Bright Outcomes LLC

Reality Check Web Weekend

Client File

Documents

Client Name ________________

Bright Outcomes LLC
REALITY CHECK WEB WEEKEND

Reality Check Web Weekend Program
Participant Completion Report Page 1

To: **88th District Court ___** **88-2 District Court ___** **81st District Court ___**
Fax: **88th:(989) 354-9785** **88-2:(989) 785-8036** **81st:(989) 984-1021**

From: **Bright Outcomes LLC: Reality Check Web Weekend Program**
Fax: **(231) 943-8935**
Date:

Regarding Client Participant: ___________________________
This letter is to verify that this participant has successfully completed the following content of Reality Check Web Weekend Program.

1. MAST and DAST
2. The Neuroscience of Substance Abuse and the Brain
3. DSM5 Values and Cognitive Therapy Approach to Substance Abuse
4. Stress, High Risk Behavior, Denial and Co-Occurring Disorders
5. Substance Use, Abuse and the Progressive Nature of Abuse
6. Medical Consequences of Alcohol and Drug Abuse
7. Cost/Benefit Analysis
8. Self-Defeating Behaviors and Cognitive Dissonance
9. Non-Violent Communications and Anger Management Skills
10. The Family: Effects of Drugs and Alcohol in Families Roles/Strategies
11. Highway Safety and Penalties
12. Self-Defeating Behaviors and Cognitive Dissonance
13. Victim Impact Presentation
14. Triggers, Relapse and Recovery, Chemical Dependency, How to Reduce Substance Abuse, Alternative Choices and Responsible Drinking Patterns
15. Self-Help Groups: Alcoholics Anonymous and SMART Recovery Programs
16. Strategies for Making an Effective Change Plan
17. Final interviews and Evaluation

Bright Outcomes LLC
REALITY CHECK WEB WEEKEND

Upon review of client's participation Reality Check Web Weekend Program, and review of client's court ordered requirements (see list), we recommend the following additional course of action:

Court Requirement	Required	RCWW Counselor Recommendations
AA & Self-Help Groups		No additional RCWW Counselor Recommendations __x____
Assessment		
Community Service		
Drug and Alcohol Testing		
Fines and Costs		
Mental Health Counseling		
Substance Abuse Counseling		
Victim Restitution		
Other		

My signature below is to declare that:

- I have discussed the above recommendations with a Reality Check Web Weekend Counselor and I understand them.
- I understand that any recommendations by Reality Check Web Weekend Counselors do not override any existing court ordered requirements.
- I give Reality Check Web Weekend Counselor or Bright Outcomes LLC Staff permission to share this information with the court.

____
Participant Name

______________________________ __________________
Participant Signature Date

Reality Check Web Weekend Participant Response Summary

Participant Name: ________________________________Date ____________________________

Bright Outcomes Team is aware of the large amount of material presented to participants during Reality Check Web Weekend Intensive. Honest and candid client participant feedback about his/her experience of the Reality Check Web Weekend process is very important and valuable to our program.

Please fill out this survey and bring it to the Exit Interview. We thank you in advance for your cooperation in completing this survey.

1. When you first came to Reality Check Web Weekend, did you think the program would be a positive learning experience? ______

2. Upon completing the program, do you feel that the Reality Check Web Weekend program was a positive influence on you? ______

3. Was the material presented by the counselors in a clear and understandable way? ______

4. Did you feel that the counselors really cared about you? ______

5. Overall, did Reality Check Web Weekend influence your attitude about how drugs and alcohol will play a future role in your lifestyle? ______

6. Overall, did Reality Check Web Weekend influence how you view on drinking/ drugging and driving or your driving ability? ______

7. How would you rate the following segments of the program?

	Excellent	Very Good	Good	Fair
The counselors' presentations	○	○	○	○
Multimedia/videos messages	○	○	○	○
Topics	○	○	○	○
Break out groups/discussions	○	○	○	○

8. What immediate changes or actions will you take after of completing this program?
____

9. What was your main 'Reality Check' that you learned this weekend?
____

10. Overall, would you recommend this program to others? ______

11. After learning more about drugs and alcohol 'Reality Check Web Weekend' Program:
I now believe that, at the peak of my drug/alcohol during my life, my alcohol and drug patterns were:

Alcohol: Mild ○ Moderate ○ Severe ○ Drugs: Mild ○ Moderate ○ Severe ○

MAIL

Client File 02

CLIENT PARTICIPANT:

RESPONSES TO REALITY CHECK WEB WEEKEND PROGRAM (Page 1)

Please mark an x in the box next to each of your 5 most significant Reality Check Web Weekend Segments on the following list.

	Segment	
1	The Brain and Neuroscience	☐
2	Treatment Approaches, Movie "Pleasure Unwoven", and the Disease Concept	☐
3	Stress, High Risk Behavior, Denial, and Dual Diagnosis	☐
4	Venn Diagram and Medical Consequences	☐
5	Jellinek Chart of Progressive Nature of Alcoholism	☐
6	Cost/Benefit Analysis	☐
7	Self-Defeating Behaviors & Cog Dissonance	☐
8	Non-Violent Communications and Anger Management	☐
9	The Family: Effects of Drugs and Alcohol on the Family	☐
10	Movie "Flight"	☐
11	Highway Safety and Penalties	☐
12	Victim Impact Presentation	☐
13	Relapse, Recovery & Self-Help Groups	☐
14	Creating an Effective Change Plan	☐
15	Movie: "The Secret"	☐

CLIENT PARTICIPANT:

RESPONSES TO REALITY CHECK WEB WEEKEND PROGRAM **(Page 2)**

Re-write your responses from your Worksheet Journal to the 5 segments you marked on “Responses to Reality Check Web Weekend Program (Page 1).” on the lines below. If you need additional lined pages, your counselor has more available.
*Be sure to write your name at the top of any additional lined pages. *

CLIENT PARTICIPANT:

RESPONSES TO REALITY CHECK WEB WEEKEND COUNSELORS

MAIL

Client File 05

Change Plan

Participant Name ____

1. What change I plan to make (include the positive outcome intended):

   ____
   ____
   ____
   ____

2. Who I plan to involve to support me with my change:

   ____
   ____
   ____
   ____

3. When I plan to begin the steps to make the change, and how long I plan to sustain the change:

   ____
   ____
   ____
   ____

4. How I plan to make the change: Steps will include:

   ____
   ____
   ____
   ____
   ____
   ____

5. Where I plan to be when making the change (include all locations):

   ____
   ____
   ____

Change Plan Page 2

Participant Name ____

6. Why I want to make this change:

____
____
____
____

7. Potential obstructions, hurdles or habit patterns that may challenge me in being able to successfully make the change I want to make:

____
____
____
____

8. How I am planning to overcome these potential obstructions:

____
____
____
____

______________________________ ________________________

Participant Signature **Date**

Client Name: ______________________________________ **Date:** _______________________

The Michigan Alcoholism Screening Test (MAST)

Please circle either Yes or No for each item as it applies to you.

1.	Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)	Yes		No
2.	Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?	Yes		No
3.	Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?	Yes		No
4.	Can you stop drinking without a struggle after one or two drinks?	Yes		No
5.	Do you ever feel guilty about your drinking?	Yes		No
6.	Do friends or relatives think you are a normal drinker?	Yes		No
7.	Are you able to stop drinking when you want to?	Yes		No
8.	Have you ever attended a meeting of Alcoholics Anonymous (AA)?	Yes		No
9.	Have you gotten into physical fights when drinking?	Yes		No
10.	Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?	Yes		No
11.	Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?	Yes		No
12.	Have you ever lost friends because of drinking?	Yes		No
13.	Have you ever gotten into trouble at work or school because of drinking?	Yes		No
14.	Have you ever lost a job because of drinking?	Yes		No
15.	Have you ever neglected your obligations, your family or your work for two or more days in a row because you were drinking?	Yes		No
16.	Do you drink before noon fairly often?	Yes		No
17.	Have you ever been told you have liver trouble? Cirrhosis?	Yes		No
18.	After heavy drinking, have you ever had Delirium Tremens (D.T.$) or severe shaking, or heard voices or seen things that really were not there?	Yes		No
19.	Have you ever gone to anyone for help about your drinking?	Yes		No
20.	Have you ever been in a hospital because of drinking?	Yes		No
21.	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?	Yes		No
22.	Have you ever been seen at a psychiatric or mental health clinic, or gone to any doctor, social worker, or clergyman for help with an emotional problem, where drinking was part of the problem?			
23.	Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? YES, how many times?			
24.	Have you ever been arrested, or taken into custody even for a few hours, because of other drunk behavior? If YES, how many times? ( )	Yes		No

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Client File 08

DRUG ABUSE SCREENING TEST D.A.S.T.

Client Name: ________________________________ **Date** ________________________

In the statements below, "drug abuse" refers to (1) the use of over the counter or prescribed drugs in excess of the directions, and (2) any non-medical use of drugs. The various classes of drugs may include cannabis (marijuana, hash), solvents, tranquilizers (Valium), barbiturates, cocaine, stimulants (speed, amphetamine), hallucinogens (Ecstasy, crystal meth), or narcotics (heroin). Instruction: Write yes in left column or no in right column.

Remember the questions do not include alcohol and they cover use during the past 12 months.

	Yes	No
12. Have you used drugs other than those required for medical reasons?	_____	_____
13. Have you abused prescription drugs?	_____	_____
14. Do you abuse more than one drug at a time?	_____	_____
15. Can you get through the week without using drugs?	_____	_____
16. Are you always able to stop using drugs when you want to?	_____	_____
17. Have you had "blackouts" or "flashbacks" because of drug use?	_____	_____
18. Do you ever feel guilty about your drug use?	_____	_____
19. Does your spouse, or parents, ever complain about your drug use?	_____	_____
20. Had drug abuse created problems between you and your spouse or		
21. Your parents?	_____	_____
22. Have you lost friends because of your use of drugs?	_____	_____
23. Have you neglected your family because of your drug use?	_____	_____
24. Have you been in trouble at work because of your drug use?	_____	_____
25. Have you lost a job because of drug abuse?	_____	_____
26. Have you gotten into fights when under the influence of drugs?	_____	_____
27. Have you engaged in illegal activities in order to obtain drugs?	_____	_____
How many times? __________		
28. Have you been arrested for possession of illegal drugs?	_____	_____
29. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	_____	_____
30. Have you had medical problems as a result of your drug use (memory loss, hepatitis, convulsions, bleeding, ER visit, etc.)?	_____	_____
31. Have you gone to anyone for help for a drug problem?	_____	_____
32. Have you been involved in a treatment program specifically related to drug	_____	_____
33. use?	_____	_____

__________Score _______________

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Client File 09