-ups will be issued for non-compliance that carry the consequence of possibly losing all privileges for one (1) week.
6. NO personal pillows, blankets or stuffed animals will be allowed on-site. Pillows and blankets will be allowed only if they are brought to the center in the original, unopened plastic.
7. Hairbrushes, combs and/or makeup will not be brought to the treatment center at any time. These items will be confiscated and locked up if in possession outside of group homes and/or caught sharing with others.
8. Food and/or drink is not permitted inside of the bedrooms for any reason. Food is only to be eaten at designated times and locations.

PEER GROUP/CLASSROOM RULES

1. No vulgar or profane language.
2. No sleeping.
3. No cross talking.
4. No name calling.
5. No leaving group without permission.
6. No attacking another group member.
7. No finger pointing.
8. Only one (1) person speaks at a time.
9. Raise your hand to be recognized.
10. Maintain good eye contact with others.
11. Stay on topic.
12. Ask permission to enter or leave group.
13. Always respect Group Leader and/or Facilitator at all times.
14. The computers in the classroom are to be used for educational purposes only. You are not allowed to check personal email, Facebook accounts or search any unapproved sites.
15. No eating in class, unless it is during the site approved snack time.

DRESS CODE AND HYGIENE POLICY

While each Adolescent is afforded every reasonable freedom in their choice of attire, certain dress regulations are necessary. Adolescents are asked to dress appropriately for the season and are expected to exercise good taste and judgment in their choice of clothing.

REMINDER: Staff will be the final authority on determining the appropriateness of all clothing and any other violations set forth by the dress code.

The following list is to be used as a guide for appropriate dress:

1. Clothes must be neat and clean. No clothing with holes above the knees, unless leggings are worn underneath to prevent the exposure of skin.
2. You are to be fully dressed at ALL times. Females are to wear at minimum shorts and a t-shirt or pajamas to bed. Males are to wear at minimum shorts and a t-shirt but are permitted to sleep without shirt, but when exiting bedroom, shirt **MUST** be worn before exiting room.
3. Appropriate undergarments must be worn at all times. Undergarments must not be visible under any circumstance.
4. Clothing and/or related gear displaying logos or reference to the following will not be permitted and will be confiscated until time of discharge: *(NOTE: staff reserves the right to limit any clothing item they feel is inappropriate in nature)*
 - Satanic slogans and/or pictures
 - Drug or alcohol related slogans or reference
 - Gang and/or any associated gang related activity
 - Negative images and/or reference to such i.e. anti-social, foul, racist, sexist and/or of a violent nature
 - Pornographic and/or sexually related materials, pictures or innuendo.
5. Skirts and shorts are permitted but must be loose-fitting and no shorter than mid-thigh. Skirts and shorts will be judged for appropriate length on an individual basis.
6. Spandex shirts or shorts are not permitted. Yoga pants and leggings are **ONLY** allowed to be worn in the cottages.
7. Low-cut tops, halter-tops, midriff half shirts, or sleeveless shirts are not permitted.
8. Hats, skullcaps and sunglasses are to be worn during outside activities only and with staff permission. They must be removed once indoors or will be confiscated.
9. Do-rags, hairnets and bandanas are permitted in rooms only when going to bed.
10. Males and Females **MUST** wear appropriate pants, shirts, and tennis shoes at all times during recreation/outdoor activities. **NO** flip flops are permitted during outdoor recreational activities.
11. Shoes and appropriate dress must be at all times. No house slippers or pajama bottoms are allowed outside of group homes.
12. No baggy or sagging pants. Staff discretion is the final say on this issue.

13. There will be no writing, drawing, marking/tattooing on clothing, footwear or body at any time.
14. No sentimental or expensive clothing/jewelry/personal items should be brought to treatment as they may be ruined in the washing process, torn in recreation or stolen by another person. We make every attempt to inventory and monitor this issue; however, there are situations beyond staff control. FCC Behavioral Health will not be held responsible for any missing or damaged items. If you chose to keep such an item at CSTAR upon admission, it is your sole responsibility.
15. Staff reserves the right to request that you change clothes to ensure appropriate attire.
16. Jewelry is **NOT** permitted while in treatment, this includes necklaces, bracelets, earrings, rings, etc. You are allowed to wear a wristwatch. All other jewelry that is permitted are items made in a therapeutic group activity with staff approval.
17. If you have a piercing, you are allowed to wear a plastic plug only. Tapers are not permitted.
18. You are NOT allowed to braid or style another person's hair, this includes cutting hair.
19. You are required to take a shower daily, to include washing your hair and using deodorant.
20. Males are to be clean-shaven. If you are admitted with an established mustache or beard, you may keep them, provided they are maintained. Once they are shaved off, you may not grow another while in this facility.
21. Disposable razors are not permitted. You are only allowed to use an electric razor for shaving. Due to safety concerns, straight or disposable razors are not allowed.
22. Hygiene items must be placed in assigned hygiene basket and stored in locked cabinet.
23. Residents may **ONLY** bring TEN (10) outfits to the treatment center at any time to include:
 - Ten (10) shirts, Ten (10) pants/shorts that are knee length (can be combination of jeans, khakis, sweat pants, Capri's, etc.), Two (2) pairs of shoes (at least one pair of tennis shoes mandatory for recreation), One (1) pair sandals/flip flops, Seven (7) sleeveless T-shirts/A-shirts/tank-tops, Ten (10) pair of underclothes (Thong underwear is not permitted), Seven (7) Bras (For females only), One (1) Belt, Three (3) sets of Pajamas, One (1) jacket (for use during cold weather months), Two (2) hats/skullcaps.

In Regards to the loaning and/or borrowing of items, Adolescents are to be fully aware that if they trade, loan, exchange, borrow, or give clothing, jewelry, or other personal items to another Adolescent while in treatment, FCC Behavioral Health and Adolescent CSTAR will not be held responsible for these items under any circumstances. Adolescents also are aware that they will receive marks if found with another Adolescents personal belongings, regardless of how they received them.

RULES FOR VISITATION

1. Visitation hours are from 9:00am-12:00pm for female adolescents and 1:00pm-4:00pm for male adolescents beginning on the second (2nd) Saturday following admission.
2. Visitation will be allowed with adult, immediate family members to include parents/guardians, grandparents and/or siblings. Siblings under the age of 18 must be accompanied by an adult visitor at all times. In families with divorced parents, it is suggested that the family make arrangements for the visitation time to be split in half, with each parent taking part in the visitation.
3. Visitors may only bring a valid identification and vehicle keys into the facility. A valid ID is required at all times and will be requested of by any person visiting.
4. Visitors must leave all personal items such as purses, handbags, cameras, cell phones, etc. in the vehicle during visitation.
5. Visitors are not allowed to smoke in the presence of the adolescents. Smoking is to be done outside of the facility.
6. Adolescents are NOT to leave the building with visitors under any circumstance.
7. Visitors are NOT allowed to leave the building and then re-enter the building (for smoke breaks, etc.). If someone leaves the visitation area, they will not be allowed to return. Adolescents look forward to this time all week and we encourage you to spend the entire visitation time with your child.
8. Visitors are not allowed to bring any food or drink into the facility during visitation. Regardless of whether or not the family member has enough for all residents in the program, the items will not be accepted.
9. Visitors are not to give anything to an adolescent without checking in with staff first. All items must be approved and inventoried by staff. Give all personal items to staff prior to visitation.
10. Adolescents are not allowed to have money in their possession. Any money that is left must be checked in with staff for lock up. We request that no more than \$10.00 be left at any one time.
11. Bringing drugs, alcohol, or fire arms onto this facility is a CRIME and all parties involved with be PROSECUTED. Anyone visiting who is under the influence of drugs and/or alcohol will be asked to leave after we have notified the local police or Sheriff's department.
12. Visitors are responsible for the supervision of children which accompany them to visitation. They are to be in the sight of the parent at all times. Visitors must remain in visitation area.
13. If a visitor becomes disruptive, or is upsetting to an adolescent, they will be required to leave.
14. Adolescents are not forced to have visitation with any person whom they do not wish to visit.
15. No pets of any kind are to be brought to the facility.
16. Visitation will be held at the treatment center.
17. All visitors must be on pre-approved authorization list signed by parent/guardian during the admission process. Any additions to visiting list must be cleared through Clinical Manager.
18. Visitors that are wearing clothing that is too tight, too short, see-through, backless or is in any way considered inappropriate, will be requested to leave by staff on duty.
19. Any failure to strictly adhere to these rules will result in visitors being prohibited from returning for future visits.

VISITATION/HEALTH CONCERNS

IN ORDER TO PROMOTE THE RESIDENTS/YOUR CHILD'S HEALTH AND WELL-BEING, FCC BEHAVIORAL HEALTH AND CSTAR ASK THAT YOU DO NOT VISIT THEM IF YOU ARE RUNNING A FEVER, HAVE A SEVERE COUGH OR INFECTION, A STOMACH VIRUS, OR ANY OTHER KIND OF ILLNESS THAT CAN POSSIBLY SPREAD TO THE OTHER RESIDENTS AND/OR STAFF MEMBERS.

THE STAFF MEMBERS AT CSTAR DO EVERYTHING IN THEIR POWER TO ENSURE YOUR CHILD'S WELL-BEING. IT HAS BEEN OBSERVED IN THE PAST, THAT IT IS USUALLY OUTSIDE VISITORS THAT TEND TO BRING ILLNESS INTO THE FACILITY, AND DUE TO THE CLOSE PROXIMITY OF THE RESIDENTS AND ONE ANOTHER, AS WELL AS THEIR INTERACTIONS WITH STAFF MEMBERS, SICKNESS TENDS TO QUICKLY SPREAD.

WE ARE COMMITTED TO ENSURE THAT YOU ARE GIVEN THE TIME TO VISIT WITH YOUR CHILD. WE ALSO REALIZE HOW IMPORTANT IT IS TO YOU AND MORE IMPORTANTLY, HOW IT IS FOR YOUR CHILD'S WELL-BEING AND OVERALL GENERAL WELFARE. ALL WE ASK IS THAT YOU RESPECT OUR REQUEST IN ENSURING THAT YOUR CHILD AND THE OTHER RESIDENTS WITHIN THIS FACILITY ARE HEALTHY AND ARE ABLE TO WORK ON THE GOALS SET FOR THEM WHILE IN TREATMENT.

PASS REQUIREMENTS/AGREEMENT

STODDARD COUNTY JUVENILE AUTHORITIES HAVE A NO PASS POLICY FOR ALL PERSONS IN TREATMENT.

Certain requirements must be met before you are eligible for a therapeutic pass. You must reach a Level III to be eligible for passes. In addition, the family must actively participate in at least 3 family therapy sessions. Family therapy plays an important role in the treatment program. First, it seeks to use your family's strengths and resources to help you find or develop ways to live without substances. Second, it helps reduce the impact of substance use on both you and your family. The treatment team will determine the length of all passes based upon family goals developed and achieved.

All passes are considered to be therapeutic passes. A therapeutic pass is a contractual commitment to treatment goals between the Adolescent, the treatment team and his/her parents/guardians. Parents/Guardians are responsible for re-enforcing treatment goals while the Adolescent is on pass. Parents/Guardians are to ensure that pass time is spent with family members only; not boyfriends/girlfriends or friends that may be considered negative influences. Adolescents and their family members are encouraged to attend community NA/AA meetings during pass time.

Passes are approved by the treatment team each week. If referral sources such as DYS, DFS or Juvenile Authorities are involved with the Adolescents care, passes **MUST** be authorized by personnel from that agency.

If passes need to be arranged on a day or time other than designated day and time, our treatment team will make every effort to work with families to accommodate those special requests. Special considerations may be made for Adolescents to receive extended passes based on distance the family resides from facility. Any adjustments on pass days or times should be coordinated with the Care Coordinator and/or the Family Therapist.

Any Negative Behavior Write-Ups within (7) seven days of the pass date will result in the pass being denied. Future pass privileges will be suspended if the Adolescent or Family Members bring any unauthorized items back into facility upon returning from pass. Future pass privileges will depend on the individual's conduct and his/her families' involvement in the treatment process while he/she is away from facility.

Staff are required to check the identification of any person picking up an adolescent from this facility before being taken for any pass.

CONTRABAND AND SEARCH POLICY

The Adolescent CSTAR Program recognizes that each adolescent has a right to privacy, dignity, and to be free from unreasonable searches. Adolescents, staff, and visitors also have the right to a safe and therapeutic environment which under certain circumstances necessitates taking the necessary steps to ensure that all Residents are not in possession of items that may present a hazard to personal safety or the therapeutic environment. Searches of every adolescent and their living areas are permitted in order to prevent the possession of any potentially dangerous items or to recover stolen or missing property.

Non-Invasive measures are taken to ensure the safety of the environment, the staff members as well as all adolescents, through the use of initial and periodic searches. Searches are also conducted in order to identify prohibited items and to prevent the entry of prohibited items into the therapeutic environment.

Any time the adolescent leaves from the care of the facility with a family member or anyone that is not a member of the Adolescent CSTAR Treatment Team, a search will be conducted to ensure the safety and security of all persons and to reduce the risk of prohibited items being brought into the facility.

Contraband is a term used to describe prohibited or unauthorized items that the Adolescent CSTAR staff consider unsafe or dangerous to you and your peers. These include weapons, illegal or unauthorized drugs, intoxicants, tobacco and tobacco products, smoking paraphernalia, flammable items and items with a sharp edge. Other items may also be considered unauthorized and the decision of the safety of those items is based upon staff discretion. In order to maintain a safe and protective environment, the treatment staff reserves the right to search you and any belongings that you wish to bring into the facility. A detailed listed of items that are permitted can be located in this handbook.

Searches of each adolescent will be conducted in a location which affords reasonable privacy. Same sex staff members are the **ONLY** ones who will conduct the searches. For example, Male staff members will only conduct searches with male adolescent and female staff members will only conduct searches with female adolescent. The cooperation of every adolescent should be solicited by explaining the reason for the search and using a sensitive and straightforward approach.

SELF-PAT INDIVIDUAL SEARCH

In the Self-Pat Individual Search, the adolescent will be instructed by the staff member conducting the search to participate in the following steps. Adolescents will Pat their own legs, arms, etc, shake out hoods on sweatshirts with staff directives. This is a Staff Member Hands-Off Search Procedure that ensures all adolescents receive a non-intrusive search.

CONTRABAND AND SEARCH POLICY (CONT'D)

- Instruct the adolescent to remove shoes, socks, hat, belt, pull-over, coat or jacket, and empty pockets – turning them inside out. Check pockets to ensure they are empty and closely examine any items that have been removed.
- Closely examine adolescents and look behind the ears to locate any possible concealed items. If necessary, have the individual flip their hair over and “shake out” hair.
- Ask the adolescent to stand with legs apart and arms extended outward. Conduct a systematic head-to-toe search as follows:
 1. Observe closely for inappropriate or unusual bulky areas, or areas that the individual may appear reluctant to reveal.
 2. Instruct the individual to run hands under shirt collar, across shoulders and down upper part of each arm to the wrists. Have the individual to shake arms to ensure no items are in the sleeves.
 3. Instruct the individual to use the back of hand, run hands inside waistband, back pockets and down each leg. Have him/her shake legs to check for unauthorized items.
 4. Check each sock and shoe.
 5. Instruct individual to shake out back of their shirt
 6. If appropriate ask to look inside the individual’s mouth. This step should be taken if it appears the individual may be holding an unauthorized item in their mouth during the search.

We make every effort to ensure that all persons served are safe while in our care. Therefore, behaviors including possession of contraband, physical aggression, self-destructive behaviors, alcohol and drug use, running away from the program, property destruction, theft, verbal/emotional abuse and/or possession of weapons of any kind will result in strong action up to and including referral to a more intense level of services and/or criminal prosecution.

DAMAGE/DESTRUCTION OF PROPERTY LIABILITY NOTICE

In the event that you purposefully damage or destroy any property of FCC Behavioral Health, you will be required to repair or replace such property. This will include any destruction or damage done to the treatment facility and/or group home, including, but not limited to the structures, furniture, electronic equipment, treatment materials, recreational equipment and/or van. Property damage charges will be filed with the proper authorities. Parents and/or guardians must understand they will be responsible for this compensation prior to discharge.

Mattress	\$ 225.00
Pillow	\$ 30.00
Comforter Set	\$ 35.00
Wall Damage	\$ 40.00 (avg w/labor)

Upon admission to the program, you will be issued the following treatment materials for your use. These materials must be returned to staff at time of discharge. If you damage any of these workbooks, or fail to return them, you will be charged for the replacement cost.

How to Escape Your Prison – Juvenile MRT	\$ 25.00
Staying Quit – MRT Relapse Prevention	\$ 10.00
Coping with Anger – MRT Anger Management	\$ 10.00
Self- Management: Addiction Treatment Edition	\$ 8.50
Voices (Females Only)	\$ 9.25
My Personal Journal (Relapse Program Only)	\$ 8.00
CSTAR Library Books	\$ 18.00 (avg)

RIGHTS AND PRIVILEGES

Each adolescent will be entitled to the following rights and privileges without limitation:

- to receive prompt evaluation, care and treatment
- to be evaluated and cared for in the least restrictive environment
- to receive services in a safe and clean setting
- to not be denied admission or services because of race, sex, creed, sexual preference, color, religion, marital status, national origin or handicap
- to have records kept confidential in accordance with federal and state law regulation
- to be treated with respect and dignity as a human being in an age appropriate manner
- to be free from abuse, neglect, corporal punishment and other mistreatment such as humiliation, threats or exploitation
- To be free from misuse of funds or property
- to be subject of an experiment only with the consent of the adolescent, or the consent of a person legally authorized to act on behalf of Resident
- to medical care and treatment in accordance with the highest standards accepted of medical practice, if the program offers medical care and treatment
- to consult with a private practitioner at the expense of the person served

Additional Rights and Privileges Applicable to Individuals in Residential Setting and Where Otherwise Applicable:

- to have nourishing, well-balanced varied diet
- to attend or not attend religious services
- to correspond by sealed mail with officials of the Department of Mental Health, a lawyer or a court
- to have private visits from a lawyer, doctor or clergyman at reasonable times
- to be paid commensurate wages for work in the program unrelated to your treatment in compliance with applicable local, state or federal requirements
- to not work unless part of the treatment plan
- to humane care and treatment
- to have the same legal rights and responsibilities as any other citizen, unless otherwise stated by law
- to have rights explained to them
- an individual will not be denied admission or services on the grounds of prior treatment, withdrawal from treatment against advise, or continuation or return if symptoms after prior treatment.

Rights and privileges, which may be limited, are:

- to wear own clothes and use personal articles
- to keep some money for expenses and small purchases
- to send and receive mail
- to have visitors at reasonable times
- to see own records
- to have physical exercise and outdoor recreation

- to have access to current newspapers, magazines and radio and television programming
- to be free from chemical or physical restraint, seclusion or isolation
- to use the telephone at reasonable times

When it becomes necessary to limit rights, the limitations will be done on an individualized basis, be clinically justified and such will be documented in your record for administrative review by the program director/supervisor. As soon as it is clinically feasible, the limited right(s) will be restored. Any limitation of a right will be re-evaluated at each review of the treatment/rehabilitation plan, or more often if necessary.

Each individual will be entitled to see his or her own records except to the extent that the individual's primary therapist/counselor determines this would be detrimental. When an individual reviews his/her own record, this will be documented in the case record. If it is determined that review of the case record will be detrimental to the individual, this will be documented in the case record. Because of confidentiality standards, individuals will be advised to contact the original source of any such information. Whenever an individual accesses personal records, a staff member will be present.

RELAPSE POLICY

The CSTAR program has in place written policies which address the process that occurs when an adolescent uses alcohol or drugs while participating in a level of care in the CSTAR program. Individuals will not be denied services solely because of a relapse. Each case is dealt with on an individualized basis.

In the event of a relapse, the following process will be followed:

- Staff will review the possible need for medical detoxification.
- Referral to a more restrictive level of care within the CSTAR program if deemed appropriate.
- Continuation of the same level-of-care.
- Discharge from the program and an appropriate referral made.

If it is determined through self-disclosure; reports from family and/or referral sources; or positive drug screen results that you have actively used during a treatment episode, the clinical staff will hold a conference to discuss and determine an action plan for further treatment. In this conference, the staff will evaluate whether medical detoxification is needed, time in this level of care, progress in the program, and any and all related issues. At the conclusion of the conference an appropriate therapeutic recommendation will be made.

DISCHARGE CRITERIA

The length of stay in Level I residential treatment shall be individualized based on the individual's needs and progress in achieving treatment goals. To qualify for successful completion and discharge from residential treatment:

- You should demonstrate recognition and understanding of his/her substance use problem and its impact.
- You should achieve an initial period of sobriety and accept the need for continued care.
- You have developed a plan for continuing recovery and sobriety.
- You have taken initial steps to mobilize supports in the community for continuing recovery, and have demonstrated improvement in problem areas related to the ASAM dimensions of care.
- You have reached an internal level three within the residential program by active participation, completion of journal assignments and cooperation with program rules.

You may be discharged before accomplishing these goals if maximum benefit has been achieved and;

- There is no further progress imminent or likely to occur;
- Clinically appropriate therapeutic efforts have been made by staff; and
- Commitment to continuing care and recovery is not demonstrated by the individual.

The length of stay in Level I day treatment services shall be individualized based on the individual's needs and progress in achieving treatment goals. The Resident should be considered for successful completion and discharge from outpatient services when:

- You demonstrate recognition and understanding of his/her substance use problem and its impact.
- You have achieved a continuous period of sobriety.
- There is absence of immediate or recurring crisis that poses a substantial risk of relapse.
- Emotional symptoms have stabilized.
- You have demonstrated independent living skills.
- You have implemented a relapse prevention plan.
- You have developed family and/or social networks which support recovery and a continuing recovery plan.
- You have demonstrated continued improvement and stabilization of problem areas related to the ASAM dimensions of care.

You may be discharged from day treatment services before accomplishing these goals if;

- There is no commitment to continuing services.
- No further progress imminent or likely to occur.

Treatment Team has the discretion to discharge any Adolescent due to issues of non-compliance. These decisions will be made on a case-by-case basis.

FCC BEHAVIORAL HEALTH

NOTICE OF ETHICAL PRACTICES



FCC Behavioral Health is committed to providing you with the best available care in a caring, respectful and ethical manner. FCC Behavioral Health has corporate compliance policies in place to assure that billing procedures adhere to legal and ethical rules and standards according to the Missouri Department of Behavioral Health (DBH), Missouri Department of Social Services, and other state and/or federal agencies that fund health care services to community mental health centers.

We want to assure that all person(s)-served have the ability to report any suspicious activity concerning any insurance, Medicaid, Medicare or other claims filed by our organization in our service to you. Reporting can be done in-person, over the phone, by mail, or via email. You have the right to remain anonymous; however, it may prove difficult to investigate anonymous reports.

Should you need to file a complaint or concern about services billed, please use any one of the following methods:

1. Report the incident, **in-person**, to the Facility Director. You may ask the front desk who the Director is and request to see them.
2. Report the incident, **over the phone**, to the Chief Compliance Officer. Please call the toll free number (800) 455-2723 to report a concern over a private line (anonymous) or through the agency phone at (573) 888-6545. You may leave your name and number or, if you choose, you may remain anonymous. Anonymous reports are difficult to investigate, but we will do all that we can to investigate anonymous reports.
3. Report the incident, **by mail**, to the Chief Compliance Officer. Please send your report to:
FCC Behavioral Health, Inc. ATTN: Chief Compliance Officer, 925 Highway V V, PO Box 71, Kennett, MO 63857.
Anonymous reports are difficult to investigate, but we will do all that we can to investigate anonymous reports.
4. Report the incident, **by email**, to the Chief Compliance Officer at compliance@fccinc.org. Anonymous reports are difficult to investigate, but we will do all that we can to investigate anonymous reports.

We appreciate your confidence in FCC Behavioral Health's reputation as a quality provider of behavioral health services to Southern Missouri since 1976. If there is anything that we can do to enhance the services our agency is providing to you, please do not hesitate to let one of our staff members know.

FCC BEHAVIORAL HEALTH

NOTICE OF PRIVACY PRACTICES



THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

FCC Behavioral Health is committed to providing quality healthcare services to you. An important part of that is protecting your medical information according to applicable law. This notice ("Notice") describes your rights and our duties under Federal Law, as well as other pertinent information. We are happy to answer any questions you may have regarding this Notice. Our staff will briefly review the key points contained herein once you have had an opportunity to read and sign. PHI includes any information that relates to (1) your past, present, or future physical or mental health or condition; (2) providing health care to you; and (d) the past, present, or future payment of your health care. FCC Behavioral Health participates in a clinically integrated health care setting which is considered an organized health care provider. Each entity within the agency's arrangements will be able to access and use your PHI to carry out treatment, payment, or health care operations. The terms of this notice shall apply to FCC Behavioral Health privacy practices until it is changed by FCC Behavioral Health.

DEFINITIONS

- 1. Healthcare Operations.** "Healthcare Operations" means business activities that we engage in so as to provide healthcare services to you, including but not limited to, quality assessment and improvement activities, personnel training and evaluation, business planning and development, and other administrative and managerial functions.
- 2. Payment.** "Payment" means activities that we undertake as a healthcare provider to obtain reimbursement for the provision of healthcare to you which include, but are not limited to: determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and processing health benefit claims.
- 3. Protected Health Information.** "Protected Health Information" or "PHI" means information which identifies you (e.g. name, address, social security number, etc.) and relates to your past, present, or future physical or mental health or condition; the provision of healthcare to you; or the past, present, or future payment for the provision of healthcare to you.
- 4. Treatment.** "Treatment" means the provision, coordination, or management of healthcare and related services on your behalf, including the coordination or management of healthcare with a third party; consultation between FCC Behavioral Health and other healthcare providers relating to your care; or the referral by FCC Behavioral Health of your care to another healthcare provider.
- 5. Appointment Reminders.** FCC Behavioral Health may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

YOUR PRIVACY RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get an electronic or paper copy of your medical record.** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your medical record.** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- **Ask us to limit what we use and share.** You can ask us NOT to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment, or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- **Get a list of those with whom we've shared information.** You can ask for a list (accounting of disclosure) of the times we've shared your health information for six years prior to the date you ask, who we shared it with,

and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide accounting once a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12-months.

- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you have agreed to receive this notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a written complaint if you feel your rights are violated.** You may file a written complaint in one (1) of the following ways;

CONTACT FCC BEHAVIORAL HEALTH PRIVACY OFFICER AT:

HIPAA Privacy and Security Officer
925 Highway V V, Kennett, MO 63857
Email: shirleens@fccinc.org
Phone: (573) 888-5925; Ext: 1027

CONTACT THE OFFICER OF CIVIL RIGHTS AT:

United States Dept. of Health and Human Services
www.hhs.gov/ocr/privacy/hipaa/complaints/
Phone: (816) 436-7279

We will **NOT** retaliate or take action against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

I. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care;
- Share information in a disaster relief situation;
- If you are not able to tell us your preference, for example, if you are unconscious, we may share your information if we believe it is in your best interest.
- We may also share your information when needed to lessen a serious and imminent threat to health or safety.

II. In these cases we will never share your information unless you give us written permission:

- Marketing purposes;
- Sale of your information;
- Sharing of psychotherapy notes

FCC BEHAVIORAL HEALTH USES AND DISCLOSURES:

How do we typically use or share your health information? We typically use or share your health information in the following ways.

The following uses do **NOT** require your authorization, except where required by Missouri law.

- **Treat you.** We can use your health information and share it with other professionals who are treating you. For example: a doctor treating you for an injury asks another doctor about your overall health condition.
- **Run our organization.** We can use and share your health information to run our practice, improve your care, and contact you when necessary. For example, we use health information about you to manage your treatment and services.
- **Bill for your services.** We can use and share your health information to bill and get payment from health plans or other entities. For example, we give information about you to your health insurance plan so it will pay for your services.
- **In the case of fundraising.** We may use your PHI to contact you for fundraising efforts. We must include in any fundraising material you receive a description of how you may opt out of receiving future fundraising communications.
- How else can we use or share your health information? We are allowed or required to share your information in other ways-usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Help with public health and safety issues. We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Conducting Research. We can use or share your information for health research.

Comply with the law. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests. We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government request.

We can use or share health information about you:

- For workers' compensation claims;
- For law enforcement purposes or with a law enforcement official;
- With health oversight agencies for activities authorized by law;
- For special government functions such as military, national security, and presidential protective services;
- Respond to lawsuits and legal actions.

FCC BEHAVIORAL HEALTH RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGE IN NOTICE OF PRIVACY PRACTICES

FCC Behavioral Health reserves the right to change the terms of this notice, and the changes will apply to all information we have about you. The notice will be available upon request, in our office, and on our website.

QUESTIONS

If you have any questions about this notice or would like additional information, please contact the privacy official at the address and telephone number listed below or you may visit our web site at www.fccinc.org.

CONTACT INFORMATION

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your

CHIEF COMPLIANCE OFFICER

Tracy Ellis
925 Hwy V. V.; Kennett, MO 63857
Email: tracye@fccinc.org
Phone: (573) 888-5925

PRIVACY AND SECURITY OFFICER

Shirleen Sando
925 Hwy V. V.; Kennett, MO 63857
Email: shirleens@fccinc.org
Phone: (573) 888-5925 Ext. 1027

FCC BEHAVIORAL HEALTH

FINANCIAL POLICY



Thank you for choosing our Agency as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read prior to any treatment. All person(s)-served must complete our Admission and Insurance Form before seeing a doctor/counselor.

**PAYMENT IS DUE AT THE TIME OF SERVICE.
WE ACCEPT CASH, MONEY ORDERS, CASHIER CHECKS, CHECKS,
etc. SORRY NO CREDIT CARDS.**

DBH PERSON(S)-SERVED:

Regarding Department of Mental Health Standard Means Form (Partial Fee):

FCC Behavioral Health abides by the policy set forth by the State of Missouri. The policy states that the Standard Means must be done on all Missouri residents in our catchment area to determine if they have the ability to partially pay for treatment (the first days of treatment each month, then the State will pay the rest). If an ability to pay is found, the Partial Fee is due upon admission of the person(s)-served and on every month thereafter.

EX: person(s)-served admission 2-28-04, fee \$300.00, person(s)-served discharge 3-1-04, fee \$300.00, Balance Due \$600.00.

The policy also states that the PARTIAL FEE NOT EXCEED CHARGES for any one (1) month.

EX: If person(s)-served has a Partial Fee of \$300.00 per month, but has only accumulated \$100.00 worth of services, then your Partial Fee would be \$100.00 instead of \$300.00 for that month. Only one (1) Partial Fee can be charged per family, please notify us if any other family members are being treated at any DBH facility in Missouri.

NON-DBH PERSON(S)-SERVED:

Regarding Insurance:

All co-pays and deductibles are due at the time of treatment. The balance of charges due is your responsibility, whether your insurance company pays or not.

Usual and Customary Rates:

FCC Behavioral Health is committed to providing the best treatment for our person(s)-served and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Regarding Insurance Information:

FCC Behavioral Health will accept assignment of insurance benefits. However, we cannot bill your insurance company unless you provide us with your insurance information.

Regarding Failure To Pay: FCC Behavioral Health may take action to collect any unpaid amounts.

Minors: The Parent/Guardian accompanying a minor is responsible for payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

FCC Behavioral Health's billing department can be reached at (573) 888-9525

FCC BEHAVIORAL HEALTH **GRIEVANCE POLICY AND PROCEDURE**



As a person(s)-served of FCC Behavioral Health, you have the right to be given basic information regarding how complaints and grievances are addressed.

1. FCC Behavioral Health provides you with a means of expressing and resolving complaints or appeals.
2. If you, or your family, have a grievance, you should inform the staff, or the site's Clinical Manager. You may discuss your concerns with the Clinical Manager at your convenience. If the grievance cannot be resolved with the staff, you may request a meeting with the site's Program Director. This will be scheduled at an agreed upon time by both parties.
3. If the grievance cannot be resolved with the staff, you, or your family member, you can complete the agency Complaint/Grievance Form and submit to the

FCC Behavioral Health
Chief Compliance Officer
PO Box 71, Kennett, MO 63857
OR Email complaint to compliance@fccinc.org
OR call toll free number (800) 455-2723

This form can be obtained from program staff upon request.

4. The written grievance will be handled in the following manner:
 - The department program director will be informed of the grievance.
 - You, or your family, will receive a response concerning the grievance from the Chief Compliance Officer within five (5) working days.
 - If you or your family is dissatisfied with the response, a meeting can be arranged within three (3) working days with the Chief Executive Officer and the appropriate staff.
 - The final disposition for grievances rests with the Chief Executive Officer.
 - If you are still dissatisfied with the response obtained in the above stated manner, the Chief Executive Officer will assist you with contacting the Consumer's Rights Monitor at the Department of Behavioral Health (DBH).

Consumer Rights Monitor

Department of Behavioral Health
P.O. Box 687
Jefferson City, Mo 65102
1-800-364-9687

FCC BEHAVIORAL HEALTH COMPLAINT/GRIEVANCE FORM



Every person should have reasonable expectations of care and services provided to him/her while in the care of this agency. FCC is committed to addressing situations when those expectations are not met in a timely, reasonable and consistent manner. Your actions will not result in retaliation or barriers to services. Every effort will be made to resolve the complaint within a reasonable timeframe.

Name: _____ Date: _____
(LAST) (FIRST) (MI)

Address: _____

Telephone: _____ Email: _____

Please return this form to the Program Director at your site or a trusted staff member. If the grievance cannot be resolved with the staff, you, or your family member, you can submit this form to the Corporate Compliance Officer at PO Box 71, Kennett, Mo 63857 or email to compliance@fccinc.org or call the toll free number (800) 455-2723.

DETAILS OF YOUR COMPLAINT

(Please be as specific as possible with the following: [1] state your concern; [2] date of event; [3] time of event; [4] staff member(s) involved, [5] witness(es) and [6] location of event.) *(Use back of this form and/or separate sheets for further information)*

Date: _____
Signature of Patient or Legal Representative If Legal Representative, state relationship

THIS SECTION TO BE COMPLETED BY THE REVIEWER

Reviewer's Comments:

Action Taken:

Date Reviewed: _____
Compliance Officer

FCC BEHAVIORAL HEALTH

REASONABLE ACCOMMODATION REQUEST FORM



Name: _____ Date: _____
(LAST) (FIRST) (MI)

1. What specific accommodation are you requesting?

2. Is your accommodation request time sensitive? YES NO

3. What, if any, function are you having difficulty performing?

4. What, if any, benefit/service are you having difficulty accessing?

5. What limitation is interfering with your ability to function or access a benefit/service?

6. Have you had any accommodations in the past for this same limitation? YES NO

If yes, what were they and how effective were they?

7. If you are requesting a specific accommodation, how will that accommodation assist you?

Please provide any additional information that might be useful in processing your accommodation request.

 Signature of Patient or Legal Representative

 If Legal Representative, state relationship

Telephone: _____ Email: _____

Send this completed form to the Accessibility Chair at access@fccinc.org

BEHAVIOR MARKS

These violations will be submitted to Treatment Staff for resolution.

1. Not up on time after 2 warnings
 2. Disruption of group
 3. Food in bedroom
 4. Room not properly cleaned and/or maintained
 5. Incomplete cleaning chore
 6. Inappropriate verbal comment/reaction
 7. Vulgar language (Cursing/Gestures)
 8. Negative attitude/behavior
 9. Borrowing items from another resident (MP3 Players included)
 10. Trading items with another peer
 11. Inappropriate wearing of clothes (i.e. sagging pants)
 12. Continuous sleeping in group
 13. Non-compliance with staff directives
 14. Horseplay of any kind
 15. Disrespectful behavior toward staff
 16. Disrespectful behavior toward another peer
 17. Refusal to participate in group
 18. MISCELLANEOUS –behaviors not listed that needs addressing
- Receiving 25+ Behavior Marks during the course of a staffing week (Wednesday all day through the following Tuesday all day) will result in a Negative Behavior Write-Up.
- Receiving excessive Behavior Marks during the course of a staffing week may result in the denial of a level move and/or loss of current level status.

**STAFF MEMBERS HAVE FINAL AUTHORITY
REGARDING GENERAL RULES**

BEHAVIOR WRITE-UP POLICY

The Behavior Write-Up is an important document that carries with it several options in order for the Treatment Team to make a decision on how to address specific behaviors that you display and to help you to improve and/or make better choices in the future. This form can be used to either to address negative behaviors or it can be used to address the positive behaviors that may not be exhibited on a daily basis so that it can be recognized and rewarded accordingly in the hopes that in doing so will encourage you to continue practicing said behavior in the future. Our main goal is to address the negative behaviors that they exhibit by helping you to find other positive avenues in which to deal with certain situations and to re-direct said behavior so that you can better recognize them sooner and make better choices. Below is a list of some negative behaviors that requires an automatic Write-Up along with the consequences that come with them...

FOR THE FOLLOWING: YOU WILL LOSE ALL PRIVILEGES FOR ONE (1) WEEK
(INCLUDING NO LATE NIGHT, NO PHONE CALLS, NO VISITS, NO STORE PRIVILEGES, NOT OUTINGS AND DEPENDING UPON THE SEVERITY OF THE SITUATION, POSSIBLE LEVEL DROP AND ORDER IMMEDIATE DISMISSAL FROM PROGRAM)
AND WILL PARTICIPATE IN A CONFERENCE CALL WITH EITHER PARENTS AND/OR REFERRAL SOURCE TO DISCUSS SAID BEHAVIOR.

- **Leaving group room/classroom without permission.**
- **Entering another adolescent's room.**
- **Receiving 25 or more negative Behavior Marks during the course of a staffing week.**
- **Physical aggression of any kind – charges will be filed.**
(This includes Horseplay of any kind)
- **Destruction of facility property in any way – charges will be filed.**
- **Verbally assaulting another peer and/or staff member.**
- **Threatening of physical aggression to another adolescent and/or staff member – charges will be filed.**
- **Any action deemed dangerous to self, peers and/or staff members.**
- **Absconding from the facility – Police will be contacted immediately.**

BEHAVIOR WRITE-UP POLICY (CONT'D)

- **Continued non-compliance after several warnings.**
 - CONSEQUENCE – THREE (3) PAGE PAPER ON THE IMPORTANCE OF STRUCTURE/RULES/ COMPLIANCE PRESENTED IN GENDER SPECIFIC GROUP COUNSELING.
- **Any Behavior that displays the total lack of respect towards staff.**
 - CONSEQUENCE – APOLOGY LETTER WRITTEN TO THE STAFF MEMBER AND PRESENTED TO THE STAFF MEMBER IN FRONT OF FACILITY MANAGER AND CLINICAL MANAGER.
- **Any Behavior that displays the total lack of respect towards another peer.**
 - CONSEQUENCE – APOLOGY LETTER READ IN FRONT OF THE GROUP IN GENDER SPECIFIC GROUP COUNSELING.
- **Continually pursuing a relationship with another peer after warnings have been given.**
 - CONSEQUENCE – THREE (3) PAGE RESEARCHED ARTICLE ON HEALTHY BOUNDARIES PRESENTED IN GENDER SPECIFIC GROUP COUNSELING.
- **Possessing any items against Facility rules.**
 - CONSEQUENCE – NO VISITATION FOR ONE (1) WEEK AND AFTER ONE (1) INSTANCE OF PARENTS/FAMILY MEMBER(S) BRINGING ITEMS INTO FACILITY, FAMILY MEMBER(S) WILL BE ASKED TO NOT RETURN UNTIL DISCHARGE DATE.
- **Smoking cigarettes on property.**
 - CONSEQUENCE – THREE (3) PAGE RESEARCHED ARTICLE ON THE DANGERS OF TOBACCO USE PRESENTED IN A&D EDUCATION (INFORMATION CAN BE RETRIEVED THROUGH THE HELP OF ACADEMIC COORDINATOR)
- **Stealing another peer's belongings.**
 - CONSEQUENCE – THREE (3) PAGE PAPER ON THE CONSEQUENCES OF STEALING TO BE PRESENTED IN GROUP COUNSELING. IN ADDITION, AN APOLOGY LETTER TO THE VICTIM TO BE PRESENTED IN GROUP COUNSELING. YOU MAY ALSO BE RESPONSIBLE FOR THE REPLACEMENT OF STOLEN/DAMAGED ITEM.

NOTE:

Every Write-Up will be reviewed by the Clinical Manager to determine if discharge is appropriate. Anyone who receives a behavior write-up for running (absconding) away from the facility may lose all pass privileges for the remainder of your time in treatment. This will be determined by the treatment team.

BEHAVIOR CONTRACT POLICY

You may be placed on a Behavior Contract for continuous rule infractions and ongoing inappropriate behavior. A written agreement between you and your counselor will be developed that specifies the needed changes in your behavior. If you have a Juvenile officer, DYS Service Coordinator, or DFS case worker they will be notified of your status and may also be involved in the development of your specific Behavior Contract. Your Parents and/or Guardians will also be notified of the contract and will be given the opportunity to participate in the development of the contract when applicable. Consequences of violating the contract will be specifically listed in the contract that is signed by you and any others involved.

VIDEO/AUDIO SURVEILLANCE

For the purposes of the Adolescent and the staff members' safety and supervision, The FCC Behavioral Health's Adolescent program is equipped with video and audio surveillance equipment. These surveillance cameras are located within the general living area of the group homes, treatment center and cafeteria spaces. In order to respect the privacy of adolescents, cameras are not located in the sleeping and lavatory areas.

The surveillance cameras are equipped with both video and audio capabilities and can be reviewed by management personnel as the need arises.

POSITIVE BEHAVIOR SUPPORTS

The Behavior Write-Up can also be used to address the positive behaviors that are exhibited as well. Examples of this can be you having some difficulty getting acclimated to the program and therefore have been displaying constant negative behavior and/or attitude and then out of nowhere you begin showing signs of improvement such as mentoring a new resident or trying to re-direct another peer by giving advice as to what behaviors can get them into trouble through examples of situations that you have encountered personally. Once the facts have been entered into the Behavior Write-Up, the observing staff will then give a recommendation of an appropriate consequence, or in the case of a positive behavior, an appropriate reward to include (but not limited to)...

Extra Phone Call Lunch with Staff Extra Merits for Store
Extra Time on Pass Extra Late Night (For Level 2)

BEHAVIOR MERITS

Although rules are an important part of ensuring order within the facility and respect amongst the adolescents and staff, it is important to recognize the positive behaviors exhibited by each individual in order to better ensure their recovery process not only in treatment but once they have discharged from the program.

Adolescents are given points based on the positive behaviors they exhibit during all phases of the inpatient treatment process to go toward purchasing items set up to encourage positive behavior and positive peer support amongst the group and are based on the following criteria:

LEADERSHIP, RESPONSIBILITY, FOCUS, HONESTY, SUPPORT OF PEERS, ATTITUDE, PARTICIPATION, INITIATIVE, RESPECT AND FEEDBACK.

CSTAR STORE ITEMS FOR PURCHASE

Here at CSTAR we have put together a “Store” in order for adolescents to purchase items by using the Merits they earn on a daily basis. Many of the items are small tier items of everyday use and then there are larger items such as journals, plastic water bottles, extra phone calls, as well as earning an opportunity for a staff member to take them out for a meal. Adolescents have to display all the requirements listed under the Behavior Merits section by fully participating in groups and showing leadership amongst your peers.

The items currently in stock in the store are listed on the following pages. The transaction sheet is your way of keeping track of the Merits you earn each week so that you can see what you have earned, as well as help you keep track of what you have to spend. Keep in mind to look upon these Merits as money; if you do not have the Merits (money) to spend, you cannot purchase said item, so if you want a higher tier item, you are going to have to save for it. NOTE: exceptions can be made for hygiene items.

<u>CSTAR STORE ITEM</u>	<u>PRICE (IN MERITS)</u>
BAG OF CHIPS	25
PEANUTS	40
OTHER SNACKS (NUTTER BUTTER, M&M COOKIES, ETC)	100
CANDY BARS (SKITTLES, STARBURST, SNICKERS, ETC)	100
CAN SODA	125
LIP BALM	25
WORD PUZZLES	75
PLAYING CARDS	100
DOMINOS	100
WATER BOTTLE (PLASTIC)	350
CAP ERASERS	10
WOOD PENCIL	25
BIG ERASERS	20
POCKET FOLDER (ANY COLOR)	30
RULER (6 INCH)	40
MECHANICAL PENCIL	50
SPIRAL NOTEBOOK	115
COLORED PENCILS (BOX)	125
COLORED BINDER	150
3-RING BINDER POUCHES	85-125
COMPOSITION NOTEBOOK/JOURNAL	200
SKETCH PAD	250
LEATHER BOUND JOURNAL	350
\$10.00 iTunes GIFT CARD	850
MEAL OUT IN TOWN WITH STAFF	850
EXTRA 5 (FIVE) MIN IN SHOWER (ONE USE AT A TIME)	115
5 (FIVE) MIN PHONE CALL	250
EXTRA LATE NIGHT (FOR LEVEL 2 CONSUMERS)	300
GET OUT OF ONE (1) GROUP PASS	400
10 (TEN) MIN PHONE CALL	450
LOTION	85
SHAMPOO	85
DEODORANT	90
TOOTHPASTE	90
TOOTHBRUSH	90
BODY WASH (3-IN-1)	115
TOOTHPASTE/TOOTHBRUSH COMBO	165

RESIDENTIAL DAILY GROUP SCHEDULE

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TIME	SATURDAY	SUNDAY
6:30A	Wake-up/Bkfst A&D Educ. Christina BU - Mary	Wake-up/Bkfst A&D Educ. Christina BU - Mary	Wake-up/Bkfst A&D Educ. Christina BU - Mary	Wake-up/Bkfst A&D Educ. Christina BU - Mary	Wake-up/Bkfst A&D Educ. Christina BU - Mary	7:30A	Wake Up Breakfast	Wake Up Breakfast
8:05A						8:30A		
9:05A	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	9:00A	Visitation Begins	
9:10A	Group Couns. (GENDER SPEC.) Larry/Jessica	5C/ Coping w/Angel (GENDER SPEC.) Larry/Jessica	Group Couns. (GENDER SPEC.) Larry/Jessica	5C/ Coping w/Angel (GENDER SPEC.) Larry/Jessica	Group Couns. (GENDER SPEC.) Jessica Wilson	9:00A	Group Couns.	Group Couns.
10:10A	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	10:00A	Elisha Thomason 5 MIN BREAK	Elisha Thomason 5 MIN BREAK
10:15A	Academic Ed Christina BU - Mary	Academic Ed Christina BU - Mary	Academic Ed Christina BU - Mary	Academic Ed Christina BU - Mary	Academic Ed Christina BU - Mary	10:05A	Anger Management (TT Staff)	Health (TT Staff)
11:15A	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	11:05A	5 MIN BREAK	5 MIN BREAK
11:20A	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	11:10A	Group Couns.	Group Couns.
12:20P	Larry/Jessica	Larry/Jessica	Larry/Jessica	Larry/Jessica	Jessica Wilson	12:10A	Elisha Thomason	Elisha Thomason
12:20P	Lunch - Josh	Lunch - Josh	Lunch - Josh	Lunch - Josh	Lunch - Josh	12:10P	Lunch	Lunch
12:50P	Academic Ed Christina BU - Mary	Academic Ed Christina BU - Mary	Academic Ed Christina BU - Mary	Academic Ed Christina BU - Mary	Academic Ed Christina BU - Mary	12:50P	Self Esteem (TT Staff)	House Manage. Skills (TT Staff)
1:50P	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	1:50P	5 MIN BREAK	5 MIN BREAK
1:55p	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	Grp Couns. (MRT) Grp Couns. (MRT) Grp Couns. (MRT)	1:55p	Group Couns.	Group Couns.
2:55P	Larry/Jessica	Larry/Jessica	Larry/Jessica	Chase Willett	Jessica Wilson	2:55P	Elisha Thomason 5 MIN BREAK	Elisha Thomason 5 MIN BREAK
3:00P	Recreation/ Team Building Brandon Vanvickle TT Floater (BU - Josh Gattis)	Recreation/ Team Building Brandon Vanvickle TT Floater (BU - Josh Gattis)	Recreation/ Team Building Brandon Vanvickle TT Floater (BU - Josh Gattis)	Recreation/ Team Building Brandon Vanvickle TT Floater (BU - Josh Gattis)	Recreation/ Team Building Brandon Vanvickle TT Floater (BU - Josh Gattis)	3:00P	Healthy Living/ Recreation	Recreation/ Team Building
4:00P	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	4:00P	2:30-4:30P (TT Staff)	1:30-3:30P (TT Staff)
5:00P	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5 MIN BREAK	5:00P	Visits End/Dinner	Dinner
5:30P	Recrtn Boys GIRLS	Recrtn Boys GIRLS	Recrtn Boys GIRLS	Recrtn Boys GIRLS	Recrtn Boys GIRLS	5:30P	Recrtn Boys GIRLS	Recrtn Boys GIRLS
6:30P	BREAK	BREAK	BREAK	BREAK	BREAK	6:30P	BREAK	BREAK
6:35P	Recrtn Boys GIRLS	Recrtn Boys GIRLS	Recrtn Boys GIRLS	Recrtn Boys GIRLS	Recrtn Boys GIRLS	6:35P	Recrtn Boys GIRLS	Recrtn Boys GIRLS
7:35P	BREAK	BREAK	BREAK	BREAK	BREAK	7:35P	BREAK	BREAK
7:40P	Life Skills (TT Staff)	Life Skills (TT Staff)	Life Skills (TT Staff)	Life Skills (TT Staff)	Life Skills (TT Staff)	7:40P	Life Skills (TT Staff)	Life Skills (TT Staff)
8:40P	Study Skills (TT Staff)	Study Skills (TT Staff)	Study Skills (TT Staff)	Study Skills (TT Staff)	Study Skills (TT Staff)	8:40P	Study Skills (TT Staff)	Study Skills (TT Staff)
9:40P	Snacks/ Showers/ Chores	Snacks/ Showers/ Chores	Snacks/ Showers/ Chores	Snacks/ Showers/ Chores	Snacks/ Showers/ Chores	9:40P	Snacks/ Showers/ Chores	Snacks/ Showers/ Chores
10:30P	Lights Out	Lights Out	Lights Out	Lights Out	Lights Out	10:30P	Lights Out	Lights Out

ADOLESCENT CSTAR - KENNETT

DISASTER PLAN

FIRE: Exit the building through the NEAREST and SAFEST available EXIT.

NOTE: Fire exits and location of fire extinguishers are clearly marked throughout the facility. Never use the elevator in any type of evacuation, ALWAYS use stairs.

- Treatment Center: Two (2) exits in rear (classroom and recreation room) and One (1) exit located in the front lobby.
- Group Homes: Two (2) exits in the front and rear (living room and kitchen).

Fire safety and evacuation drills are conducted on a regular basis.

NOTE: ASSEMBLY AREA:

Follow directions of Staff Members located at your site during any type of emergency and/or drill.

- All persons will muster in the back parking lot near the grass field area (for both treatment center and group home evacuations) away from emergency personnel and vehicles

For further information seek guidance from Staff or look for Emergency Evacuation Plan located throughout the facility as well as in your Handbook given to you upon admission

TORNADO:

All Staff Members on duty shall escort all person(s)-served and visitors to a safe and secure location away from windows and wait for instructions from staff and/or emergency personnel. If time does not allow, escort person(s)-served and visitors to the nearest main hallway. (*Refer to the Emergency Evacuation Plan located throughout the facility*)

EARTHQUAKE:

Take cover under sturdy furniture (desk, flipped couch, etc.) or supported doorway.

STORM:

Stay in building and away from windows.

FLOOD:

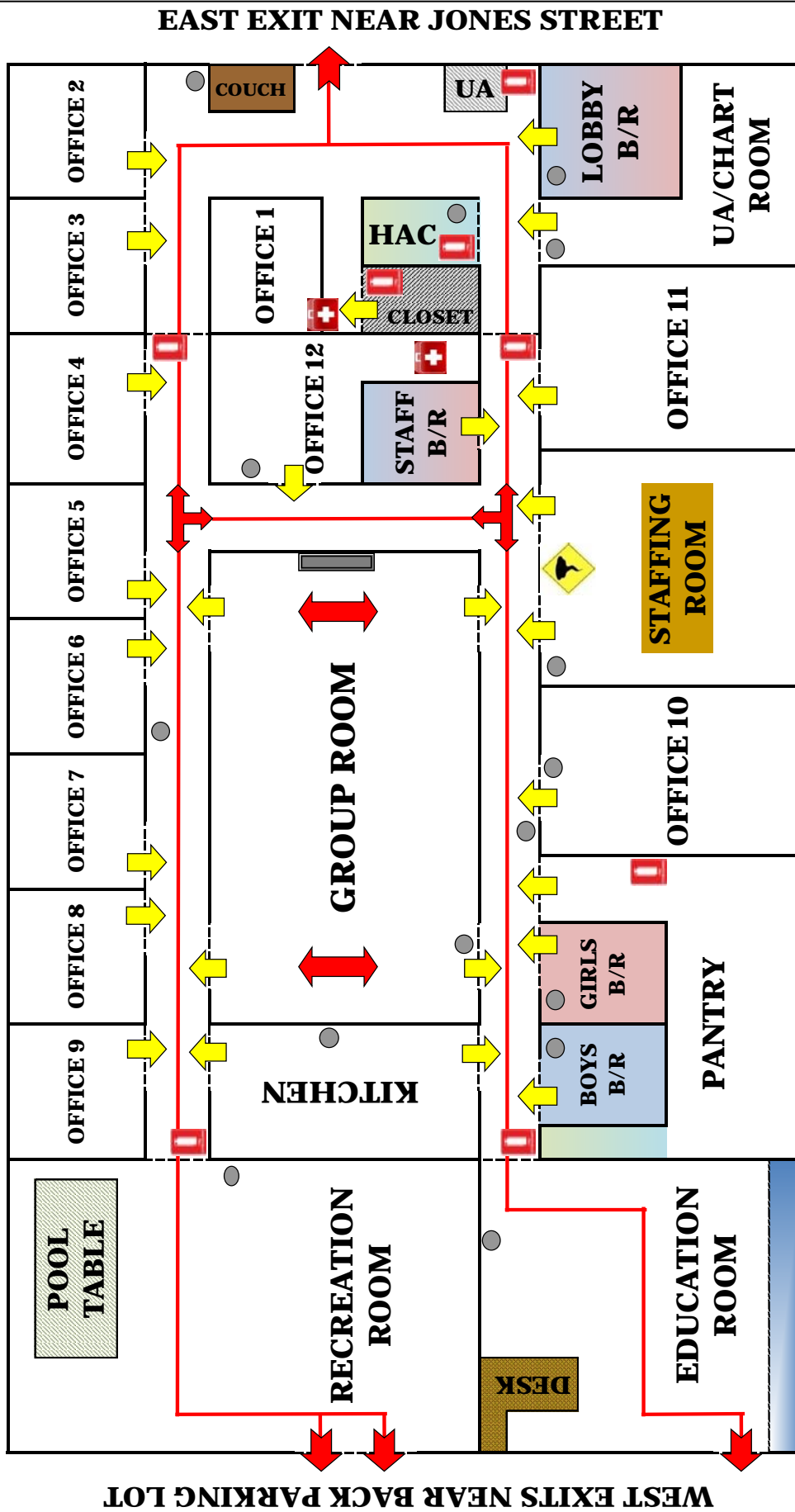
Stay in building and do not attempt to travel in your vehicle.








BOMB:

Exit the building through the NEAREST and SAFEST available exit. Meet in the assembly area, away from the route of emergency personnel/vehicles.

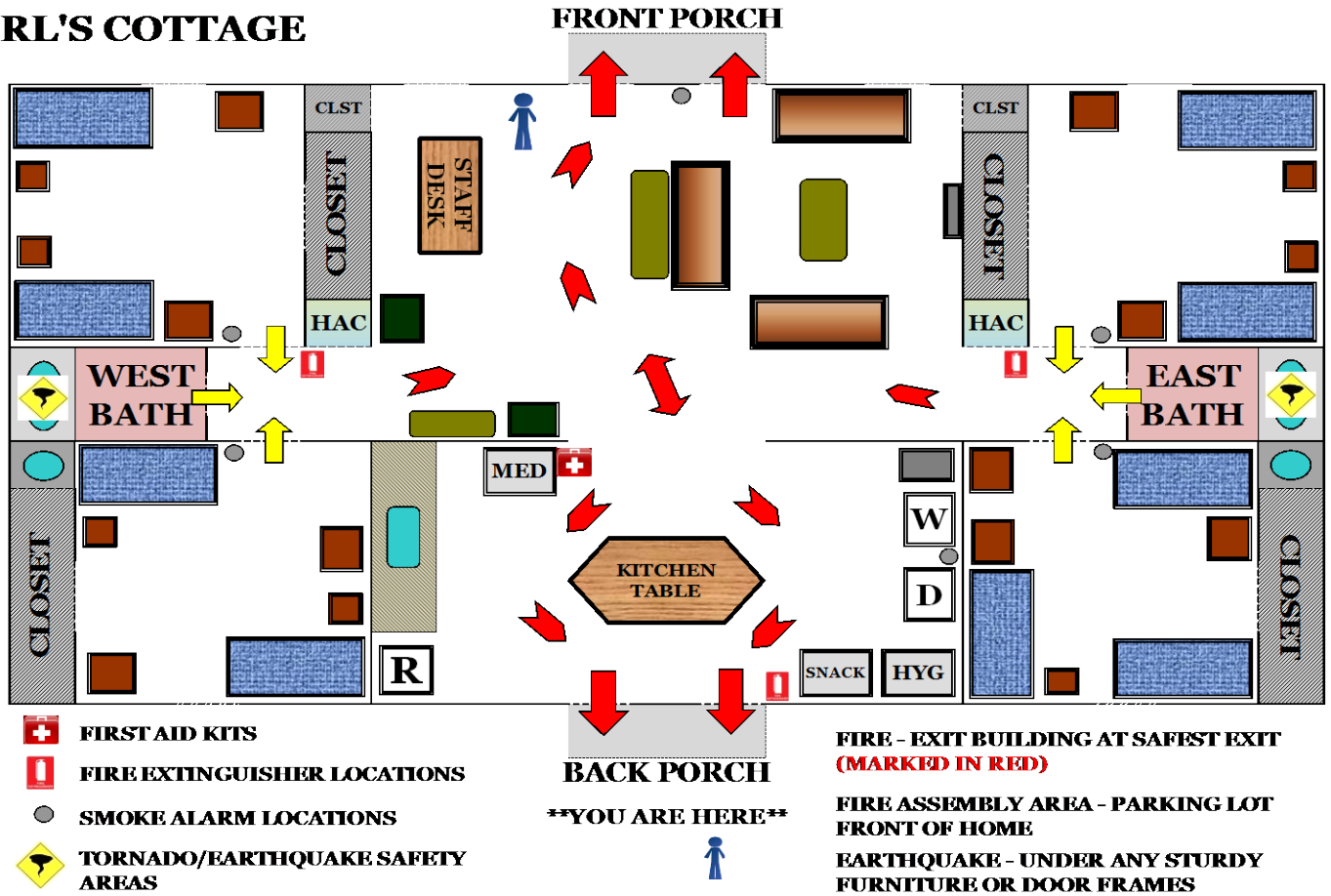
NOTE: DO NOT for any reason use a cellular telephone or any other electronic device, until given the clear from emergency personnel.

KENNETT CSTAR EMERGENCY PLAN

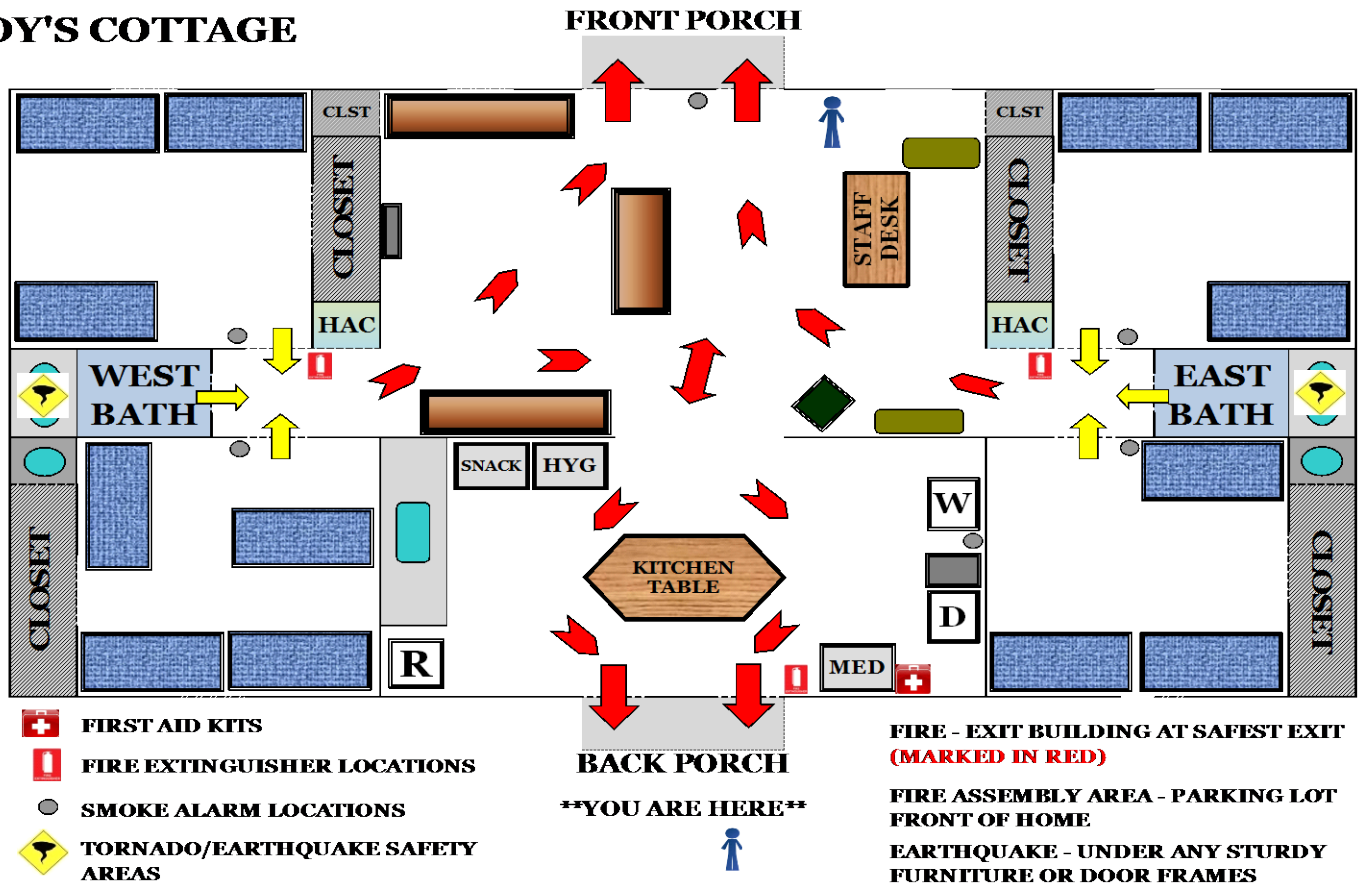


-  **FIRST AID KITS**
-  **FIRE EXTINGUISHER LOCATIONS**
-  **SMOKE ALARM LOCATIONS**
-  **TORNADO/EARTHQUAKE SAFETY AREAS**
-  **FIRE - EXIT BUILDING AT SAFEST EXIT (MARKED IN RED)**
-  **FIRE ASSEMBLY AREA - PARKING LOT REAR OF BUILDING**
-  **EARTHQUAKE - UNDER ANY STURDY FURNITURE OR DOOR FRAMES**

GIRL'S COTTAGE



BOY'S COTTAGE



STAGES OF CHANGE PHILOSOPHY

We believe in a philosophy of change that is internally motivated from the individual. What's going on in your life that has you or the people around you concerned and how can we work together to reach goals of change in these areas? Many people come to treatment not really sure what the problems are or that they really have a problem at all. The Stages of Change allow people to start right where they are in their own process of change. Adolescent CSTAR has Stages of Change packets and materials that help people understand the reasons why they may be in treatment and help to set goals for personal change.

PRE-CONTEMPLATION:

“I don't think I have a problem at all, everything is going just fine in my life.” Packets and material *on* this stage of change helps people to take a look at potentially risky behaviors and discuss the pros and cons of behaviors that can be self-harmful. Exercises are designed to encourage individuals to contemplate their lives and set goals for change.



CONTEMPLATION:

“I might have a problem, but I'm still gathering information and thinking about it.” Packets and material on this stage of change helps people prepare for change by taking an in depth look at personal substance use behavior, learning about addiction and recovery, identifying triggers, identifying relapse warning signs, identifying barriers to change, and identifying what recovery skills will help to achieve personal goals.



PREPARATION:

“I know I have a problem and I need to learn as much as possible about how to manage my problem so that I can move forward into an active change.” Packets and materials on this stage of change helps teach recovery skills that are based in Cognitive Behavioral Therapy such as: Craving Management, Refusal Skills, Trigger Management, Relapse Prevention Skills, Communication Skills, Anger Management Skills, and Stress Management Skills. Recovery support networks are identified and Emergency Plans using these supports are developed.



ACTION:

“I have begun applying the skills that I have learned. I can actually see some of the benefits of my changes and I have a desire to keep moving forward” Packets and materials on this stage of change help individuals on restructuring cues and social supports., helps enhance confidence in dealing with obstacles. Provides support on how to continue developing and refining the skills learned.



MAINTENANCE:

“I am stable and doing well. What can I do to continue with my ongoing recovery?” Packets and materials on this stage of change help individuals continue to build their tool kit of recovery skills. At this stage individuals are increasingly more confident that they can continue on their path of recovery.



ADDITIONAL INFORMATION

As an adolescent and/or Parent/Guardian of Adolescent CSTAR Services, we encourage you to share your ideas and suggestions with staff to help us improve the program and make it better for the adolescents. You can express your ideas and suggestions in the following ways:

- Use the site suggestion box which is located in the hallway, outside of the group room, across from the staffing room.
- Include information on your person served survey.
- Participate in community meetings between staff and the group members.
- File a formal grievance according to agency policy.

FCC Behavioral Health does not practice seclusion or restraint at its facilities. All staff are trained in Nonviolent Crisis Intervention Techniques in the event of a situation which would require staff intervention.

The use of any and all tobacco products is prohibited by all adolescent while in the care of the Kennett Adolescent CSTAR program, this also includes electronic cigarettes.

Gambling is not allowed on the premises.

In the event that illegal drugs or unauthorized prescription medication is brought into the facility for the purpose of illegal use or distribution, Juvenile office or local law enforcement will be contacted and possible charges filed. Such behavior will not be tolerated. This behavior could result in criminal charges, unsuccessful discharge from the program, and extended time in the program or transfer to a more intensive level of care.

Weapons are not permitted for any reason at the Adolescent CSTAR programs. All weapons will be confiscated and the proper authorities will be contacted.

All of your belongings will be searched and inventoried on your first evening of treatment. All belongings will be labeled with your initials and a written description of them will be documented on an inventory sheet for you to sign. It is your responsibility to keep up with your belongings. Sharing or loaning your belongings to another person in the program is strongly discouraged. This program is not responsible for lost or stolen property.

All prescription medication will be collected at time of admission. The nurse will contact the prescribing physician and/or filling pharmacy to verify your medication dosage and schedule. Your medication will be made available to you at prescribed times for you to self-administer under staff supervision. All medication will be kept under two locks at all times.

In the event of a crisis situation, staff is on call to respond on a 24 hour a day, 7 days a week availability. If additional assistance is needed in the event of a mental health emergency, the MOCARS crisis line is utilized. The crisis number is 1-800-356-5395. In the event of a medical emergency, 911 will be utilized.

For the purpose of safety and supervision, all adolescent FCC Behavioral Health group homes are equipped with video and audio surveillance equipment. These surveillance cameras are located within the general living area of the group homes.

COMMON CSTAR TERMINOLOGY/LANGUAGE

Acting Out	Occurs when someone feels the need to shock and attract attention, usually by acting silly or childish, or by other inappropriate behaviors.
Bad Rapping	Belittling someone who is not present in the conversation.
Being Aware	Knowing what is going on at all times around you.
Behavior Marks	Marks given to Adolescents by staff members, when the individual has displayed a negative attitude and/or behavior, or has broken a rule. It is designed to help the person served reflect and be accountable for his/her behavior and to learn from it. They can result in the loss of privileges, denial of level move and/or loss of current level status.
Behavior Merits	Points that are given based on the positive behaviors shown by the Adolescents throughout their daily activities. These points accumulate through the week to go towards the purchase of items through the CSTAR store.
Behavior Write-Up (BW)	Form that is filled out in order to document the exact details of an occurrence or behavior that occurs while in treatment. The Adolescent will lose all privileges for (1) one week from the date of the issuance of IR.
Care and Concern	Demonstration of interest in the well-being of a fellow peer. Can be expressed in a variety of interactions to express the message, "The reason I am bringing this to your attention is because I care about you and do not want to see you mess up your life."
CSTAR Store	Store on facility property where Adolescents can use their Behavior Merits points accumulated during the week to purchase small tier items for use while in treatment.
Disrespect	To insult, act rude, impolite and/or offensive to and/or towards others.
Flip-It	Occurs when a group member who is being confronted for inappropriate behavior tries to make it look like the person confronting him/her is the one who is really at fault.
Focus-Up	To make someone aware of their negative behavior in order to raise their awareness of the behavior. To reinforce attitudes of mutual self-help. To make each Adolescent more accountable for his/her actions and behaviors.
General Rules	These rules protect the facility from behaviors that threaten the viability of the facility and the services provided. An infraction will warrant severe consequences or removal from treatment.
Guilt	Feelings of remorse for behaviors and actions.
Hang-Up	Having trouble with problem solving.
Horseplay	Any kind of rough or rowdy play that can result in either intentional or unintentional physical harm to self of others.
Jailing	Holding on to negative behavior patterns.
Leaking	May occur in an Adolescent who has an understanding of CSTAR concepts but reverts to old attitudes and behaviors. Displaying negative attitude and behavior in group setting. It is also a form of negative verbal feedback.
Level Move	Adolescents can request a change in level status (Level 2 – two weeks after initial admission; Level 3 – three weeks after receiving Level 2; Level 4 – three weeks after receiving Level 3). Residents must exhibit positive behavior, adhere to facility rules and

regulations, and have met all treatment goals set out by counselors and staff in order to request level move.

Level Status	Current level in which the Adolescent is on in the Level 1 residential treatment program.
Negative	A value, attitude or behavior that is destructive to the individual and/ or others.
Non-Compliance	Failure or refusal of the Adolescent to conform to or follow rules, regulations, advise or wishes of the Staff Members.
Peer Group	Weekly session held on Wednesdays before Staffing, involving Staff Members and persons served in which the behaviors, both positive and negative, are addressed.
Personalizing	Taking anything that someone says in general as a personal remark.
Positive	A value, attitude, or behavior that is constructive and goal directed.
Program Levels	States what level of services are being provided to the individual. Can be through either inpatient services, outpatient services, or day treatment services.
Projection	Consciously or unconsciously assigning your own ideas, impulses or motives to someone else.
Rat Pack	Two or more persons verbally attacking an individual in group.
Sense of Entitlement	Feeling above others.
Shooting a Curve	Going to another individual when someone has already told you what the answer was (by passing or going around until you get the answer you want).
Staffing	Weekly session, held on Thursdays where the Treatment Team makes decisions regarding level moves as well as addressing Treatment Goals with each Adolescent in treatment.
Stuffing Feelings	Keeping feelings locked up inside, which may result in physical illness or explosions of anger.
Support	Acknowledgement of positive attitude and behavior. Examples are supportive statements, applause, handshakes and back pats.
Talking To	When an individual is given information in a positive manner after displaying a negative behavior.
Therapeutic Community	A residential, drug-free treatment modality that is highly structured and ritualized. Residents confront one another's negative attitudes and/or behaviors and work together to achieve a positive goal-oriented change.
Trafficking/Trading	When an Adolescent receives or exchanges personal item that go against the CSTAR rules and regulations.
Treatment Goals	Goals outlined by the Resident and staff as to what he/she will work towards while in treatment. The treatment team will guide the individual through the treatment planning process.
Treatment Team	A group of people, including the Adolescent, who make decisions about substance use treatment. Team members may include any and all staff members employed by FCC Behavioral Health and CSTAR.

SUBSTANCE USE AND CO-OCCURRING MENTAL HEALTH DISORDERS

Adolescents are often referred to treatment for substance use, but are not referred to a qualified mental health professional for appropriate diagnosis and treatment of any underlying cause for their drug and alcohol use. However, many teens have symptoms of a mood disorder that may in fact have led to self-medicating with street drugs and alcohol.

Families and caregivers know how difficult it is to find treatment for an adolescent who uses drugs or alcohol, but who also is diagnosed with a brain disorder (mental illness); i.e., ADHD, depression, or bipolar disorder. Traditionally, programs that treat individuals with brain disorders do not treat individuals with active substance use problems, and programs for substance users are not geared for people with mental illness. Adolescents are often caught in this treatment or services gap.

IS DUAL DIAGNOSIS COMMON?

The combination of mental illness and substance use is so common that many clinicians now expect to find it. Studies show that more than half of young persons with a substance use diagnosis also have a diagnosable mental illness.

WHAT CAUSES THESE DISORDERS?

Mental health and addiction counselors increasingly believe that brain disorders and substance use disorders are biologically and physiologically based.

WHAT KIND OF TREATMENT WORKS?

Families and caregivers may feel angry and blame the adolescent for being foolish and weak-willed. They may feel hurt when their child breaks trust by lying and stealing. But it's important to realize that mental illness and often substance use are disorders that the adolescent cannot take control of without professional help.

Teens with difficult problems such as concurrent mental illness and substance use disorders do not respond to simplistic advice like "just say no" or "snap out of it." Psychotherapy and medication combined with appropriate self-help and other support groups help most, but patients are still highly prone to relapse.

Treatment programs designed primarily for substance users are not recommended for individuals who have a diagnosed mental illness. Their reliance on confrontation techniques and discouragement of use of appropriate prescription medications tend to compound the problems of individuals with mental illness. These strategies may produce stress levels that make symptoms worse or cause relapse.

WHAT IS A BETTER APPROACH?

Increasingly, the psychiatric and drug counseling communities agree that both disorders must be treated at the same time. Early studies show that when mental illness and substance use are treated together, suicide attempts and psychotic episodes decrease rapidly.

Since dually diagnosed clients do not fit well into most traditional 12-step programs, special peer groups based on the principle of treating both disorders together should be developed at the community level. Individuals who develop positive social networking have a much better chance of controlling their illnesses. Healthy recreational activities are extremely important.

WHAT'S THE FIRST STEP IN TREATMENT?

The presence of both disorders must first be established by careful assessment. This may be difficult because the symptoms of one disorder can mimic the symptoms of the other. Seek referral to a psychologist or psychiatrist. Local NAMI affiliates are happy to refer families to mental health professionals their members recommend. (Call the NAMI HelpLine at 1-800-950-6264 for a local contact).

Once a professional assessment has confirmed a dual diagnosis of mental illness and substance use, mental health professionals and family members should work together on a strategy for integrating care and motivating the adolescent.

WHAT DO MODEL PROGRAMS FOR TREATING MENTAL ILLNESS AND SUBSTANCE USE LOOK LIKE?

There is a growing number of model programs. Support groups are an important component of these programs. Adolescents support each other as they learn about the negative role that alcohol and drugs has had on their lives. They learn social skills and how to replace substance use with new thoughts and behaviors. They get help with concrete situations that arise because of their brain disorder (mental illness). Look into programs that have support groups for family members and friends.

IF YOUR TEEN HAS A SUBSTANCE USE DISORDER...

- Don't regard it as a family disgrace. Recovery is possible just as it is with other illnesses.
- Encourage and facilitate participation in support groups during and after treatment.
- Don't nag, preach, or lecture.
- Don't use the "if you loved me" approach. It is like saying, "If you loved me, you would not have tuberculosis."
- Establish consequences for behaviors. Don't be afraid to call upon law enforcement if teens engage in underage drinking on your premises. You can be held legally responsible for endangering minors if you do not take timely action.
- Avoid threats unless you think them through carefully and definitely intend to carry them out. Idle threats only make the person with a substance use disorder feel you don't mean what you say.
- During recovery, encourage teens to engage in after-school activities with adult supervision. If they cannot participate in sports or other extracurricular school activities, part-time employment or volunteer work can build self-esteem.
- Don't expect an immediate, 100-percent recovery. Like any illness, there is a period of convalescence with a brain disorder. There may be relapses and times of tension and resentment among family members.
- Do offer love, support, and understanding during the recovery.

ANXIETY DISORDERS IN CHILDREN AND ADOLESCENTS

WHAT ARE ANXIETY DISORDERS?

Anxiety disorders cause people to feel excessively frightened, distressed, and uneasy during situations in which most others would not experience these symptoms. Left untreated, these disorders can dramatically reduce productivity and significantly diminish an individual's quality of life. Anxiety disorders in children can lead to poor school attendance, low self-esteem, deficient interpersonal skills, alcohol use, and adjustment difficulty.



Anxiety disorders are the most common mental illnesses in America; they affect as many as one in 10 young people. Unfortunately, these disorders are often difficult to recognize, and many who suffer from them are either too ashamed to seek help or they fail to realize that these disorders can be treated effectively.

Anxiety can be a normal reaction to stress. It can help us deal with a tense situation, study harder for an exam, keep focused on an important speech. In general, it can help us cope. But when anxiety becomes an excessive, irrational dread of everyday situations, it has become a disabling condition. Examples of anxiety disorders are obsessive compulsive disorder, post-traumatic stress disorder, social phobia, specific phobia, and generalized anxiety disorder. Symptoms of many of these disorders begin in childhood or adolescence.

YESTERDAY

- The brain areas and circuitries underlying symptoms of anxiety disorders were unknown.
- No targeted psychotherapies for anxiety disorders existed.
- Clinicians did not have strong information to help them make treatment decisions between a specific psychotherapy, medication alone, or a combination of medication and psychotherapy.

TODAY

- A large, national survey of adolescent mental health reported that about 8 percent of teens ages 13-18 have an anxiety disorder, with symptoms commonly emerging around age 6. However, of these teens, only 18 percent received mental health care.

- Imaging studies show that children with anxiety disorders have atypical activity in specific brain areas, compared with other people. For example:
 - In one, very small study, anxious adolescents exposed to an anxiety-provoking situation showed heightened activity in brain structures associated with fear processing and emotion regulation, when compared with normal controls.
 - Another small study found that youth with generalized anxiety disorder had unchecked activity in the brain's fear center, when looking at angry faces so quickly that they are hardly aware of seeing them.
- Brain scans of teens sizing each other up reveal an emotion circuit activating more in girls as they grow older, but not in boys. This finding highlights how emotion circuitry diverges in the male and female brain during a developmental stage in which girls are at increased risk for developing mood and anxiety disorders.
- The Child/Adolescent Anxiety Multimodal Study (CAMS), in addition to other studies on treating childhood anxiety disorders, found that high-quality cognitive behavioral therapy (CBT), given with or without medication, can effectively treat anxiety disorders in children. One small study even found that a behavioral therapy designed to treat social phobia in children was more effective than an antidepressant medication.

TOMORROW

Novel approaches to treatment and prevention that are currently being studied in adults with anxiety disorders may someday lead to advances in treatment for children.

Examples of such approaches include:

- Identifying predictive markers, such as hormone levels and genes, for determining people at risk for developing PTSD after a traumatic event.
- Developing Internet-based cognitive and behavioral therapies to make interventions more widely available.
- Imaging, molecular biology, and genetics research are pointing the way to brain mechanisms involved in anxiety disorders. Features of these mechanisms are potential biomarkers that could identify people at risk—a key to early intervention—or help clinicians to determine which treatments are likely to work for different patients.
- Research to identify brain mechanisms involved in anxiety disorders also holds the potential to reveal targets for better medications with fewer side effects.

HELLO
my name is

Anxiety

WHAT CAUSES ADHD?

Scientists are not sure what causes ADHD, although many studies suggest that genes (the “blueprints” for who we are) play a large role. Like many other illnesses, ADHD probably results from a combination of genetic and environmental factors such as nutrition, brain injuries, or social environment.

CAN A TEENAGER HAVE ADHD?

Most children with ADHD continue to have symptoms as they enter adolescence. Some may not be diagnosed until then. It’s not easy being a teenager, but for a teenager with ADHD, it can be especially hard. Staying with the recommended treatments, prescribed medications, psychosocial interventions, or a combination of the two, is also a challenge. Since inattention can be a problem, driving is another major concern for those with ADHD. Working cooperatively with parents, schools, and health care professionals is key.

Q: HOW IS ADHD TREATED?

A: Available treatments focus on reducing the symptoms of ADHD and improving functioning. A one-size-fits-all treatment does not exist and sometimes several different medications or dosages must be tried before finding one that works for a specific person. Anyone taking medications must be closely watched by their doctors. Parents and doctors need to work together to decide which medication is best, if the young person needs medication only for school hours or also for evenings and weekends, and also what psychosocial interventions are best for that individual.

WHAT CAN BE DONE IF YOU OR YOUR FRIEND HAS ADHD?

First you need to help reduce the stress caused by the frustration that is experienced with these conditions. It is best for you or your friend to work with your family and a team of health professionals to find the best treatments.

ONCE DIAGNOSED, WHAT IS THERE TO DO ABOUT IT?

With the right kind of help, most children and teens with ADHD can usually improve dramatically.

WHERE CAN I GET MORE INFORMATION?

Knowledge in genetics, brain imaging, and behavioral research is leading to a better understanding of the causes of the disorder, how to prevent it, and how to develop more effective treatments for all age groups. NIMH has studied ADHD treatments for pre-school and school-aged children in a large –scale, long term studies. NIMH-sponsored scientists are continuing to look for the biological basis of ADHD and how differences in genes and brain structures may combine with life experiences to produce the disorder.

BIPOLAR DISORDER

WHAT IS BIPOLAR DISORDER?

Bipolar disorder, also known as manic-depressive illness, is a brain disorder characterized by episodes of mania and depression. These episodes are associated with unusual shifts in mood and energy. Early onset bipolar disorder, which starts during childhood or during the teen years, may be more severe than forms that first appear in older teens and adults. Some evidence suggests that young people with the illness may have more frequent mood switches, be sick more often, and have more mixed episodes (both manic and depressive symptoms).



WHAT ARE THE SYMPTOMS OF BIPOLAR DISORDER?

Bipolar mood changes are called "mood episodes." People may have manic episodes, depressive episodes, or "mixed" episodes. A mixed episode has both manic and depressive symptoms. These mood episodes cause symptoms that last a week or two-sometimes longer. During an episode, the symptoms last every day for most of the day.

Mood episodes are intense. The feelings are strong and happen along with extreme changes in behavior and energy levels. People having a manic episode may:

- Feel very "up" or "high"
- Feel "jumpy" or "wired"
- Talk really fast about a lot of different things
- Be agitated, irritable, or "touchy"
- Have trouble relaxing or sleeping
- Think they can do a lot of things at once and are more active than usual
- Do risky things, like spend a lot of money or have reckless sex.

People having a depressive episode may:

- Feel very "down" or sad
- Feel worried and empty
- Have trouble concentrating
- Forget things a lot
- Lose interest in fun activities and become less active
- Feel tired or "slowed down"
- Have trouble sleeping
- Think about death or suicide.
- Can bipolar disorder coexist with other problems?

YESTERDAY

- Few experts believed that bipolar disorder could occur in childhood.
- Depression and bipolar disorder weren't considered brain illnesses, and distinct treatments for each illness did not exist.
- Researchers could not distinguish between severe irritability and bipolar disorder in children, which would make it possible to develop more effective treatments for each.

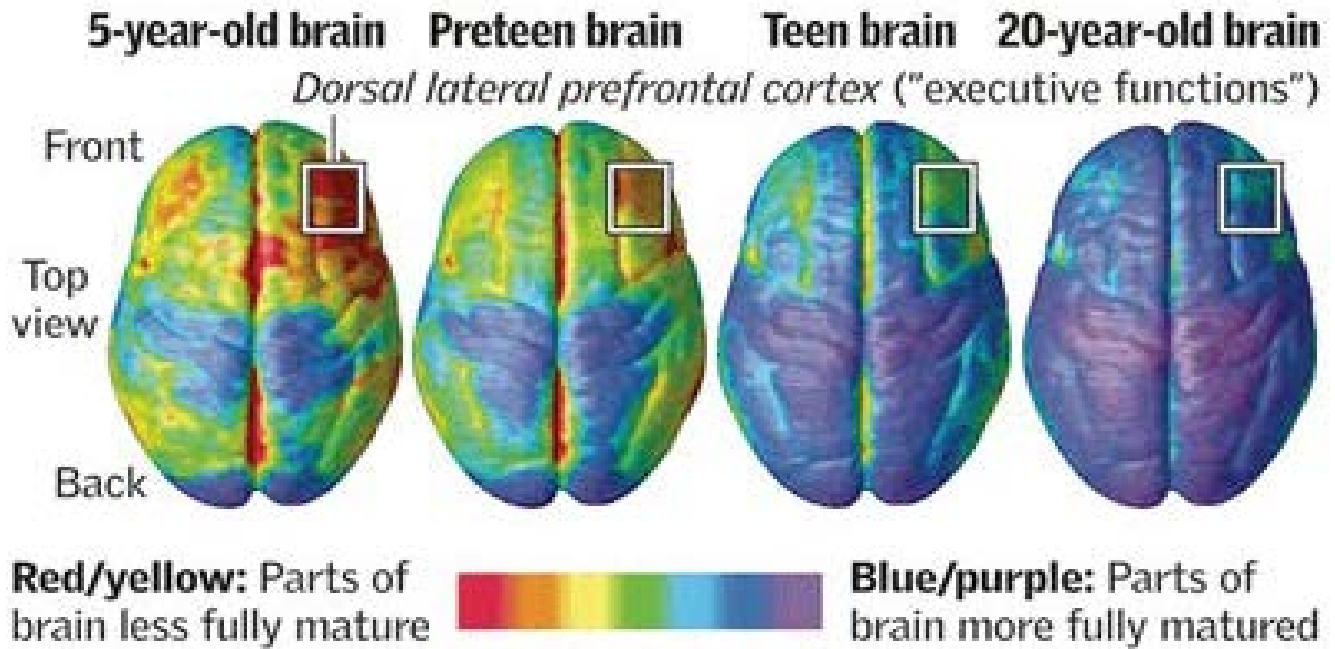
TODAY

- A large, nationally representative survey shows that at least half of all cases of bipolar disorder start before age 25.
- Some medications have been approved for treating bipolar disorder in children and teens, and psychotherapies, such as family focused therapy, also appear to be effective in helping children to manage their symptoms.
- Children with bipolar disorder can have co-occurring disorders, such as attention deficit hyperactivity disorder, anxiety disorders, or other mental disorders, in addition to bipolar disorder. Scientists and doctors now know that, while having co-occurring disorders can hinder treatment response, treating bipolar disorder can have positive effects on treatment outcomes and recovery from co-occurring disorders as well. Studies focusing on conditions that frequently co-occur and how they affect one another may lead to more targeted screening tools and interventions.
- Imaging studies are beginning to reveal brain activity patterns and connections associated with specific traits associated with children who have bipolar disorder, such as mood instability and difficulty interpreting social or emotional cues.
- Genetic research reveals genetic similarities among bipolar disorder, depression, and schizophrenia. Such studies point to possible common pathways that give rise to these disorders but also highlight limitations in focusing on specific diagnoses in research. This issue has spurred a new NIMH initiative—the Research Domain Criteria (RDoC) project—to make sense of research findings that don't fit neatly into current diagnostic categories.

TOMORROW

- Though there is currently no way to prevent bipolar disorder, NIMH is studying how to limit or delay the first symptoms in children with a family history of the illness.
- Research on novel treatment delivery approaches, such as telemedicine (providing services over satellite, Internet, or other remote connections) and collaborative or team-based care in medical care settings will improve the quality of mental health care, particularly for special populations, such as minorities and people in rural communities.
- Due to concerns that many children are being mistakenly diagnosed with bipolar disorder, many researchers are working to refine the diagnostic criteria. For example, one subset of children whose primary symptom is chronic, severe irritability may instead be better described as having a syndrome called severe mood dysregulation, while another group of children with rapidly changing moods and high energy may not have bipolar disorder at all, despite showing symptoms commonly associated with it.

BRAIN DEVELOPMENT (CHILDHOOD/ADOLESCENCE)



In recent years, powerful new imaging technologies and other approaches have allowed scientists to track the development of the brain during childhood. These studies offer a way to understand how the intellectual abilities and behavioral maturity of children at various ages are rooted in the developing brain. Studies of the developing brain also offer the best possibility for understanding the origins of mental illnesses. Research suggests that vulnerability to mental illness—and resilience—is rooted in development. Both risk and resilience are shaped by genes and environment interacting together, through childhood and adolescence. Research can show how.

YESTERDAY

- Thirty years ago, it was thought that children did not experience mood disorders like depression.
- In the 1980s and 1990s, national surveys revealed that many adults with mental illness recall having had their first symptoms in youth. Subsequent work confirmed that early signs of psychiatric disorders are often present years before a diagnosis is made.
- Studies tracking the maturation of the brain showed that different parts of the brain grow at different times. There are growth spurts as well as periods of more gradual growth. Imaging studies have also shown that youth diagnosed with mental disorders show patterns of development different than in unaffected youth.
- Research in animals has shown that early experience, including the quality of early parental nurturing, has measurable effects on the brain and later behavior. Early experiences shape how the brain-based stress response system develops and can influence later stress resilience.

TODAY

- Scientists are continually refining imaging techniques to provide more detailed information on brain development, even in very young children. Researchers are tracing how changes in the developing brain underlie milestones in a child's mental and physical abilities, and behavior.
- Scientists are conducting studies to determine what individual genes do in the brain and how changes in genes disrupt brain function. Already this work has led to the identification of candidate compounds to correct deficits associated with neurodevelopmental disorders like Fragile X syndrome; clinical trials are underway.
- Research on early childhood stress is showing how early trauma can alter the brain's stress response system and contribute to future risk of anxiety and mood disorders.
- Scientists are also studying how genes that convey vulnerability to stress may increase risk.
- Studies of how the environment can turn genes on and off—a field called epigenetics—are providing clues to how early experience can have lasting effects on behavior, even across generations. Epigenetic changes are likely to be involved in the effects of the environment on development of the nervous system. Knowledge of epigenetic processes may offer targets for the development of new medications.

TOMORROW

- Ongoing research will clarify the relationship between genes and risk for mental illness. Rather than finding genes that cause a particular disorder—for example, a gene for bipolar disorder—it is more likely that genes will be identified that contribute to behavioral, emotional, and social tendencies, including responses to stress. The mosaic of these traits will contribute to vulnerability or resilience to illness.
- Scientists are increasingly focusing on neural circuits in the brain and how they develop during childhood. Research will map neural circuits in the brain, clarify how genes and environmental factors shape them, and determine how they become disrupted in mental illness.
- One of the major goals of research is to identify biomarkers of disease to enable early and accurate diagnosis of mental illness. In diseases like schizophrenia, for example, early identification of risk may make it possible to intervene early and prevent the lasting disability associated with this disease. The genetics of mental illness is complex; still, knowledge of how genes shape brain function should make it possible to determine whether particular genes increase or protect against risk. Research also suggests that genes may help determine how a person will respond to treatment.
- Research on the effects of early stress on the brain will help inform efforts to support the healthy emotional and intellectual development of children.

DEPRESSION IN CHILDREN AND ADOLESCENTS

About 11 percent of adolescents have a depressive disorder by age 18 according to the National Comorbidity Survey-Adolescent Supplement (NCS-A). Girls are more likely than boys to experience depression. The risk for depression increases as a child gets older. According to the World Health Organization, major depressive disorder is the leading cause of disability among Americans age 15 to 44.

Because normal behaviors vary from one childhood stage to another, it can be difficult to tell whether a child who shows changes in behavior is just going through a temporary “phase” or is suffering from depression.



YESTERDAY

- People believed that children could not get depression. Teens with depression were often dismissed as being moody or difficult.
- It wasn't known that having depression can increase a person's risk for heart disease, diabetes, and other diseases.
- Today's most commonly used type of antidepressant medications did not exist. Selective serotonin reuptake inhibitors (SSRIs) resulted from the work of the late Nobel Laureate and NIH researcher Julius Axelrod, who defined the action of brain chemicals (neurotransmitters) in mood disorders.

TODAY

- We now know that youth who have depression may show signs that are slightly different from the typical adult symptoms of depression. Children who are depressed may complain of feeling sick, refuse to go to school, cling to a parent or caregiver, or worry excessively that a parent may die. Older children and teens may sulk, get into trouble at school, be negative or grouchy, or feel misunderstood.
- Findings from NIMH-funded, large-scale effectiveness trials are helping doctors and their patients make better individual treatment decisions. For example, the Treatment for Adolescents with Depression Study (TADS) found that combination treatment of medication and psychotherapy works best for most teens with depression.
- The Treatment of SSRI-resistant Depression in Adolescents (TORDIA) study found that teens who did not respond to a first antidepressant medication are more likely to get better if they switch to a treatment that includes both medication and psychotherapy.
- The Treatment of Adolescent Suicide Attempters (TASA) study found that a new treatment approach that includes medication plus a specialized psychotherapy designed specifically to reduce suicidal thinking and behavior may reduce suicide attempts in severely depressed teens.

- Depressed teens with coexisting disorders such as substance use problems are less likely to respond to treatment for depression. Studies focusing on conditions that frequently co-occur and how they affect one another may lead to more targeted screening tools and interventions.
- With medication, psychotherapy, or combined treatment, most youth with depression can be effectively treated. Youth are more likely to respond to treatment if they receive it early in the course of their illness.
- Although antidepressants are generally safe, the U.S. Food and Drug Administration has placed a “black box” warning label—the most serious type of warning—on all antidepressant medications. The warning says there is an increased risk of suicidal thinking or attempts in youth taking antidepressants. Youth and young adults should be closely monitored especially during initial weeks of treatment.
- Studies focusing on depression in teens and children are pinpointing factors that appear to influence risk, treatment response, and recovery. Given the chronic nature of depression, effective intervention early in life may help reduce future burden and disability.
- Multi-generational studies have revealed a link between depression that runs in families and changes in brain structure and function, some of which may precede the onset of depression. This research is helping to identify biomarkers and other early indicators that may lead to better treatment or prevention.
- Advanced brain imaging techniques are helping scientists identify specific brain circuits that are involved in depression and yielding new ways to study the effectiveness of treatments.

TOMORROW

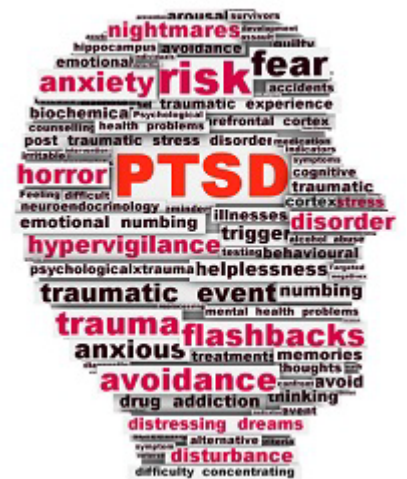
- Years of basic research are now showing promise for the first new generation of antidepressant medications in 2 decades, with a goal of relieving depression in hours, rather than weeks. Such a potential breakthrough could reduce the rate of suicide, which is consistently one of the leading causes of death for young people. In 2007—the most recent year for which we have statistics—it was the third leading cause of death for youth ages 15 to 24.
- Research on novel treatment delivery approaches, such as telemedicine (providing services over satellite, Internet, phone, or other remote connections) and collaborative or team-based care in medical care settings will improve the quality of mental health care for youth.
- Sophisticated gene studies have suggested common roots between depression and possibly other mental disorders. In addition to identifying how and where in the brain illnesses start before symptoms develop, these findings have also encouraged a new way of thinking about and categorizing mental illnesses. In this light, NIMH has embarked on a long-term project—called the Research Domain Criteria (RDoC) project—aimed at ultimately improving the treatment and prevention of depression by studying the classification of mental illnesses, based on genetics and neuroscience in addition to clinical observation.

POST-TRAUMATIC STRESS DISORDER (PTSD)

WHAT IS POST-TRAUMATIC STRESS DISORDER, OR PTSD?

PTSD is an anxiety disorder that some people get after seeing or living through a dangerous event.

When in danger, it's natural to feel afraid. This fear triggers many split-second changes in the body to prepare to defend against the danger or to avoid it. This "fight-or-flight" response is a healthy reaction meant to protect a person from harm. But in PTSD, this reaction is changed or damaged. People who have PTSD may feel stressed or frightened even when they're no longer in danger.



WHO GETS PTSD?

Anyone can get PTSD at any age. This includes war veterans and survivors of physical and sexual assault, use, accidents, disasters, and many other serious events.

Not everyone with PTSD has been through a dangerous event. Some people get PTSD after a friend or family member experiences danger or is harmed. The sudden, unexpected death of a loved one can also cause PTSD.

WHAT ARE THE SYMPTOMS OF PTSD?

PTSD can cause many symptoms. These symptoms can be grouped into three categories:

1. Re-experiencing symptoms:

- Flashbacks—reliving the trauma over and over, including physical symptoms like a racing heart or sweating
- Bad dreams
- Frightening thoughts.

Re-experiencing symptoms may cause problems in a person's everyday routine. They can start from the person's own thoughts and feelings. Words, objects, or situations that are reminders of the event can also trigger re-experiencing.

2. Avoidance symptoms:

- Staying away from places, events, or objects that are reminders of the experience
- Feeling emotionally numb
- Feeling strong guilt, depression, or worry
- Losing interest in activities that were enjoyable in the past
- Having trouble remembering the dangerous event.

Things that remind a person of the traumatic event can trigger avoidance symptoms. These symptoms may cause a person to change his or her personal routine. For example, after a bad car accident, a person who usually drives may avoid driving or riding in a car.

3. Hyperarousal symptoms:

- Being easily startled
- Feeling tense or “on edge”
- Having difficulty sleeping, and/or having angry outbursts.

Hyperarousal symptoms are usually constant, instead of being triggered by things that remind one of the traumatic event. They can make the person feel stressed and angry. These symptoms may make it hard to do daily tasks, such as sleeping, eating, or concentrating.

It’s natural to have some of these symptoms after a dangerous event. Sometimes people have very serious symptoms that go away after a few weeks. This is called acute stress disorder, or ASD. When the symptoms last more than a few weeks and become an ongoing problem, they might be PTSD. Some people with PTSD don’t show any symptoms for weeks or months.

DO CHILDREN REACT DIFFERENTLY THAN ADULTS?

Children and teens can have extreme reactions to trauma, but their symptoms may not be the same as adults. In very young children, these symptoms can include:

- Bedwetting, when they’d learned how to use the toilet before
- Forgetting how or being unable to talk
- Acting out the scary event during playtime
- Being unusually clingy with a parent or other adult.

Older children and teens usually show symptoms more like those seen in adults. They may also develop disruptive, disrespectful, or destructive behaviors. Older children and teens may feel guilty for not preventing injury or deaths. They may also have thoughts of revenge. For more information, see the NIMH booklets on helping children cope with violence and disasters.

HOW IS PTSD DETECTED?

A doctor who has experience helping people with mental illnesses, such as a psychiatrist or psychologist, can diagnose PTSD. The diagnosis is made after the doctor talks with the person who has symptoms of PTSD.

To be diagnosed with PTSD, a person must have all of the following for at least 1 month:

- At least one (1) re-experiencing symptom
- At least three (3) avoidance symptoms
- At least two (2) hyperarousal symptoms
- Symptoms that make it hard to go about daily life, go to school or work, be with friends, and take care of important tasks.

WHY DO SOME PEOPLE GET PTSD AND OTHER PEOPLE DO NOT?

It is important to remember that not everyone who lives through a dangerous event gets PTSD. In fact, most will not get the disorder.

Many factors play a part in whether a person will get PTSD. Some of these are risk factors that make a person more likely to get PTSD. Other factors, called resilience factors, can help reduce the risk of the disorder. Some of these risk and resilience factors are present before the trauma and others become important during and after a traumatic event.

Risk factors for PTSD include:

- Living through dangerous events and traumas
- Having a history of mental illness
- Getting hurt
- Seeing people hurt or killed
- Feeling horror, helplessness, or extreme fear
- Having little or no social support after the event
- Dealing with extra stress after the event, such as loss of a loved one, pain and injury, or loss of a job or home.

Resilience factors that may reduce the risk of PTSD include:

- Seeking out support from other people, such as friends and family
- Finding a support group after a traumatic event
- Feeling good about one's own actions in the face of danger
- Having a coping strategy, or a way of getting through the bad event and learning from it
- Being able to act and respond effectively despite feeling fear.
- Researchers are studying the importance of various risk and resilience factors. With more study, it may be possible someday to predict who is likely to get PTSD and prevent it.

HOW IS PTSD TREATED?

The main treatments for people with PTSD are psychotherapy ("talk" therapy), medications, or both. Everyone is different, so a treatment that works for one person may not work for another. It is important for anyone with PTSD to be treated by a mental health care provider who is experienced with PTSD. Some people with PTSD need to try different treatments to find what works for their symptoms.

If someone with PTSD is going through an ongoing trauma, such as being in an abusive relationship, both of the problems need to be treated. Other ongoing problems can include panic disorder, depression, substance use, and feeling suicidal.

WHAT EFFORTS ARE UNDER WAY TO IMPROVE THE DETECTION AND TREATMENT OF PTSD?

Researchers have learned a lot in the last decade about fear, stress, and PTSD. Scientists are also learning about how people form memories. This is important because creating very powerful fear-related memories seems to be a major part of PTSD. Researchers are also exploring how people can create “safety” memories to replace the bad memories that form after a trauma. NIMH’s goal in supporting this research is to improve treatment and find ways to prevent the disorder.

PTSD research also includes the following examples:

- Using powerful new research methods, such as brain imaging and the study of genes, to find out more about what leads to PTSD, when it happens, and who is most at risk.
- Trying to understand why some people get PTSD and others do not. Knowing this can help health care professionals predict who might get PTSD and provide early treatment.
- Focusing on ways to examine pre-trauma, trauma, and post-trauma risk and resilience factors all at once.
- Looking for treatments that reduce the impact traumatic memories have on our emotions.
- Improving the way people are screened for PTSD, given early treatment, and tracked after a mass trauma.
- Developing new approaches in self-testing and screening to help people know when it’s time to call a doctor.
- Testing ways to help family doctors detect and treat PTSD or refer people with PTSD to mental health specialists.

For more information on PTSD research, please see NIMH’s PTSD Research online Fact Sheet or the PTSD Clinical Trials Web site.

SOCIAL PHOBIA

WHAT IS SOCIAL PHOBIA?

Social phobia is a strong fear of being judged by others and of being embarrassed. This fear can be so strong that it gets in the way of going to work or school or doing other everyday things.



Everyone has felt anxious or embarrassed at one time or another. For example, meeting new people or giving a public speech can make anyone nervous. But people with social phobia worry about these and other things for weeks before they happen.

People with social phobia are afraid of doing common things in front of other people. For example, they might be afraid to sign a check in front of a cashier at the grocery store, or they might be afraid to eat or drink in front of other people, or use a public restroom. Most people who have social phobia know that they shouldn't be as afraid as they are, but they can't control their fear. Sometimes, they end up staying away from places or events where they think they might have to do something that will embarrass them. For some, social phobia is a problem only in certain situations, while others have symptoms in almost any social situation.

Social phobia usually starts during youth. A doctor can tell that a person has social phobia if the person has had symptoms for at least 6 months. Without treatment, social phobia can last for many years or a lifetime.

WHAT ARE THE SIGNS AND SYMPTOMS OF SOCIAL PHOBIA?

People with social phobia tend to:

- Be very anxious about being with other people and have a hard time talking to them, even though they wish they could
- Be very self-conscious in front of other people and feel embarrassed
- Be very afraid that other people will judge them
- Worry for days or weeks before an event where other people will be
- Stay away from places where there are other people
- Have a hard time making friends and keeping friends
- Blush, sweat, or tremble around other people
- Feel nauseous or sick to their stomach when with other people.

WHAT CAUSES SOCIAL PHOBIA?

Social phobia sometimes runs in families, but no one knows for sure why some people have it, while others don't. Researchers have found that several parts of the brain are involved in fear and anxiety. Some researchers think that misreading of others' behavior may play a role in causing social phobia. For example, you may think that people are staring or frowning at you when they truly are not. Weak social skills are another possible cause of social phobia. For example, if you have weak social skills, you may feel discouraged after talking with people and may worry about doing it in the future. By learning more about fear and anxiety in the brain, scientists may be able to create better

treatments. Researchers are also looking for ways in which stress and environmental factors may play a role.

HOW IS SOCIAL PHOBIA TREATED?

First, talk to your doctor about your symptoms. Your doctor should do an exam to make sure that an unrelated physical problem isn't causing the symptoms. The doctor may refer you to a mental health specialist. Social phobia is generally treated with psychotherapy, medication, or both.

Psychotherapy. A type of psychotherapy called cognitive behavioral therapy (CBT) is especially useful for treating social phobia. It teaches a person different ways of thinking, behaving, and reacting to situations that help him or her feel less anxious and fearful. It can also help people learn and practice social skills.

Medication. Doctors also may prescribe medication to help treat social phobia. The most commonly prescribed medications for social phobia are anti-anxiety medications and antidepressants. Anti-anxiety medications are powerful and there are different types. Many types begin working right away, but they generally should not be taken for long periods.

Antidepressants are used to treat depression, but they are also helpful for social phobia. They are probably more commonly prescribed for social phobia than anti-anxiety medications. Antidepressants may take several weeks to start working. Some may cause side effects such as headache, nausea, or difficulty sleeping. These side effects are usually not a problem for most people, especially if the dose starts off low and is increased slowly over time. **Talk to your doctor about any side effects you may have.**

A type of antidepressant called monoamine oxidase inhibitors (MAOIs) are especially effective in treating social phobia. However, they are rarely used as a first line of treatment because when MAOIs are combined with certain foods or other medicines, dangerous side effects can occur.

It's important to know that although antidepressants can be safe and effective for many people, they may be risky for some, especially children, teens, and young adults. A "black box"—the most serious type of warning that a prescription drug can have—has been added to the labels of antidepressant medications. These labels warn people that antidepressants may cause some people to have suicidal thoughts or make suicide attempts. Anyone taking antidepressants should be monitored closely, especially when they first start treatment.

Another type of medication called beta-blockers can help control some of the physical symptoms of social phobia such as excessive sweating, shaking, or a racing heart. They are most commonly prescribed when the symptoms of social phobia occur in specific situations, such as "stage fright."

Some people do better with CBT, while others do better with medication. Still others do best with a combination of the two. Talk with your doctor about the best treatment for you.

OPPOSITIONAL DEFIANT DISORDER

DEFINITION

Even the best-behaved children can be difficult and challenging at times. But if your child or teen has a frequent and persistent pattern of anger, irritability, arguing, defiance or vindictiveness toward you and other authority figures, he or she may have oppositional defiant disorder (ODD).



As a parent, you don't have to go it alone in trying to manage a child with ODD. Doctors, counselors and child development experts can help.

Treatment of ODD involves therapy, training to help build positive family interactions and skills to manage behaviors, and possibly medications to treat related mental health conditions.

SYMPTOMS

Sometimes it's difficult to recognize the difference between a strong-willed or emotional child and one with oppositional defiant disorder. It's normal to exhibit oppositional behavior at certain stages of a child's development.

Signs of ODD generally begin during preschool years. Sometimes ODD may develop later, but almost always before the early teen years. These behaviors cause significant impairment with family, social activities, school and work.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association, lists criteria for diagnosing ODD. This manual is used by mental health providers to diagnose mental conditions and by insurance companies to reimburse for treatment.

DSM criteria for diagnosis of ODD show a pattern of behavior that:

- Includes at least four (4) symptoms from any of these categories — angry and irritable mood; argumentative and defiant behavior; or vindictiveness
- Occurs with at least one (1) individual who is not a sibling
- Causes significant problems at work, school or home
- Occurs on its own, rather than as part of the course of another mental health problem, such as a substance use disorder, depression or bipolar disorder
- Lasts at least six (6) months

DSM-5 criteria for diagnosis of ODD include both emotional and behavioral symptoms.

Angry and irritable mood:

- Often loses temper
- Is often touchy or easily annoyed by others
- Is often angry and resentful

Argumentative and defiant behavior:

- Often argues with adults or people in authority
- Often actively defies or refuses to comply with adults' requests or rules
- Often deliberately annoys people
- Often blames others for his or her mistakes or misbehavior

Vindictiveness:

- Is often spiteful or vindictive
- Has shown spiteful or vindictive behavior at least twice in the past six months

These behaviors must be displayed more often than is typical for your child's peers. For children younger than five (5) years, the behavior must occur on most days for a period of at least six (6) months. For individuals five (5) years or older, the behavior must occur at least once (1) a week for at least six (6) months.

ODD can vary in severity:

- **Mild.** Symptoms occur only in one (1) setting, such as only at home, school, work or with peers.
- **Moderate.** Some symptoms occur in at least two (2) settings.
- **Severe.** Some symptoms occur in three (3) or more settings.

For some children, symptoms may first be seen only at home, but with time extend to other settings, such as school and with friends.

When to see a doctor

Your child isn't likely to see his or her behavior as a problem. Instead, your child will probably believe that unreasonable demands are being placed on him or her. But if your child has signs and symptoms common to ODD that are more frequent than is typical for his or her peers, make an appointment with your child's doctor.

If you're concerned about your child's behavior or your own ability to parent a challenging child, seek help from your doctor, a child psychologist or behavioral expert. Your primary care doctor or your child's pediatrician can refer you to the appropriate professional.

CAUSES

There's no known clear cause of oppositional defiant disorder. Contributing causes may be a combination of inherited and environmental factors, including:

- **Genetics** — a child's natural disposition or temperament and possibly neurobiological differences in the way nerves and the brain function
- **Environment** — problems with parenting that may involve a lack of supervision, inconsistent or harsh discipline, or use or neglect

RISK FACTORS

Oppositional defiant disorder is a complex problem. Possible risk factors for ODD include:

- **Temperament** — a child who has a temperament that includes difficulty regulating emotions, such as being highly emotionally reactive to situations or having trouble tolerating frustration
- **Parenting issues** — a child who experiences use or neglect, harsh or inconsistent discipline, or a lack of parental supervision
- **Other family issues** — a child who lives with parent or family discord or has a parent with a mental health or substance use disorder

COMPLICATIONS

Children with oppositional defiant disorder may have trouble at home with parents and siblings, in school with teachers, at work with supervisors and other authority figures, and may struggle to make and keep friends and relationships.

ODD may lead to problems such as:

- Poor school and work performance
- Antisocial behavior
- Impulse control problems
- Substance use disorder
- Suicide

Many children with ODD also have other mental health conditions, such as:

- Attention-deficit/hyperactivity disorder (ADHD)
- Depression
- Anxiety
- Conduct disorder
- Learning and communication disorders

Treating these other mental health conditions may help improve ODD symptoms. And it may be difficult to treat ODD if these other conditions are not evaluated and treated appropriately.

TESTS AND DIAGNOSIS

To determine whether your child has oppositional defiant disorder, the mental health provider can do a comprehensive psychological evaluation. This evaluation will likely include an assessment of:

- Your child's overall health
- The frequency and intensity of your child's behaviors
- Your child's behavior across multiple settings and relationships
- The presence of other mental health, learning or communication disorders

Related mental health issues

Because ODD often occurs along with other behavioral or mental health problems, symptoms of ODD may be difficult to distinguish from those related to other problems. It's important to diagnose and treat any co-occurring problems because they can create or worsen ODD symptoms if left untreated.

LIFESTYLE AND HOME REMEDIES

At home, you can begin chipping away at problem behaviors of oppositional defiant disorder by practicing these strategies:

- **Recognize and praise** your child's positive behaviors. Be as specific as possible, such as, "I really liked the way you helped pick up your toys tonight."
- **Model the behavior** you want your child to have.
- **Pick your battles** and avoid power struggles. Almost everything can turn into a power struggle, if you let it.
- **Set limits** and enforce consistent reasonable consequences.
- **Set up a routine** by developing a consistent daily schedule for your child. Asking your child to help develop that routine may be beneficial.
- **Build in time together** by developing a consistent weekly schedule that involves you and your child spending time together.
- **Work with your partner** or others in your household to ensure consistent and appropriate discipline procedures. Enlist support from teachers, coaches and other adults who spend time with your child.
- **Assign a household chore** that's essential and that won't get done unless the child does it. Initially, it's important to set your child up for success with tasks that are relatively easy to achieve and gradually blend in more important and challenging expectations. Give clear, easy-to-follow instructions.
- **Be prepared for challenges early on.** At first, your child probably won't be cooperative or appreciate your changed response to his or her behavior. Expect behavior to temporarily worsen in the face of new expectations. This is called an "extinction burst" by behavior therapists. Remaining consistent in the face of increasingly challenging behavior is the key to success at this early stage.

With perseverance and consistency, the initial hard work often pays off with improved behavior and relationships.

COPING AND SUPPORT

Being the parent of a child with oppositional defiant disorder isn't easy. Counseling can provide an outlet for frustrations and concerns. In turn, this can lead to better outcomes for your child because you'll be more prepared to deal with problem behaviors. Maintaining your health through relaxation, supportive relationships, and effective communication of your concerns and needs are important elements during treatment of ODD.

PREVENTION

There's no guaranteed way to prevent oppositional defiant disorder. However, positive parenting and early treatment can help improve behavior and prevent the situation from getting worse. The earlier that ODD can be managed, the better.

Treatment can help restore your child's self-esteem and rebuild a positive relationship between you and your child. Your child's relationships with other important adults in his or her life — such as teachers, community supports and care providers — also will benefit from early treatment.

SUICIDE: PREVENTABLE MENTAL HEALTH PROBLEM

HOW COMMON IS SUICIDE IN CHILDREN AND TEENS?

In 2009, suicide was the third leading cause of death for young people ages 15–24. In this age group, suicide accounted for 14.4 percent of all deaths in 2009.

While these numbers may make suicide seem common, it is important to realize that suicide and suicidal behavior are not healthy or typical responses to stress.

WHAT ARE SOME OF THE RISK FACTORS FOR SUICIDE?

Risk factors vary with age, gender, or ethnic group. They may occur in combination or change over time. Some important risk factors are:

- Depression and other mental disorders
- Substance-use disorder (often in combination with other mental disorders)
- Prior suicide attempt
- Family history of suicide
- Family violence including physical or sexual use
- Firearms in the home
- Incarceration
- Exposure to suicidal behavior of others, such as family members or peers
- However, it is important to note that many people who have these risk factors are not suicidal.

WHAT ARE SIGNS TO LOOK FOR?

The following are some of the signs you might notice in yourself or a friend that may be reason for concern.

- Talking about wanting to die or to kill oneself
- Looking for a way to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings.
- Seeking help is a sign of strength, if concerned, go with your instincts, and get help!

WHAT CAN I DO FOR MYSELF OR SOMEONE ELSE?

If you are concerned, immediate action is very important. Suicide can be prevented and most people who feel suicidal demonstrate warning signs. Recognizing some of these warning signs is the first step in helping yourself or someone you care about.

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