NEW DAY RECOVERY

Breakout Groups

Facilitator Packet

Small-group breakout groups • Five days per week • Two groups per day for clients to choose from

Every group in this packet is evidence-based. Grace is the tone, not shame. Evidence is cited honestly. Optional Scripture handouts are available separately, on request only — never required, and never part of required group time.

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Program	New Day Recovery — Senath, Missouri
For	Facilitators leading breakout groups
Group length	60 minutes per group
Packet contents	How to use this packet; weekly rotation framework; twenty-one facilitator outlines; appendix — Optional Scripture Handouts (B-1 to B-20)

The twenty topics

1. Domestic Violence — Safety First, Shame Never
2. Parenting Skills — Training in Love, Repairing in Grace
3. Life Skills — Building a Life That Holds
4. Relapse Prevention — Know the Ground Before the Battle
5. Giving Back (A Spirit of Service) — Service Keeps What Recovery Gave
6. Coping Skills (Development and Practice) — Skills Are Built by Reps
7. WRAP (Wellness Recovery Action Plan) — A Plan You Write for Your Own Wellness (Monday and Thursday outlines)
8. Nicotine Cessation — Breaking Free From Nicotine
9. Labels and the Power of Words — Shed the Labels, Define Yourself
10. Brain Science of Addiction and How It Heals in Recovery — The Brain Can Heal
11. Building and Maintaining Healthy Relationships — Boundaries, Honesty, and Trust Rebuilt
12. Managing Co-Occurring Mental Health Conditions — The Whole Person, Held Steady
13. Financial Recovery & Credit Rebuilding — Freedom Built One Step at a Time

14. Physical Health in Recovery — Tend the Body That Carries Recovery
15. Health and Wellness Basics — Sleep, Food, Movement, Hygiene, and When to Seek Care
16. Trigger & Warning Sign Mapping — Map Your Own Triggers and Warning Signs
17. Healthy Stress Management — Practical Skills for Stress
18. Life Skills for Stability — Housing Readiness and Employment Readiness
19. Identity Reconstruction & Purpose — Rebuilding Identity and Finding Purpose
20. Community Re-Engagement — Re-Entering Community Life

These twenty are the menu. WRAP runs twice a week; the other nineteen topics rotate across the remaining eight slots by current client needs, so not every topic runs every week — the rotation cycles across weeks so that every topic runs regularly and none is left out. Additional topics can be added later as the program grows, for further variation. WRAP is one topic in two outlines (Monday and Thursday), so the packet holds twenty-one outlines for twenty topics.

How to use this packet

Breakout groups give clients a real choice. Five days a week, two groups run and each client chooses the one that fits the work in front of them. Choice matters in recovery. A person who chooses the room is more likely to do the work in the room.

Each outline in this packet follows the same shape so a facilitator can pick any topic up and run it well: a clear purpose, a timed 60-minute plan, teaching points in plain language, discussion prompts, a practice activity clients do in the room, facilitator boundaries, and a Sources & Evidence box.

The standard for every group

- **What these groups are:** Recovery education and group support.
- These groups are DMH RSS support/educational groups.
- **What these groups are not:** These groups teach, support, and practice skills. They do not diagnose, and they do not replace individual clinical care, medical care, or a client's treatment plan.
- **Evidence-based core:** Every breakout group is taught from its evidence-based outline only. Scripture, faith teaching, and prayer are not part of the group, are not read aloud, taught, or practiced in the group, and are never required as group content. Faith-based lessons are never required, and faith content cannot be required — even in a faith-based program.
- **Grace, not shame:** No shame-based language, no public calling-out, and no war stories told for effect. Accountability is direct and kind. A setback is information for the next plan, not a verdict on a person.
- **Medication affirmed:** Medication for addiction treatment is a medical decision between a client and their prescriber. Facilitators affirm clients who use it as prescribed, never advise a client to start, stop, or change any medication, and refer every medication question to medical staff.
- **Optional Scripture handouts: A separate Optional Scripture Handout (Appendix, B-1 to B-20) exists for each topic, kept separate from the outline and from required group time. The facilitator mentions its availability neutrally, in one line only — "Optional Scripture handouts for this topic are available on request outside group time." — with no pressure, no invitation to respond in the room, and no comment on who does or does not ask. A handout is given only to a participant who requests one, and only outside required session time. Handout content is never delivered, read aloud, taught, or discussed as part of the required group.**
- **Requests never affect services:** Requests for a handout are never tracked in a way that affects services. Do not record a request as a measure of participation, progress, or compliance, do not note who did not ask, and never make a handout — or declining one — a condition of participation or services.

- **Care is never replaced:** Group support is never offered instead of medical care, safety help, or clinical support. When a client needs that help, the facilitator connects them to it the same day through program procedure.
- **Confidentiality and its limits:** What is shared in group stays in group, within the limits the program explains at admission — including danger to self or others and any reporting duty that applies. Facilitators state those limits plainly at the start of sensitive groups and never promise secrecy they cannot keep.
- **Right to pass:** Any client may pass on any prompt, step out with staff awareness if overwhelmed, and rejoin without explanation or penalty.

A 60-minute shape that holds for every topic

Time	Segment	What happens
0–5 min	Welcome and ground rules	Welcome, choice affirmed, ground rules and confidentiality limits stated in one minute.
5–30 min	Teaching	Teach the core points in plain language. Use the board. Keep it concrete.
30–45 min	Discussion	Work the prompts. Draw out quiet voices without forcing disclosure.
45–55 min	Practice	Clients do something in the room — a plan, a list, a rehearsal, a written step — not just talk about doing it.
55–60 min	Close	One takeaway per person who wants to share, and a clear note of any follow-up or referral made.

Materials for every group: whiteboard or flip chart and markers, paper and pens for every client, and the resource information for the topic. Topic-specific materials are listed in each outline.

Facilitator preparation — the work before the room

1. Read the full outline the day before. Do not walk in cold.
2. Review the teaching points, the practice activity, and the facilitator boundaries for the topic. Know what you will teach, what you will practice in the room, and what you will refer out.
3. Set the room: chairs in a circle or open U, materials out, distractions down.
4. Know your referral path before you need it — who on staff you go to, and how, if a client discloses danger, a medical concern, or a crisis.
5. After group, note attendance and any follow-up you promised. Do not record detailed personal disclosures in a general group note.

Weekly rotation framework

Two groups run each day, Monday through Friday; each client chooses one per breakout period — ten weekly slots. WRAP (Wellness Recovery Action Plan) is fixed twice weekly — Monday: Wellness Toolbox and Daily Maintenance; Thursday: Triggers, warning signs, and crisis planning — so the full WRAP framework is worked in order across the two sittings, drafting begun in the room. Breakout 7 holds two outlines, one for each sitting. The other nineteen topics rotate across the remaining eight slots: which run is facilitator choice, based on who is in the house and what they need, with the rotation cycling across weeks so that every rotating topic runs regularly and none is left out. The grid does not promise every topic every week.

Rotation principles

- WRAP is fixed twice weekly, Monday and Thursday. Eight of the other nineteen run each week, chosen by client need; the eleven resting topics run first the following week, longest-rested first, and rotate back in.
- Rotation cycle: The nineteen rotating topics cycle across weeks so every topic runs regularly and none is left out. The eleven topics that rest in a week run first the following week, longest-rested first. Over any three weeks, the eight rotating slots a week add up to 24 slots for 19 topics: every rotating topic runs at least once, and exactly 5 run twice. Keep a simple log of what ran, so the next week's choices follow the cycle instead of habit.
- Heavy and practical topics are balanced across the week. No day pairs two crisis-heavy topics.
- WRAP is taught across its two weekly sittings, in order: Monday, the Wellness Toolbox and the Daily Maintenance Plan; Thursday, Triggers, Early Warning Signs, When Things Are Breaking Down, the Crisis Plan, and the Post-Crisis Plan.
- Domestic Violence runs as described in its outline every time: survivor-safety-centered, no conjoint or couples work. Survivor-only, gender-specific sitting; see the Room Rule box in Breakout 1.
- If a group must be cancelled, keep the other choice running and carry it to its next rotated slot. Do not cancel a WRAP sitting without the Program Director's approval; a resting topic is not a cancellation.

Sample weekly grid — one week's pattern

Times, facilitators, and rooms are intentionally blank. Fill them in by hand or in the desk schedule for the week they apply. Do not print a time, name, or room that has not been assigned. Sample week only; Life Skills, Coping Skills, Nicotine Cessation, Labels, Brain Science of Addiction and How It Heals in Recovery, Health and Wellness Basics, Trigger & Warning Sign Mapping, Healthy Stress Management, Life Skills for Stability, Identity Reconstruction & Purpose, and Community Re-Engagement rest this week.

Day	Choice A	Choice B	Time / Facilitator / Room — A	Time / Facilitator / Room — B
Monday	WRAP —	Relapse Prevention	_____	_____

	Monday: Wellness Toolbox and Daily Maintenance			
Tuesday	Managing Co-Occurring Mental Health Conditions	Parenting Skills	_____	_____
Wednesday	Domestic Violence	Giving Back (A Spirit of Service)	_____	_____
Thursday	WRAP — Thursday: Triggers, Warning Signs, Crisis Planning, and Post-Crisis Plan	Financial Recovery & Credit Rebuilding	_____	_____
Friday	Building and Maintaining Healthy Relationships	Physical Health in Recovery	_____	_____

Why this pattern works: WRAP is fixed twice weekly, in order — Monday, the Wellness Toolbox and the Daily Maintenance Plan, so a client begins a draft grounded in their own strengths; Thursday, Triggers, Early Warning Signs, When Things Are Breaking Down, the Crisis Plan, and the Post-Crisis Plan, so both sittings together cover the whole framework. The nineteen other topics rotate by current client needs: in this sample week, Relapse Prevention opens Monday; Tuesday pairs co-occurring-disorders education with parenting; Wednesday pairs the safety group with service, so the heaviest topic is never the only choice; Thursday pairs the second WRAP sitting with financial recovery, a practical topic; Friday closes with healthy relationships and physical health. Life Skills, Coping Skills, Nicotine Cessation, Labels, Brain Science of Addiction and How It Heals in Recovery, Health and Wellness Basics, Trigger & Warning Sign Mapping, Healthy Stress Management, Life Skills for Stability, Identity Reconstruction & Purpose, and Community Re-Engagement rest this week and run first the following week, longest-rested first. The cycle works across weeks: the topics that rest run first the next week, longest-rested first, and over any three weeks the eight rotating slots a week add up to 24 slots for 19 topics, so every rotating topic runs at least once and exactly 5 run twice — so every topic runs regularly, none is left out, and the rotation flexes further as more topics are added.

Posting the choice

Post both choices where clients can see them before the breakout period — topic title, one plain sentence on what the group works on, time, facilitator, and room once assigned. Use the one-sentence descriptions from the top of each outline in this packet. Never post a description that promises an outcome, and never label a group in a way that shames the person who chooses it.

Blank weekly planning sheet

Day	Choice A — Topic / Time / Facilitator / Room	Choice B — Topic / Time / Facilitator / Room	Notes
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			

Week of: _____ Prepared by: _____ Approved by: _____

ESCALATION — IF SOMEONE MAY BE UNSAFE

If someone may be unsafe: stay with the person, ask directly, call 911 or 988, tell the Program Director or on-call supervisor the same hour, make no secrecy promise, document the same day, and follow up within 24 hours. See the Facilitator Guide crisis protocol.

Breakout 1 — Domestic Violence — Safety First, Shame Never

ROOM RULE — DOMESTIC VIOLENCE SITTING

This sitting is for survivors and people with lived experience of domestic violence only. People who have caused harm do not attend this sitting; accountability work goes to a separate accountability track — staff referral. This sitting is gender-specific. If both members of a pair arrive for the same sitting, the facilitator checks with staff BEFORE group: the survivor sitting goes ahead, the other person is offered the separate accountability track that day, and nothing is disclosed about either person. See the escalation box at the front of this packet and the Facilitator Guide crisis protocol. The facilitator does not ask participants who they are paired with and does not confirm attendance or anything disclosed. The staff check before group happens privately, without naming either person in the room. The gender this sitting serves in a given rotation is set by staff for that rotation and posted with the two daily choices, without disclosing who attends. Anyone who recognizes a partner or former partner in the room may step out at any time, tell staff privately, and return or not as they choose — no questions asked, and nothing disclosed. In a week when this sitting serves the other gender, a survivor is connected to an advocate the same day and is welcomed at the next sitting for their gender. If no advocate is reachable the same day, or the next sitting is more than one week away, staff name the interim contact, the check-in rhythm, and the date of the next sitting to the survivor privately the same day, and record only that the connection was made. This sitting runs as needed: the women's sitting every other week, and the men's sitting on the alternating weeks when there is a need.

Separate accountability track: a person who has caused harm does not attend the survivor sitting. The facilitator refers the person to staff the same day, before group, without disclosing anything about either person. Staff offer a separate accountability sitting on a different day, in a different room, where accountability work happens apart from the survivor group. The facilitator never carries messages, runs joint work, or confirms who attended either sitting. Staff hold the sitting; the facilitator never runs it.

One sentence for the board: Safety comes first, the person who caused harm owns that harm, and no one here has to earn safety by forgiving or reconciling.

Purpose	Help clients understand domestic violence clearly, center survivor safety in every part of the session, introduce safety planning as a personal and practical process led by the survivor, and connect any client who wants help to an advocate — without pressure, exposure, or couples work of any kind.

Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified; the Domestic Violence breakout is gender-specific. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. This sitting is for survivors and people with lived experience only. People who have caused harm do not attend this sitting; they go to a separate accountability track by staff referral. This sitting is gender-specific. If both members of a pair arrive for the same sitting, the facilitator checks with staff BEFORE group, the survivor sitting goes ahead, the other person is offered the separate accountability track that day, and nothing is disclosed. No participant is required to disclose anything to belong in this room. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Safety rules for this group — read before you facilitate

- **Safety first.** This group is survivor-safety-centered. If a teaching point and a survivor's safety ever conflict in the room, safety wins.
- **No couples work.** Never run conjoint or couples work in this group — no joint sessions, no mediated conversations, no messages carried between partners, and no exercises that put a survivor and a person who harmed them in the same work.
- **No pressure to forgive or reconcile.** Forgiveness and reconciliation are never presented as conditions of safety, healing, faithfulness, or program standing. A survivor may explore forgiveness in their own time, in their own faith, or not at all in this group. Facilitators do not steer toward it.
- **No required disclosure.** No one is pressed to name a person, describe an incident, or tell a story. General learning is always a complete way to participate.

- Know your lane. State confidentiality and its limits at the start, every time. If a client discloses current danger, tell the Program Director or on-call supervisor the same hour and connect them to staff and an advocate the same day. See the escalation box at the front of this packet. Do not investigate, confront any other person, or attempt rescue yourself. Document the disclosure the same day.
- Same-day pass-on — by category. Read aloud only: "If you tell us you are in danger now, we tell staff the same hour and connect you to an advocate the same day." See the facilitator card after these safety rules for the by-category detail, kept at the facilitator's seat.
- **Protect information.** Watch the room. A client may have a partner or former partner in the program. Never confirm or deny who attended, what was said, or what anyone is planning.

Time	Segment	What happens
0–5 min	Welcome and safety rules	Welcome, the safety rules above in plain language, confidentiality and limits, right to pass.
5–30 min	Teaching	What domestic violence is, why leaving is rarely simple, what safety planning is, and Lethality/Danger teaching (information only, 8 minutes within this segment). Cut point: if time runs short, shorten the discussion — never the Lethality/Danger teaching or the practice.
30–45 min	Discussion	Prompts below. General answers only — no one is asked for personal incidents.
45–55 min	Practice — private safety thinking	Clients privately work the safety-planning thinking sheet in this outline. Nothing is collected or read aloud.
55–60 min	Close and resources	Resources offered to everyone (not singled out), same-day staff follow-up for anyone who asks.

FACILITATOR CARD — SAME-DAY PASS-ON — BY CATEGORY (keep at the facilitator's seat; do not read aloud in full)

Disclosures of current danger go to the Program Director or on-call supervisor the same hour and to an advocate the same day. Disclosures that suggest a child may be unsafe, or any reporting duty that applies, go to the Program Director or on-call supervisor the same day. A participant who asks for advocate help is connected to an advocate and to staff the same day. Nothing disclosed in this group is held by the facilitator alone past the day it is shared. The connection is made privately, outside the group. The facilitator names the connection, does not investigate, and does not keep a list. Give the written note to the Program Director the same day;

do not keep your own list.

Read aloud only: “If you tell us you are in danger now, we tell staff the same hour and connect you to an advocate the same day.”

Teaching points

- Domestic violence is a pattern of coercive control by one person over a partner or family member. Coercive control means one person using threats, control of money, isolation, and fear to control another person's daily life. It can be physical, emotional, verbal, sexual, financial, spiritual, or digital — including monitoring a phone, controlling money, isolating a person from family and faith, and using threats about children, housing, or recovery.
- Substance use does not cause domestic violence, and sobriety alone does not end it. The two often travel together and each makes the other more dangerous, which is why safety planning belongs in recovery work.
- Leaving is rarely a single simple step. A survivor may depend on the other person for housing, income, transport, or care of children; may fear retaliation; may still love the person; and may have been told — sometimes in religious language — that leaving is failure. Shame keeps people isolated. Clear, non-judgmental information opens options.
- A safety plan is a personalized, practical plan a survivor builds for their own situation — while living in the situation, while preparing to leave, and after leaving. The survivor leads it, ideally with a trained advocate. This group introduces the thinking; it does not complete anyone's plan in the room.
- Faith language must never be used in this room to excuse harm, demand submission to danger, or rush forgiveness. Accountability for harm belongs to the person who caused it, and to appropriate legal and clinical processes — not to this group.
- **Lethality and danger — information only.** Teach these facts plainly, as information, not as an assessment of anyone in the room. Separation is a high-risk period: danger often rises when a person leaves or plans to leave. Strangulation is a serious danger sign. Access to firearms raises the risk of a killing. Stalking and technology monitoring — location sharing, phone tracking, shared accounts and passwords — can continue after separation and can reveal a survivor's plans. Each fact is paired with the same-day connection below: any participant who recognizes danger in their own situation is connected to an advocate and to staff the same day.
- **No in-group risk assessment.** The facilitator does not assess any participant's risk in group, does not score danger, and does not complete a safety plan for anyone in the room. The facilitator teaches the information, offers the resources to everyone, and connects any participant who asks — or who discloses current danger — to an advocate and to staff the same day.

Discussion prompts

- “What makes it hard for any person — not anyone here specifically — to ask for help when home is not safe?”
- “What does a safe, respectful relationship actually look like day to day? Name ordinary things.”

- “What can friends, family, and community members do that genuinely helps — and what well-meant responses can make things worse?”
- “Where could a person in this county start if they wanted to talk to an advocate, with no commitment to any course of action?”

Practice — private safety-planning thinking (10 minutes, never collected)

Give every participant the same sheet so no one is singled out. Participants write only for themselves and keep or fold away their sheet as they choose. A sheet goes to an advocate only, at the survivor's choice — never to staff for safekeeping. If no advocate is at hand, keep your practice sheet with you, or with a trusted person you choose. Do not leave it in the room, and do not hand it to staff for safekeeping. A basket or bin is in the room for anyone choosing to destroy their sheet here rather than carry it home. A sheet taken home can be found — decide before you leave where it will sleep tonight, and do not carry it anywhere it can be found by the person who harmed you.

- People: one trusted person who knows the situation, and a code word or signal that means “call for help.”
- Place: the safest room in the home, a neighbor or nearby place to go, and how to get there.
- Essentials: medicines, keys, phone charger, important papers or photos of them, and a small bag kept with a trusted person if that is safe.
- Children and dependents: what they should do, where they should go, and what signal they know.
- Technology: passwords, location sharing, and which device is safest for seeking help.
- After leaving: where to stay first, who to tell, and what documents or orders to ask an advocate or attorney about.

Resources — offer to everyone, every time

Read these aloud as information for anyone, for any reason, and keep printed copies where any client can take one without asking:

- **National Domestic Violence Hotline:** Call 1-800-799-7233 or text START to 88788. Advocates offer confidential support and safety planning and can connect callers with local services.
- **988 Suicide and Crisis Lifeline:** Call or text 988.
- **SAMHSA National Helpline:** Call 1-800-662-4357 for treatment referrals and information.
- **Immediate danger:** Call 911 if it is safe to do so.

Local shelter, advocate, and legal-aid information for the Senath area is posted and handed out from the program's current local resource sheet. Facilitators: use only that current sheet for local names and numbers. If you do not have it in the room, get it from staff before group — do not work from memory.

Facilitator boundaries — Domestic Violence

- Do not counsel a couple together, carry messages, verify one person's story with another, or contact any partner or family member.

- Do not promise that a disclosure stays only with you. Tell the Program Director or on-call supervisor the same hour, and follow any reporting duty that applies. See the escalation box at the front of this packet and the Facilitator Guide crisis protocol.
- Do not document detailed disclosures in a general group note. Route safety concerns to the Program Director or on-call supervisor the same day, and document the same day.
- **Warrior close:** Close in strength, not exposure: “You deserve to be safe. Needing a plan is not weakness — it is wisdom. Warriors protect life, starting with their own.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57 (2014) — trauma-informed principles, safety, and avoiding re-traumatization in behavioral health settings.

Recovery-support evidence: National Domestic Violence Hotline — confidential advocacy and personalized safety planning (thehotline.org; 1-800-799-7233; text START to 88788). Safety planning in this outline follows the Hotline's survivor-led model; this group introduces it and refers out for a full plan.

Note: No outcome is promised for any group in this packet.

Breakout 2 — Parenting Skills — Training in Love, Repairing in Grace

One sentence for the board: Children do not need a perfect parent. They need a present, consistent parent who repairs honestly when they get it wrong.

Purpose	Build practical parenting skills for recovery — structure, consistency, calm discipline, connection, and honest repair — for clients who are parenting now, parenting from a distance, or preparing to reunite with their children.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who is a parent, grandparent in a parenting role, expectant parent, or working toward reunification. No participant is asked about custody, court, or case status in group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass.
5–30 min	Teaching	Connection before correction, structure and consistency, calm discipline, and repair.
30–45 min	Discussion	Prompts below, focused on practices — not on anyone's case or custody situation.

45–55 min	Practice — one routine, one repair	Clients design one daily routine and draft one repair conversation in writing.
55–60 min	Close	Takeaways, any staff follow-up promised is noted.

Teaching points

- Connection comes before correction. A child who feels seen and safe can hear guidance. Spend connection on purpose — meals, play, listening without a phone in hand — before the moments that require discipline.
- Structure is love made visible. Predictable routines for waking, meals, school, homework, and bedtime lower conflict for children and for the parent in recovery, whose own day also holds steadier inside structure.
- Consistency beats intensity. A few clear household expectations, stated calmly in advance, with known and proportionate consequences, followed through every time — that teaches more than a loud reaction delivered once.
- Discipline means teaching, not venting. Correct the behavior, name the expectation, keep your voice and body calm, and separate the child's worth from the child's action: “You are loved. That choice is not how we do things here. Here is what happens next.”
- Repair is a skill, and children learn it by watching it. When — not if — you lose your temper, miss a promise, or return to an old pattern, go back: name what you did without excuses, say you are sorry, state what you will do differently, and follow through. An honest repair builds more trust than a pretense of perfection.
- Parent at the distance you actually have. A call kept, a letter sent, a visit shown up for sober and on time — consistency in small kept promises is the work of reunification, wherever a family is in that process. Facilitators teach the parenting; they do not advise on any court or case matter.

Discussion prompts

- “What is one routine that made you feel safe as a child — or one you wish you had had?”
- “Where does discipline go wrong most often: unclear expectations, inconsistent follow-through, or a parent's own exhaustion? What helps each one?”
- “What does a good repair actually sound like, word for word?”
- “What is one small promise to a child that a parent can keep this week, exactly as promised?”

Practice — one routine, one repair (10 minutes)

1. Write one daily routine you will build or strengthen: the time, the steps, and what could knock it off course — and your plan for that.
2. Draft one repair in writing: what happened (no excuses), the apology, what will be different, and the follow-through you can actually deliver.

3. Volunteers may read a draft aloud for group feedback on wording. No one reads about a real child by name.

Check with staff/counselor before acting on any repair draft, especially where safety, court, or a no-contact order is involved. No amend contacts unless a reviewer clears a specific one. Never role-play a real victim.

Facilitator boundaries — Parenting Skills

- Never ask about or comment on custody, visitation, court dates, or case plans. Refer those questions to the client's own case contacts and program staff.
- If a client shares something that suggests a child may be unsafe, follow program procedure and any reporting duty that applies — the same day. Do not investigate in group.
- **Warrior close:** Close in grace: "You cannot parent yesterday again. You can parent today — present, consistent, and quick to repair. That is how trust is rebuilt: one kept day at a time."

Sources & Evidence

Clinical evidence: Centers for Disease Control and Prevention. Essentials for Parenting — evidence-informed parenting practices including positive communication, structure, and discipline that teaches. Strengthening Families Program — a family skills program with an evidence base in prevention and family strengthening; named here as background for the structure-and-connection approach, with no outcome promised for this group.

Recovery-support evidence: SAMHSA. Substance Use Disorder Treatment and Family Therapy. Treatment Improvement Protocol (TIP) Series 39 — family involvement, support for recovery, and relapse-prevention planning with family where appropriate and safe.

Note: No outcome is promised for any group in this packet.

Breakout 3 — Life Skills — Building a Life That Holds

One sentence for the board: Recovery holds when daily life holds — so we build daily life on purpose, one small system at a time.

Purpose	Teach and practice the daily systems recovery stands on: time, money, home, work, documents, appointments, and clear communication — in small steps a client can start this week.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant. This is the most practical group in the rotation and a good first breakout for a participant new to choosing groups. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules.
5–30 min	Teaching	The five systems: time, money, home, work and appointments, communication.
30–45 min	Discussion	Prompts below.
45–55 min	Practice — this week's system	Each client picks one system and writes the first three steps, with dates.
55–60 min	Close	Takeaways.

Teaching points

- Time. Keep one calendar — paper is fine — and put everything on it: groups, appointments, work, family, rest. Review tomorrow before bed tonight. A missed appointment is usually a missing system, not a character flaw.
- Money. Know what comes in, what must go out, and in what order: essentials first, obligations second, everything else after. Track spending in writing for two weeks before judging it. Small leaks sink budgets; find them without shame and plug one at a time.
- Home. A living space that is clean, stocked with basics, and paid on time protects recovery. Build simple weekly rhythms — laundry, cleaning, groceries, bills — on set days so nothing piles up into a crisis.
- Work and appointments. Keep documents together in one folder: identification, certificates, program papers, pay records. Prepare the night before. Arrive early. If you will be late or miss, communicate before, not after — that habit alone rebuilds a reputation.
- Communication. Say what you mean, plainly and respectfully: state the facts, state what you need, propose a time or step, and confirm what was agreed. In writing when it matters. Clear communication prevents most of the conflicts that used to end in use.
- Start embarrassingly small. One system, one step, done daily, beats a total life overhaul announced on Monday and abandoned by Thursday. Consistency in small systems is the training ground for everything bigger.

Discussion prompts

- “Which of the five systems is strongest in your life right now? Which is leaking?”
- “What is one task you keep avoiding that would take less than an hour to start? What makes it heavy?”
- “Who taught you how to handle money and time — and what did they teach you that you want to keep, and what do you want to do differently?”

Practice — this week's system (10 minutes)

1. Choose one system: time, money, home, work and appointments, or communication.
2. Write the first three steps, each small enough to finish, with the day you will do each one.
3. Name the obstacle most likely to appear and your if–then plan for it: “If ___ happens, then I will ___.”
4. Pair up briefly: read your steps to a partner, who checks only one thing — is each step small and dated?

Facilitator boundaries — Life Skills

- Teach systems, not personal finance advice. Do not review a client's debts, benefits, taxes, or legal documents in group, and do not recommend specific financial or legal decisions. Refer those to qualified help through program staff.

- **Warrior close:** Close in dignity: “Nobody drifts into a life that holds. It is built — one list, one calendar, one kept appointment at a time. Build today's piece well.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. SAMHSA's working definition of recovery and its four major dimensions — health, home, purpose, and community — which frame the life-systems approach in this outline.

Recovery-support evidence: Casey Life Skills (Casey Family Programs) — a widely used framework for assessing and building practical life skills, named here as the framework background for the skills domains covered. Recovery-support application in this packet: peer practice, written weekly steps, and accountability in group.

Note: No outcome is promised for any group in this packet.

Breakout 4 — Relapse Prevention — Know the Ground Before the Battle

One sentence for the board: Return to use is a process, not a bolt from the blue — and a process can be interrupted at every step.

Purpose	Teach clients to recognize the relapse process early — warning signs, triggers, people, places, and high-risk situations — and to leave every session with a written, personal prevention and escape plan.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant, at any stage. Especially valuable before weekends, passes, transitions, and discharge — whenever it runs in the rotation, give its weekend-plan focus extra weight for participants facing a weekend, pass, transition, or discharge. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules. State plainly: a craving is information, not failure.
5–30 min	Teaching	The five-stage relapse process (Drift; Setup / denial; High-risk situation; Craving / decision point; Use), warning signs, triggers, and high-risk situations.
30–45 min	Discussion	Prompts below.

45–55 min	Practice — my prevention plan	Every client writes or updates a personal plan (template below).
55–60 min	Close	Plans stated in one line by volunteers, follow-ups noted.

Teaching points

- Relapse is a process before it is an event, in five stages: Drift; Setup / denial; High-risk situation; Craving / decision point; Use — the same five stages as the Warning-Sign Chain worksheet (Handout 4). It often begins with emotional drift — resentment, isolation, exhaustion, dishonesty, skipping support — long before any substance appears. Learn your own earliest signs; intervention is easiest at the first step, not the last.
- Know your triggers in four families: people, places, things, and states of body and mind — including hunger, anger, loneliness, and tiredness. A trigger is not a command. It is a cue to run your plan.
- Cravings rise, peak, and fall. The work in a craving is to delay, distract, reach out, and remember — in that order if needed — until it passes. Tell someone before you act, every time. Secrecy is the relapse process's best protection; honesty breaks it.
- Build your high-risk list honestly: the street, the person, the payday pattern, the family argument, the celebration. For each one, write the alternative in advance — a different route, a different plan, a person to call, a place to go.
- Protect the basics that protect everything else: sleep, food, meetings and groups, honest contact with support people, and any medication taken exactly as prescribed. When the basics slip, risk rises — treat slipping basics as a warning sign, not a small thing.
- If a lapse happens, the plan is immediate honesty and immediate return: tell your support people and staff, get safe, and re-engage the very next step. A lapse reported quickly is a detour. A lapse hidden becomes a road back.

Discussion prompts

- “What are your earliest warning signs — the ones that show up days before any real danger?”
- “Which high-risk situation is most likely for you in the next seven days, specifically?”
- “Who is on your call list, honestly — and would you actually call them at the hard moment? What would make the call easier to make?”

Practice — my prevention plan (10 minutes, clients keep their plan)

1. My earliest warning signs are: (write three).
2. My top three high-risk situations are: (write them, with the alternative planned for each).
3. When craving hits, I will: delay by ___ minutes, do ___, and call ___ or ___.
4. My way of escape in the hardest moment I can foresee is: (write the route, the place, and the person).

5. If I lapse, within the same day I will: (write who you will tell and where you will go).

Facilitator boundaries — Relapse Prevention

- This group teaches planning; it does not review or revise any client's individual treatment or medication plan. Refer clinical questions to clinical and medical staff.
- If a client discloses current use, danger, or a plan to leave and use, follow program procedure the same day. Respond with the plan, not with shock or shame.
- **Warrior close:** Close like a briefing: “No warrior walks into known ground without a plan. You have one now, in writing. Keep it close, tell your people, and use it early — that is how battles are won before they start.”

Sources & Evidence

Clinical evidence: Marlatt, G. A., and Gordon, J. R. (Eds.). Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors (1985) — the foundational relapse-prevention model: high-risk situations, warning signs, and coping planning. Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol series on substance use disorder treatment and family therapy — relapse-prevention and family-support principles consistent with that model.

Recovery-support evidence: Peer and mutual-support participation, sponsor and support-person contact, and written personal prevention plans — standard recovery-support practices reflected in SAMHSA recovery-support guidance. No success rate is stated or implied for this group.

Note: No outcome is promised for any group in this packet.

Breakout 5 — Giving Back (A Spirit of Service) — Service Keeps What Recovery Gave

One sentence for the board: What was freely given to us becomes truly ours when we freely give it away.

Purpose	Help clients discover service as a strength of recovery — gratitude put into action, purpose rebuilt by usefulness, and community restored one act at a time — with healthy boundaries that protect early recovery.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant. Participants very early in recovery focus on small, structured acts inside the program community; larger commitments wait until their own foundation is steady. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules.
5–30 min	Teaching	Why service strengthens recovery, forms it can take, and its boundaries.
30–45 min	Discussion	Prompts below.

45–55 min	Practice — my next act of service	Each client chooses and schedules one concrete act for this week.
55–60 min	Close	Acts named by volunteers.

Teaching points

- Service turns gratitude into action. Most clients arrived carried by other people's effort — staff, family, strangers, a neighbor, a donor they will never meet. Giving back answers that honestly, and gratitude practiced out loud protects against the resentment and self-pity that feed relapse.
- Service rebuilds identity. Addiction narrowed life to getting and using. Usefulness widens it again: I am a person who helps, who shows up, who is needed. That identity — a person who helps and shows up — is something no craving can argue with for long.
- Service connects. Isolation is dangerous ground. Serving alongside others — in this community or the wider community — builds the relationships and accountability that hold a person on hard days.
- Start where you stand: set up chairs, welcome a newcomer, make the coffee, clean what you did not dirty, write the thank-you note, sit with the person sitting alone. Small, finished, and unannounced beats grand, promised, and performed.
- Boundaries keep service healthy. Serve in measure: your own groups, sleep, family duties, and stability come first, because service that burns a person out serves no one for long. Never lend money as “service,” never carry another client's disclosures or errands outside program structure, and never serve for applause, status, or control. If it needs an audience, it is not service.
- Service is offered, never owed as penance. No client earns forgiveness, standing in this program by serving. Facilitators keep that order straight.

Discussion prompts

- “Who carried you at your lowest — and have you ever thanked them in a way they actually received?”
- “What is something you know how to do — a trade, a skill, a kindness — that this community could use this week?”
- “Where is the line for you between serving and overextending? How will you know when you are near it?”

Practice — my next act of service (10 minutes)

1. Write one act of service: specific, small enough to finish, inside your boundaries. Name what, where, and for whom.
2. Put it on a day this week. Tell the group if you want to — stating it aloud is the commitment step, and passing is complete. Volunteers name their acts at the close.

3. Note what you will not do: the boundary that keeps this act healthy for you and for the person receiving it.
4. If your act involves another person or program area, confirm it with staff before promising it.

Facilitator boundaries — Giving Back

- Never assign service as punishment or as a condition of standing, and never present service hours in this group as meeting any outside obligation.
- Route offers of skilled work, driving, money, or help outside the program through staff first. Good intentions still travel through structure.
- **Warrior close:** Close in gratitude: "You were carried here. This week, carry somebody a few steps — quietly, completely, and without keeping score. That is the spirit of this house."

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration — peer recovery support and recovery-community frameworks, in which helping others and community participation are core dimensions of recovery support. This outline applies that framework as group education; it makes no outcome claim.

Recovery-support evidence: Alcoholics Anonymous, Twelve Steps — Step Twelve carries the message and practices the principles as a recovery tradition. Cited here as recovery-support tradition, clearly distinct from clinical evidence, and presented as background — this group is not a Twelve Step meeting.

Note: No outcome is promised for any group in this packet.

Breakout 6 — Coping Skills (Development and Practice) — Skills Are Built by Reps

One sentence for the board: Coping is not a personality trait. It is a skill set — and skills are built by practice, in calm, so they hold under pressure.

Purpose	Teach a small, usable set of coping skills — noticing, breathing and grounding, reframing thoughts, riding out urges, and reaching out — and practice them in the room, every time, so clients leave with reps and not just information.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant. This group carries extra practice time by design: development and practice are the topic. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome and settle	Ground rules, one slow-breathing minute to open — practice starts immediately.
5–28 min	Teaching	The five skills, taught one at a time, briefly.
28–48 min	Practice rotations	Guided practice of each skill in the room (see Practice). This is

		the heart of the session.
48–55 min	Discussion	Prompts below — what worked, what was hard, what each client will keep.
55–60 min	Close	Each client names their first-choice skill.

Teaching points

- Skill 1 — Notice. Name what is happening before reacting to it: body (tight, hot, restless), feeling (angry, ashamed, lonely), and thought (“I can't stand this”). Naming slows the moment down and creates the space where a choice can live.
- Skill 2 — Breathe and ground. Slow the body first: breathe in slowly, out more slowly, several rounds. Then ground in the senses: name five things you see, four you hear, three you can touch, two you smell, one you taste. A settled body gives the mind a chance to work.
- Skill 3 — Reframe. Catch the thought driving the surge and test it: Is it the whole truth? What would I say to a friend thinking this? What is true instead — including what is true about the facts of the situation and my own progress?
- Skill 4 — Ride the urge. Urges and emotional surges rise, peak, and fall like a wave. Set a timer, surf the minutes with a skill — walk, water, a call — and watch the peak pass. Every ridden-out wave is proof the next one can be ridden too.
- Skill 5 — Reach out. The strongest skill is a person. Call or go to a support person, staff member, or meeting before the moment becomes a decision. Reaching out early is strength, and this program treats it that way.
- Build a personal order of battle: which skill first, which second, who to call third. Write it down. Under pressure, people do not rise to a new plan — they fall back on a practiced one.

Practice rotations (20 minutes — guided, in the room)

1. Breathing round (3 minutes): lead slow breathing aloud, eyes open or closed by choice.
2. Grounding round (4 minutes): lead the five-senses grounding; clients name items silently or aloud by choice.
3. Reframe drill (5 minutes): give three common thoughts (“Everyone here judges me,” “One slip erases everything,” “I will feel like this forever”). In pairs, test each one and write a truer replacement.
4. Urge-surf rehearsal (4 minutes): clients recall a mild, recent urge — not their worst moment — and walk their skill sequence aloud in pairs.
5. Reach-out rep (4 minutes): each client writes the exact words they would use to open a help-seeking call or conversation. Volunteers read theirs aloud; the group affirms the ask, never the struggle.

Discussion prompts

- “Which skill came most naturally? Which felt foreign — and does foreign mean useless, or just unpracticed?”
- “When this week are you most likely to need your first-choice skill? What is your if–then plan for that moment?”

Facilitator boundaries — Coping Skills

- Teach skills at an education level. If a client is in acute distress, is dissociating, or discloses trauma material that needs clinical care, steady the room, stay with the client, and connect them to clinical staff the same day. Do not process trauma in this group. See the escalation box at the front of this packet and the Facilitator Guide crisis protocol.
- Never frame a client's medication, diagnosis, or treatment as a coping failure. Skills support care; they never replace it.
- **Warrior close:** Close with the rep principle: “You do not need these skills to be perfect. You need them practiced. One rep today, one tomorrow — warriors are built in training, not in wishing.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services (TIP 57, 2014) and Anger Management for Substance Abuse and Mental Health Clients (SAMHSA) — grounding, self-regulation, and coping-skills education in behavioral health settings. Cognitive behavioral and dialectical behavior therapy skills literatures are the broader clinical background for reframing, grounding, and distress-tolerance skills; named generally here, with no specific outcome claimed for this group.

Recovery-support evidence: Written personal coping plans, in-session guided practice, and peer rehearsal — standard recovery-support practices. SAMHSA National Helpline, 1-800-662-4357, for referrals when a client needs support beyond this group.

Note: No outcome is promised for any group in this packet.

Breakout 7 — Monday: Wellness Toolbox and Daily Maintenance

One sentence for the board: Nobody knows your wellness better than you do — WRAP turns that knowledge into a written plan, in your own words, before you need it.

Purpose	Teach the first half of the WRAP framework as recovery education — the Wellness Toolbox and the Daily Maintenance Plan — and give every participant supported time to draft those parts. Teach the parts assigned to the day in depth and name the rest briefly, so a client who attends only one session still hears where it sits in the whole plan. Personal WRAP plans belong to the participant and stay with the participant.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant. Especially valuable for participants approaching transitions, passes, or discharge, and for any participant who wants their hard-won knowledge of their own warning signs written down where they can use it. No participant is asked to share the contents of their plan in group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens

0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: your WRAP is yours — drafts stay with you and are never collected.
5–30 min	Teaching	The Wellness Toolbox and the Daily Maintenance Plan, in depth, on the board; the Thursday parts named briefly. Teach the parts assigned to the day in depth and name the rest briefly, so a client who attends only one session still hears where it sits in the whole plan.
30–45 min	Discussion	Prompts below. General examples only — no one is asked to share their plan's contents.
45–55 min	Practice — draft your Toolbox and Daily Maintenance Plan	Participants start their own draft: the Wellness Toolbox, the "when I am well" description, and daily actions. Drafts stay with the participant.
55–60 min	Close	Takeaways, and a note of Thursday's sitting for participants building the later parts.

Teaching points

- **Where WRAP comes from.** WRAP — the Wellness Recovery Action Plan — was developed by Mary Ellen Copeland, working with people who had lived experience of mental health challenges, and is carried forward by the Copeland Center for Wellness and Recovery. It is a self-designed plan: the person it protects is the person who writes it. WRAP starts from strengths, not deficits. This group teaches the framework as recovery education and starts the drafting. A full WRAP is built and revised over time; it is not finished in one session, and it is never finished for good — it changes as you learn.
- **Wellness Toolbox.** The toolbox comes first because every later part of the plan draws from it. It is your personal list of things that help you stay well or feel better — people to contact, rest, food, movement, music, writing, time outside, meetings, and anything else that genuinely works for you. If it helps and it is safe, it belongs in the toolbox, whether or not it would help anyone else.

- **Daily Maintenance Plan.** Two parts. First, a plain description of what you are like when you are well — how you feel, act, and spend your day — written while you are well enough to recognize it. Second, the daily wellness actions that keep you there: the toolbox tools you use every day, plus the ordinary responsibilities you handle daily. On a hard day, this page answers the question: what does a well day for me actually require?
- **The rest of the framework, named briefly.** Thursday teaches the rest, in order: Triggers; Early Warning Signs; When Things Are Breaking Down; Crisis Plan; Post-Crisis Plan. A participant who attends only Monday still hears where each part sits in the whole plan.

Discussion prompts

- "What is in your Wellness Toolbox already — including things you use without calling them tools?"
- "What are you like when you are well, in ordinary words? What would someone who knows you say?"

Practice — draft your Toolbox and Daily Maintenance Plan (10 minutes, your plan stays with you)

1. Start your Wellness Toolbox: list at least five things that help you stay well or feel better.
2. Write your "when I am well" description: three to five plain sentences someone who knows you would recognize.
3. List your daily wellness actions: the toolbox tools and daily responsibilities that keep a well day well.
4. Note which Thursday part you most want to draft on Thursday — triggers, early warning signs, or the supporters you would name in a crisis plan — and bring this draft on Thursday.
5. Keep your draft. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — WRAP

- **The plan belongs to the client.** Facilitators do not collect, copy, photograph, file, or keep a client's WRAP or draft, and never require a client to show or share any part of it. A client may choose to share a Crisis Plan with supporters or staff — that choice, and exactly what is shared, is the client's.
- **Teach it as education.** This session is recovery education that teaches the WRAP framework and starts personal drafting. It is not a Copeland Center WRAP seminar and does not certify anyone — participant or facilitator — in WRAP. Do not present yourself as a certified WRAP facilitator unless you hold that credential.
- **Care is never replaced.** A WRAP supports a client's care; it does not replace their treatment plan, medication, or clinical support, and it never delays help. If a client is in crisis in the room, follow program procedure and connect them to staff the same day. The plan is preparation — it is not how an emergency in group is managed.

- **Warrior close:** Close with ownership: “Nobody here needs permission to know themselves. You know what keeps you well and what knocks you down — now it is getting written, in your words, where future-you can find it. That is a warrior's preparation.”
- **Escalation.** See the escalation box at the front of this packet and the Facilitator Guide crisis protocol.

How the plans fit together. A licensed counselor completed an assessment, safety plan, and treatment plan before the first group. The safety plan reviewed in Session 8 is the Appendix A / Handout 1 plan, and that counselor-completed safety plan governs in a crisis. The chain (Appendix C / Handout 4) is the participant's five-stage warning-sign worksheet — Drift; Setup / denial; High-risk situation; Craving / decision point; Use — carried by the participant to spot trouble early. A WRAP Crisis Plan is the participant's own written preferences for supporters; it supplements the counselor's safety plan and never replaces it. A WRAP is never collected: facilitators do not collect, copy, photograph, file, or keep it.

Sources & Evidence

Clinical evidence: Copeland Center for Wellness and Recovery — originator and steward of the Wellness Recovery Action Plan (WRAP), developed by Mary Ellen Copeland with people with lived experience of mental health challenges. The seven parts taught in this outline — Wellness Toolbox; Daily Maintenance Plan; Triggers; Early Warning Signs; When Things Are Breaking Down; Crisis Plan; Post-Crisis Plan — follow the WRAP framework as the Copeland Center presents it. WRAP is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice and was listed in NREPP in 2010; NREPP was discontinued in January 2018; the current resource is SAMHSA's Evidence-Based Practices Resource Center, which carries no NREPP ratings.

Recovery-support evidence: Cook, J. A., Copeland, M. E., Jonikas, J. A., et al. “Results of a Randomized Controlled Trial of Mental Illness Self-Management Using Wellness Recovery Action Planning.” Schizophrenia Bulletin, 38(4), 881–891 (2012) — in that trial of peer-led WRAP groups, participants reported greater reductions in psychiatric symptoms and greater improvements in hopefulness and quality of life than the comparison group, sustained at six-month follow-up. A further randomized trial by Cook and colleagues reported reduced self-reported need for and use of formal mental health services among WRAP participants over time. This outline teaches the framework as one hour of group education; it does not reproduce the studied multi-session, peer-led WRAP format, and, like every group in this packet, it promises no outcome.

Note: No outcome is promised for any group in this packet.

Breakout 7 — Thursday: Triggers, Warning Signs, Crisis Planning, and Post-Crisis Plan

One sentence for the board: You can spot trouble early and plan for it while you are well — including what supporters should do if you cannot speak for yourself.

Purpose	Teach the second half of the WRAP framework as recovery education — Triggers, Early Warning Signs, When Things Are Breaking Down, the Crisis Plan, and the Post-Crisis Plan — and give every participant supported time to draft those parts. Teach the parts assigned to the day in depth and name the rest briefly, so a client who attends only one session still hears where it sits in the whole plan. Personal WRAP plans belong to the participant and stay with the participant.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant. Especially valuable for participants approaching transitions, passes, or discharge, and for any participant who missed Monday — the Thursday-first recap names Monday's parts. No participant is asked to share the contents of their plan in group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every participant, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome and Thursday-first recap	Ground rules, confidentiality limits, right to pass. Thursday-first recap (2 minutes within this segment): the Wellness Toolbox and Daily Maintenance Plan in brief, for anyone who missed Monday. State plainly: your WRAP is yours — drafts stay with you and are never collected.
5–28 min	Teaching	Triggers, early warning signs, when things are breaking down, the Crisis Plan, and the Post-Crisis Plan, in order, on the board. Teach the parts assigned to the day in depth and name the rest briefly, so a client who attends only one session still hears where it sits in the whole plan.
28–43 min	Discussion	Prompts below. General examples only — no one is asked to share their plan's contents.
43–55 min	Practice — draft the Thursday parts	Participants draft the Thursday parts: triggers, early warning signs, breaking-down actions, Crisis Plan preferences, and the Post-Crisis Plan. Drafts stay with the participant.
55–60 min	Close	Takeaways, the Monday catch-up note, and which WRAP sitting comes next.

Teaching points

- **Monday's parts, named briefly.** The Wellness Toolbox is the personal list of things that help you stay well or feel better, and the Daily Maintenance Plan describes what you are like when you are well plus the daily actions that keep you there. Thursday teaches the rest in depth.
- **Triggers.** Triggers are external events or circumstances that, if they happened, could make things worse — an argument, bad news, a loss, a bill, a place, an anniversary. Naming them in

advance is not dwelling on them; it is reconnaissance. For each trigger, the plan names an action plan: the toolbox actions you will use if it happens, decided before the moment arrives.

- **Early Warning Signs.** Early warning signs are internal and subtle — changes in sleep, appetite, patience, thinking, or follow-through that tell you things are beginning to move the wrong way while you are still managing. They are easy to explain away in the moment, which is exactly why they are written down in advance. The plan pairs them with an action plan: the stronger daily actions you will take as soon as you notice them.
- **When Things Are Breaking Down.** This part names the signs that things are clearly getting worse — you are uncomfortable and at risk, but can still act on your own behalf with effort. The action plan here is firmer and more specific: which tools to use, which obligations to set down for now, who to tell, and what help to accept. The purpose is to take charge early enough that a crisis does not have to happen.
- **Crisis Plan.** The Crisis Plan is written while you are well, for a time when you may not be able to speak for yourself. It names your supporters and what you want them to do and not do, who should be contacted and who should not, your preferences for care and for help with responsibilities at home, and what has helped — and not helped — in past crises. Unlike the rest of the plan, this part is often shared with supporters on purpose, by your choice, so they can follow it.
- **Post-Crisis Plan.** Recovery after a crisis is planned, not improvised: what you need in the first days, who checks on you, how you ease back into daily responsibilities, what supporters can do that genuinely helps, and what you learned that should be folded back into the earlier parts of the plan. A crisis that teaches you something makes the whole plan stronger.

Monday catch-up: a participant who missed Monday is not behind. The Thursday-first recap names Monday's parts, and Monday's drafting is picked up at the next Monday sitting. Nothing is gated, and no participant waits to join Thursday.

Discussion prompts

- “Which is harder to spot in yourself: a trigger arriving from outside, or an early warning sign starting inside? What helps you catch each one?”
- “Who would you want named in a crisis plan — and what would you want them to know before a crisis, not during one?”
- “What should a Post-Crisis Plan hold for the first days after a crisis — and what did a past crisis teach that belongs in the earlier parts of the plan?”

Practice — draft the Thursday parts (12 minutes, your plan stays with you)

1. Draft your Triggers: name two external events or circumstances that could make things worse, and the toolbox action you will use for each.

2. Draft your Early Warning Signs: name two internal, subtle changes, and the stronger daily actions you will take as soon as you notice them.

3. Draft When Things Are Breaking Down: the signs that things are clearly getting worse, which tools you will use, which obligations you will set down, who you will tell, and what help you will accept.

4. Draft your Crisis Plan preferences: supporters and what you want them to do and not do, who should and should not be contacted, your preferences for care and for help with responsibilities, and what has helped — and not helped — in past crises. Sharing this part with supporters is your choice.

5. Draft your Post-Crisis Plan: what you need in the first days, who checks on you, how you ease back into daily responsibilities, and what you learned that should be folded back into the earlier parts of the plan.

6. Keep your draft. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — WRAP (Thursday)

- **The plan belongs to the client.** Facilitators do not collect, copy, photograph, file, or keep a client's WRAP or draft, and never require a client to show or share any part of it. A client may choose to share a Crisis Plan with supporters or staff — that choice, and exactly what is shared, is the client's.
- **Teach it as education.** This session is recovery education that teaches the WRAP framework and starts personal drafting. It is not a Copeland Center WRAP seminar and does not certify anyone — participant or facilitator — in WRAP. Do not present yourself as a certified WRAP facilitator unless you hold that credential.
- **Care is never replaced.** A WRAP supports a client's care; it does not replace their treatment plan, medication, or clinical support, and it never delays help. If a client is in crisis in the room, follow program procedure and connect them to staff the same day. The plan is preparation — it is not how an emergency in group is managed.
- **Escalation.** See the escalation box at the front of this packet and the Facilitator Guide crisis protocol.
- **Warrior close: Close with ownership: "You planned for trouble while you were well — that is preparation future-you can use.** Keep the draft with you, share only what you choose, and let the plan grow as you learn."

How the plans fit together. A licensed counselor completed an assessment, safety plan, and treatment plan before the first group. The safety plan reviewed in Session 8 is the Appendix A / Handout 1 plan, and that counselor-completed safety plan governs in a crisis. The chain (Appendix C / Handout 4) is the participant's five-stage warning-sign worksheet — Drift; Setup / denial; High-risk situation; Craving / decision point; Use — carried by the participant to spot trouble early. A WRAP Crisis Plan is the participant's own written preferences for supporters; it supplements the counselor's safety plan and never replaces it. A WRAP is never collected: facilitators do not collect, copy, photograph, file, or keep it.

Clinical evidence: Copeland Center for Wellness and Recovery — originator and steward of the Wellness Recovery Action Plan (WRAP), developed by Mary Ellen Copeland with people with lived experience of mental health challenges. The seven parts taught in this outline — Wellness Toolbox; Daily Maintenance

Plan; Triggers; Early Warning Signs; When Things Are Breaking Down; Crisis Plan; Post-Crisis Plan — follow the WRAP framework as the Copeland Center presents it. WRAP is recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA) as an evidence-based practice and was listed in NREPP in 2010; NREPP was discontinued in January 2018; the current resource is SAMHSA's Evidence-Based Practices Resource Center, which carries no NREPP ratings.

Recovery-support evidence: Cook, J. A., Copeland, M. E., Jonikas, J. A., et al. "Results of a Randomized Controlled Trial of Mental Illness Self-Management Using Wellness Recovery Action Planning." Schizophrenia Bulletin, 38(4), 881–891 (2012) — in that trial of peer-led WRAP groups, participants reported greater reductions in psychiatric symptoms and greater improvements in hopefulness and quality of life than the comparison group, sustained at six-month follow-up. A further randomized trial by Cook and colleagues reported reduced self-reported need for and use of formal mental health services among WRAP participants over time. This outline teaches the framework as one hour of group education; it does not reproduce the studied multi-session, peer-led WRAP format, and, like every group in this packet, it promises no outcome.

Note: No outcome is promised for any group in this packet.

Breakout 8 — Nicotine Cessation — Breaking Free From Nicotine

One sentence for the board: Nicotine dependence is treatable — a quit date, a coping plan, and real support beat willpower alone.

Purpose	Teach nicotine cessation as recovery education: what nicotine dependence is and which products carry it, what tobacco and nicotine use do to health and what quitting gives back, and the evidence-based ways people quit — behavioral counseling and coping strategies, a written quit plan, and pharmacotherapy education with referral to medical providers. Every participant who wants one leaves with a personal quit plan: a quit date, named triggers, a coping step for each trigger, and a nicotine-free routine and environment to support it.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who smokes, vapes, or uses smokeless tobacco or

	other nicotine products — whether they are ready to set a quit date today or only thinking about it. No participant is shamed for current use, and no participant is required to set a quit date in this group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: this group is education, not medical advice — medication questions go to medical providers.
5–30 min	Teaching	The teaching points below, in order, on the board: dependence, the neurobiology, and the products; health effects and the benefits of quitting; why nicotine is so hard to quit; what works to quit; quit planning; and quitting alongside the rest of recovery.
30–45 min	Discussion	Prompts below. Each client speaks from their own experience; no one is pressed to commit to a date before they are ready.
45–55 min	Practice — write your quit plan	Clients write a personal quit plan: quit date, triggers, a coping step for each, support people, and one change to their daily routine and environment. Plans stay with the client.
55–60 min	Close	Takeaways, quit dates shared by anyone who wants to share theirs, and the referral path for anyone who wants medical support to quit.

Teaching points

- **Nicotine dependence.** Nicotine is the addictive drug in tobacco products and in most vaping products. Dependence is not a character flaw and it is not simply a habit: nicotine changes how the brain responds, producing cravings, withdrawal discomfort when a person stops, and a strong pull to use again — which is why quitting usually takes planning and support, and why many people make more than one quit attempt before they quit for good. Each attempt teaches something the next one uses.
- **The neurobiology — receptors and dopamine.** Nicotine binds to nicotinic acetylcholine receptors — receptors built for the brain's own messenger, acetylcholine, which is involved in attention, learning, and alertness. The subtype most central to dependence is the alpha4beta2 receptor. When nicotine activates these receptors on dopamine-producing neurons, dopamine is released in the brain's reward pathways, including the nucleus accumbens — the same reward circuitry other addictive substances act on — and that dopamine signal teaches the brain: this matters, repeat it. That is the start of dependence, and it is chemistry, not character.
- **Upregulation, desensitization, and withdrawal.** With repeated use, the receptors adapt. After activation, many receptors become desensitized — switched off for a time — and with chronic use the brain upregulates these receptors, increasing their number. The adapted brain now expects nicotine to feel normal: tolerance builds, and when nicotine clears — between cigarettes, overnight, or on a quit attempt — the system is left out of balance, producing withdrawal: craving, irritability, anxiety, restlessness, low mood, poor concentration, increased appetite, and disturbed sleep. The next cigarette, vape, or dip relieves that state quickly, so use is reinforced twice — by the reward when nicotine arrives, and by relief when withdrawal ends. This is why dependence is learned at the receptor level, why withdrawal eases as receptors readjust over time, and why medication that acts on this same system can take the edge off while new routines are built.
- **The products.** Cigarettes are the most common source, but they are not the only one. Cigars and other smoked tobacco, smokeless tobacco (chewing tobacco and snuff, including pouches), and e-cigarettes and vapes all deliver nicotine and all can maintain dependence. A client who has stopped smoking but vapes or uses smokeless tobacco has changed products, not yet broken the dependence — name that honestly and without judgment, because the quit plan has to cover every product the client uses.
- **Health effects.** The Centers for Disease Control and Prevention (CDC) is direct about the harm: smoking damages nearly every organ of the body and causes serious disease, including cancer, heart disease, stroke, and lung diseases such as COPD; smokeless tobacco causes cancers of the mouth, esophagus, and pancreas and harms the mouth and teeth; nicotine itself is harmful in pregnancy and to the developing adolescent brain. Secondhand smoke harms the people around the smoker, including children. There is no product switch inside this list that makes nicotine use safe.
- **Benefits of quitting.** Quitting helps at any age, and the body begins recovering soon after the last use — the CDC describes benefits that start within minutes to hours, including heart rate and carbon monoxide levels moving back toward normal, and continue for years as the added risks of heart disease, stroke, and cancer fall. Breathing, circulation, taste, and smell commonly improve. Quitting also protects the people the client lives with, and it removes a daily trigger and expense that press on the rest of recovery. No specific timeline or result is promised to

any client — the honest claim is the CDC's: quitting is one of the most important steps a person can take for their health.

- **Why nicotine is so hard to quit.** Clients often ask how a legal product can be harder to put down than the illicit substances they have already stopped — sometimes including the substances that brought them to this program. The mechanisms explain it, and the comparative evidence agrees. Availability: nicotine is legal, sold nearly everywhere, and usable all day in most settings, so a craving is rarely more than minutes from an answer. Speed: smoked nicotine reaches the brain within seconds, and rapid delivery strengthens the learning that binds use to reward. Frequency: a cigarette is not one event — every puff is a small dose and a small reinforcement, repeated many times a day, every day, often for years, giving nicotine more daily practice than almost any other pattern of drug use. Pairing: because use is so frequent, nicotine becomes welded to ordinary life — waking, coffee, meals, driving, work breaks, stress, celebration, the phone, other people's company — so the triggers are not one place or one crowd a person can avoid; they are the whole day. Mild intoxication: nicotine does not visibly intoxicate the way alcohol or other drugs do, so use can continue alongside work, family, and even treatment, with no immediate consequence that interrupts the pattern. The comparative evidence matches the mechanisms: in the National Comorbidity Survey's comparison of dependence across substances (Anthony, Warner, & Kessler, 1994), the share of people who had used a substance and went on to develop dependence was higher for tobacco than for alcohol or the controlled substances compared. And relapse after a quit attempt is the common pattern in nicotine dependence, much as it is in other substance use disorders — which is why the clinical practice guideline treats tobacco dependence as a chronic, relapsing condition to be managed over time, not a bad habit to break once by force of will.
- **Behavioral counseling and coping.** The evidence is consistent across the sources in this outline's Sources & Evidence box: behavioral support works, medication works, and the two together work better than either alone. Behavioral counseling — individual, group, and telephone counseling, including quitlines — helps people plan a quit, build coping skills, and stay quit. Coping strategies for cravings are practical: delay (cravings peak and pass), deep breathing, drinking water, and doing something else with hands and attention; avoiding or reworking the situations tied to use; and telling support people what helps. This group is itself one piece of that behavioral support. The national quitline is 1-800-QUIT-NOW (1-800-784-8669): free, confidential telephone counseling that connects callers to their state's quitline.
- **Quit planning.** A quit plan turns a wish into a date and a set of steps. It names: a quit date, close enough to prepare for and soon enough to matter; the client's personal triggers — times, places, people, feelings, and routines tied to use; a coping step chosen in advance for each trigger; support people who will be told about the quit and asked for specific help; and a plan for the first hard days, including what to do with cigarettes, lighters, and ashtrays, and what to do instead during smoke breaks and after meals. Written plans are kept by the client and revised after any slip — a revised plan is progress, not failure.
- **Pharmacotherapy education.** Three kinds of medication are approved to help adults quit and are covered in this group as education only. Nicotine replacement therapy (NRT) — patch, gum, lozenge, inhaler, and nasal spray — supplies nicotine without the other harmful chemicals in tobacco smoke, easing withdrawal while the client breaks the routines of use; some forms are sold over the counter and others are prescription. Varenicline and bupropion are prescription medications that reduce cravings and withdrawal in different ways. Cochrane

systematic reviews and the clinical practice guideline find that these medications, behavioral support, and especially the combination increase the chances of quitting successfully. Which medication, if any, is right for a client — and its dose, duration, interactions, and safety for that client — is a medical decision. Facilitators teach what these options are and refer every client who is interested to a medical provider; facilitators never prescribe, never recommend a specific medication or dose to a client, and never advise a client to start, stop, or change any medication. Ask your provider/pharmacist about risks before starting any cessation medication.

- **Quitting nicotine supports the rest of recovery.** An older idea in treatment held that a client should not try to quit nicotine while working on other substances — that quitting smoking would put sobriety at risk, so cigarettes were left alone, sometimes even treated as a lesser evil that helped a person cope. The evidence has moved against that idea. A meta-analysis of randomized trials of smoking cessation interventions delivered during addiction treatment (Prochaska, Delucchi, & Hall, 2004) found that taking part in a cessation intervention was associated with a greater likelihood of long-term abstinence from alcohol and illicit drugs — not a lesser one. Later systematic reviews, including a Cochrane review of tobacco cessation for people in treatment for or recovery from substance use disorders (Apollonio and colleagues, 2016) and a systematic review and meta-analysis by Thurgood and colleagues (2016), found that cessation treatment helped people stop tobacco and did not worsen substance use outcomes. Recent national evidence points the same direction: a National Institute on Drug Abuse (NIDA)–funded analysis of the national PATH Study, published in JAMA Psychiatry, found that adults who had quit cigarette smoking were more likely to be in sustained remission from their other substance use disorder than when they continued to smoke. The pattern makes sense in the room: continued nicotine use keeps the daily rituals of addiction practiced — craving, ritual, relief — and keeps a person tied to the places and company where other substances circulate. Quitting nicotine removes a standing trigger, builds lived proof that cravings can be survived, and lets one recovery reinforce the other. The choice and the timing of a quit attempt still belong to the client, made with their treatment team — but no one in this group will be told that protecting their recovery requires keeping nicotine.
- **Relapse prevention, nicotine-specific.** Nicotine has its own relapse pattern, and it deserves its own plan inside the client's wider relapse-prevention work. The common nicotine-specific risks: the “just one” cigarette, dip, or hit off a vape, which commonly reopens full use; alcohol and other substance use, which lower resolve and are often paired with smoking; other people smoking or vaping nearby, and being offered a product socially; stress and strong emotion; and the built-in daily pairings — waking up, coffee, driving, meals, breaks, and the phone. For each risk, the plan names the coping step in advance. A slip is data: what happened, what the plan missed, what changes. It is never a verdict, and it never erases the days already quit.
- **A nicotine-free routine and environment.** Quitting holds better when the day itself is rebuilt. Clients plan a nicotine-free routine: new break activities and break places, a different route or morning order where the old one was built around use, hands and mouth occupied (water, gum, a toothpick, a task), and regular meals, movement, and sleep protecting the basics. And a nicotine-free environment: tobacco, vaping devices, lighters, and ashtrays out of the home, room, and vehicle; clothes and spaces aired and cleaned; support people asked not to offer

products or use around the client where that can be arranged. Environment is willpower's backup — set it up while motivation is high.

Cut points — teaching (25 minutes): teach the points in order. If time runs short, compress “Why nicotine is so hard to quit” and “Quitting nicotine supports the rest of recovery” to one sentence each, and shorten the product list — never cut the quit-planning steps, the pharmacotherapy-education and referral lines, the quitline number, or the practice. Cut teaching, never skill practice.

Discussion prompts

- “Which product or products carry your nicotine use right now — and which daily moment is most tightly tied to using?”
- “What have you already noticed, in your body or your day, that makes you want your health back from nicotine?”
- “What got in the way on a past quit attempt — and what would a plan do about that specific thing this time?”
- “Who would you want in your corner for a quit — and what exactly would you ask them to do, or not do?”

Practice — write your quit plan (10 minutes, your plan stays with you)

1. Set a quit date. If you are not ready to set one, write the date you will decide by — and what you will do between now and then to get ready.
2. List your top three triggers — the times, places, people, or feelings most tied to your use.
3. For each trigger, write one coping step you will use instead: delay, breathe, water, walk, call, or leave the spot — chosen now, not in the moment.
4. Name your support: one person you will tell, the specific help you will ask for, and whether you want a referral to a medical provider to talk about medication options.
5. Choose one routine change and one environment change to make before your quit date — a new break plan, and tobacco, devices, and lighters out of one space you control.

Facilitator boundaries — Nicotine Cessation

- **Education only; referral always.** This group teaches cessation options as recovery education. Facilitators do not provide medical advice, do not prescribe, and do not recommend a specific medication, product, or dose to any client. Every question about whether a medication is right for a client, and every medication decision, is referred to the client's medical provider or program medical staff — the same day the client asks.
- **Medication decisions belong to providers.** Facilitators never advise a client to start, stop, or change any medication — including any medication for addiction treatment. A client using cessation medication exactly as their provider directed is affirmed, the same as any client using medication as prescribed.
- **No shame for use or for slips.** Nicotine dependence is a treatable, relapsing condition, and a return to use is handled like any return to use in this packet: as information for the next plan,

never as shame, discipline in group, or a verdict on the client's recovery. Do not single out clients who still use, and do not use group time to police use outside the room — program rules are staff's to enforce through program procedure, not through this group.

- **Care is never replaced.** A quit plan supports a client's care; it does not replace medical evaluation, treatment for tobacco-related disease, or the client's treatment plan. Chest pain, breathing difficulty, or any other medical concern raised in group is referred to medical staff the same day.
- **Warrior close:** Close with the plan, not the pressure: “Nobody in this room has to white-knuckle this. You have a date, a plan for the hard moments, people in your corner, and medical help you can ask for. That is how warriors take ground — prepared, supported, and one day at a time.”

Sources & Evidence

Clinical evidence: Centers for Disease Control and Prevention (CDC), Office on Smoking and Health — health effects of cigarette smoking and smokeless tobacco use, the harms of nicotine in pregnancy and adolescent brain development, secondhand smoke, and the benefits of quitting, which begin soon after quitting and continue over years. American Lung Association — tobacco and nicotine cessation education for the public and for people helping others quit. Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline, 1-800-662-4357, for treatment referrals. U.S. Preventive Services Task Force (USPSTF), Tobacco Smoking Cessation in Adults, Including Pregnant Persons (2021) — a Grade A recommendation that clinicians ask all adults about tobacco use, advise them to stop, and provide behavioral interventions and U.S. Food and Drug Administration–approved pharmacotherapy for cessation to nonpregnant adults who use tobacco; the USPSTF found the evidence on e-cigarettes as a cessation aid insufficient and directs patients to interventions with proven effectiveness. National Institute on Drug Abuse (NIDA) — research and research reporting on tobacco use disorder and on the association between quitting smoking and improved recovery from other substance use disorders. Substance Abuse and Mental Health Services Administration (SAMHSA) — tobacco dependence addressed as part of substance use disorder treatment in behavioral health programs. Wittenberg, R. E., Wolfman, S. L., De Biasi, M., & Dani, J. A. “Nicotinic Acetylcholine Receptors and Nicotine Addiction.” Neuropharmacology (2020), and De Biasi, M., & Dani, J. A. “Reward, Addiction, Withdrawal to Nicotine.” Annual Review of Neuroscience, 34, 105–130 (2011) — nicotine acting mainly through alpha4beta2-containing nicotinic acetylcholine receptors, increasing dopamine neuron firing and dopamine release in reward pathways; chronic exposure producing neuroadaptations including receptor upregulation and long-term desensitization; a withdrawal syndrome developing when nicotine is removed.

Recovery-support evidence: Treating Tobacco Use and Dependence: 2008 Update, Clinical Practice Guideline (Fiore, M. C., et al., U.S. Public Health Service) — tobacco dependence treated as a chronic condition; effective treatments include behavioral counseling and the approved cessation medications, and combining counseling with medication is more effective than either alone. Cochrane systematic reviews of nicotine replacement therapy, varenicline, bupropion, and behavioral support for smoking cessation — each finds that the treatment increases the chances of quitting successfully compared with placebo or minimal support. Anthony, J. C., Warner, L. A., & Kessler, R. C. “Comparative Epidemiology of Dependence on Tobacco, Alcohol, Controlled Substances, and Inhalants.” Experimental and Clinical Psychopharmacology, 2(3), 244–268 (1994) — among people who had used each substance, dependence developed in a higher share of tobacco users than of alcohol users or users of the controlled substances compared. Prochaska, J. J., Delucchi, K., & Hall, S. M. “A Meta-Analysis of Smoking Cessation Interventions With Individuals in Substance Abuse Treatment or Recovery.” Journal of Consulting and Clinical Psychology, 72(6), 1144–1156 (2004) — cessation interventions during addiction treatment were associated with an increased likelihood of long-term abstinence from alcohol and illicit drugs. Apollonio, D., Philipps, R., &

Bero, L. “Interventions for Tobacco Use Cessation in People in Treatment for or Recovery From Substance Use Disorders.” Cochrane Database of Systematic Reviews (2016), and Thurgood, S. L., and colleagues, systematic review and meta-analysis (2016) — cessation treatment increased tobacco abstinence and did not worsen substance use outcomes. Parks, M. J., and colleagues, JAMA Psychiatry (2025) — an analysis of the national Population Assessment of Tobacco and Health (PATH) Study, funded by the National Institutes of Health and the U.S. Food and Drug Administration and reported by the National Institute on Drug Abuse (NIDA): quitting cigarette smoking was associated with greater odds of sustained remission from a non-tobacco substance use disorder. No statistics or quit rates are claimed in this outline, and no outcome is promised to any participant: which medication, if any, is appropriate is decided by the client with a medical provider, never in this group.

Note: No outcome is promised for any group in this packet.

Breakout 9 — Labels and the Power of Words — Shed the Labels, Define Yourself

One sentence for the board: A label is somebody else's sentence about you — you do not have to serve it.

Purpose	Teach how labels and words shape identity and behavior — stigma, labeling, and the stigma a person turns inward — and why person-first language about substance use matters for help-seeking and recovery. Give every participant structured time to name the labels they have carried, from family, from systems, and from themselves, examine each one honestly, and begin re-authoring: shedding the terms that defined them and defining themselves, in their own words. What a participant writes in this group belongs to the participant and stays with the participant.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant. Especially valuable for participants who introduce themselves by their worst chapter, who hesitate to ask for help because of what they have been called, or who are approaching discharge and deciding who they will be outside this program. No participant is required to share a label, a story, or anything they write. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip

	chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: nothing you write in this group is collected, and no one has to say a label out loud to belong here.
5–30 min	Teaching	The teaching points below, in order, on the board: how labels stick, stigma turned inward, person-first language, examining a label, and re-authoring.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to disclose their own labels.
45–55 min	Practice — name it, test it, re-author it	Clients privately work the three-part practice in this outline: name the labels, test one, and write the words they choose instead. Writing stays with the client.
55–60 min	Close	Takeaways. Anyone who wants to may read only the words they chose for themselves — never the labels they shed — and the facilitator notes any follow-up a client asks for.

Teaching points

- **Labels stick, and then they steer.** Every person in this room has been handed words: names from family, words from courtrooms, clinics, and case files, words from the street, and words from the mirror at 3 a.m. A label is a word or phrase other people — or we ourselves — attach to a person until it starts to sound like the person's name. Labels are powerful because they do not stay descriptions. Repeated often enough, a label becomes an expectation, then an identity, then a set of instructions a person starts living out. A stigmatized attribute can swallow the whole person in other people's eyes — the person stops being seen as a whole person and is seen as the mark. The companion point is: when a label is applied and enforced by people with authority, a person can be pushed toward living inside it, because the labeled role starts to be the only role left open.

- **Whose lens is it?** Stigma is several things happening together: people are labeled and set apart, the label is tied to negative stereotypes, the labeled person loses status and is treated unequally — and all of it depends on power, on who gets to make their label stick to somebody else. That power piece matters in this room. The words piled on you were piled on by people and systems looking through their own lens — their fears, their failures, their need for a simple story. A distorted lens produces a distorted picture. What they handed you says at least as much about the lens as it ever said about you.
- **When the label moves inside.** The hardest labels to shed are often not the ones shouted at us. They are the ones we picked up and started carrying ourselves — what the literature calls internalized stigma, or self-stigma: a person absorbs the public story about "people like me," agrees with it, and applies it to themselves. Self-stigma sounds like: I am the problem. People like me do not get better. There is no point asking for help — they will see the label, not me. It shrinks what a person attempts: help not sought, treatment left early, chances not taken, because the verdict already feels delivered. Naming self-stigma in the room is not blame. A person did not invent these words; they were handed over, usually young, usually by people who should have known better. But what was handed over can be handed back.
- **Person-first language, and why it matters.** Words are not decoration on recovery; they are part of its machinery. The Substance Abuse and Mental Health Services Administration (SAMHSA) advises person-first, non-stigmatizing language in substance use care: a person with a substance use disorder, a person in recovery — language that names a condition a person has, not a verdict on who a person is. Compare the two shapes. "Addict," used as a person's whole name, carries a stereotype into every room the person enters — including the rooms where they go for help. "A person with a substance use disorder" leaves the person standing next to the condition, able to be treated, housed, hired, and heard. Words like "clean" and "dirty" for test results do the same quiet damage, implying the person is dirty while using and clean only when not. In this program we watch our words — staff included — because people deciding whether to seek help are listening to how help talks about them.
- **Examine the label before you carry it.** A label is a claim, and claims can be examined. Painful beliefs are treated the way this group treats labels: as thoughts to be tested, not facts to be obeyed. Three questions do the testing in this group. First: what is the evidence — what actually supports this word, and what in my life stands against it? Second: whose lens is it — who handed me this word, what did they see, what did they miss, and what did they need to believe? Third: what do I choose to keep — is there a hard truth inside this label I honestly own, separated from the contempt wrapped around it? A label usually fails at least one of the three. And where a piece of it is true — I did harm, I do have a disorder — it gets restated in honest, person-first words a person can act on, not a name they have to wear.
- **Re-authoring — define yourself.** Start from a simple separation: the person is not the problem; the problem is the problem. A life gets told as a story, and a label is a story somebody else edited — usually down to the worst chapters. Re-authoring is the disciplined work of telling the fuller story: finding the chapters the label edited out — the times you showed up, protected someone, told the truth, got back up — and letting those chapters carry weight too. This is not pretending. Nothing in re-authoring erases what happened or what it cost. It refuses to let the worst pages be the whole book, and you write your own line about yourself, in words you chose. Nobody else can do this work for you. A facilitator can hand you the questions; only you know your whole story, and only you can decide what it means.

- **The warrior's naming.** So the core of this group, said plainly: let go of the words and attitudes people pile on you. That pile is their problem — their distorted lens, their unfinished business — and carrying it was never your assignment. Shed the terms that defined you. Keep the honest lessons; lessons are yours. Then define yourself, in words you chose and can defend with evidence, and let your conduct argue for those words every day. That is the naming this group teaches: do not let the crowd or the past do the naming. Know who you are, say it straight, and walk it out.

Discussion prompts

- "What kinds of labels get handed to people in recovery — from family, from systems, from the street? Name the kinds, not anyone's story."
- "How can a label change what a person attempts — asking for help, applying for work, walking back into a room?"
- "What is the difference between honest accountability — 'I did that, and I am repairing it' — and a label: 'that is all I am'?"
- "Whose words about you have proved wrong over time? What did you do that the label said you could not?"

Practice — name it, test it, re-author it (10 minutes, your writing stays with you)

1. On your own paper, list the labels you have carried, grouped by where they came from: family, systems (courts, clinics, case files, programs), and self — the ones you say about yourself. Write small and honestly; no one will see this list but you. Step 1 is homework-before or optional pre-writing. The 10 in-room minutes cover only testing one label (steps 2 and 3) and writing the re-authored line (step 4).
2. Test one label with the three questions: choose the one label that weighs the most right now. What is the evidence for it — and against it? Whose lens handed it to me, and what did that lens miss? What, if anything, do I choose to keep — restated in honest words?
3. Write the verdict in one line: what you are shedding, in the label's own words, struck through or set aside on the page as shed.
4. Write your own line about yourself, in words you chose: "I am a person who ..." — in person-first language, that your own evidence supports. If you want, that is the only line you may choose to read aloud at the close.
5. Keep your paper or fold it away — your choice. Nothing from this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Labels and the Power of Words

- **Education, not therapy.** The examination in this group is of labels and beliefs, using CBT-style questions as recovery education. It is not individual therapy, not a clinical assessment, and not treatment of any diagnosis. A client who wants to work a label through in depth is connected to their counselor through program procedure.

- **The writing belongs to the client.** Labels written or spoken in this practice belong to the client. Facilitators do not collect, copy, photograph, file, or keep a client's label list or re-authored writing, and never require a client to read their labels aloud. Only the re-authored line may be shared, and only by the client's own choice.
- **Watch every word in the room.** Facilitators use person-first, non-stigmatizing language throughout this group and correct the room's language the same way — directly and kindly, including their own slips. No facilitator repeats a client's label back to them as a name, in group or anywhere else.
- **Truth stays; contempt goes.** Shedding a label never means shedding accountability, a diagnosis that guides real treatment, or a legal obligation. This group separates a person from a contemptuous name; it does not erase conduct, consequences, or care. If a client uses the session to dismiss a genuine safety or treatment concern, name that plainly and connect them to staff the same day.
- **Warrior close:** Close with the naming: “Other people handed you their words through their lens — that was their problem, and it stops being your load today. You tested the labels. You kept what was true. The rest, you shed. Now walk out of here under your own name — the one you chose, the one your evidence backs. That is what a warrior does.”

Sources & Evidence

Clinical evidence: Goffman, E. Stigma: Notes on the Management of Spoiled Identity (Prentice-Hall, 1963) — stigma as an attribute that discredits a person in others' eyes and can engulf the whole identity. Link, B. G., & Phelan, J. C. “Conceptualizing Stigma.” Annual Review of Sociology, 27, 363–385 (2001) — stigma as the co-occurrence of labeling, stereotyping, separation, status loss, and discrimination in a situation of power. Internalized (self-) stigma is described in the stigma literature as the process by which a person endorses public stereotypes about their group and applies them to themselves. Beck, A. T. — cognitive therapy's foundational literature: distressing beliefs and automatic thoughts are examined against evidence rather than accepted as fact; the three examination questions in this outline adapt that method to labels, as education.

Recovery-support evidence: Substance Abuse and Mental Health Services Administration (SAMHSA) — guidance for behavioral health communication favoring person-first, non-stigmatizing language about substance use (for example, “person with a substance use disorder”), on the ground that stigmatizing words shape attitudes toward people who use substances and can stand between a person and help. White, M., & Epston, D. Narrative Means to Therapeutic Ends (W. W. Norton, 1990) — narrative practice: externalizing the problem (“the person is not the problem; the problem is the problem”) and re-authoring, in which a person develops a fuller account of their life from evidence the problem story left out. This outline teaches these ideas as recovery education in one group hour; it does not reproduce narrative therapy, and, like every group in this packet, it promises no outcome.

Facilitator background only: the Goffman, Link and Phelan, Beck, and White and Epston citations in this box are background for the facilitator. In the room, teach only the plain sentences, in order: labels stick and steer; whose lens; labels move inside; person-first words; three test questions; re-authored line. Do not teach the names, books, or years aloud.

Note: No outcome is promised for any group in this packet.

Breakout 10 — Brain Science of Addiction and How It Heals in Recovery — The Brain Can Heal

One sentence for the board: Addiction changed your brain by learning — and the same brain that learned it can learn recovery.

Purpose	Teach, as recovery education, how addiction changes the brain — the reward circuitry, the three-stage cycle, the prefrontal cortex and impaired control, the stress systems, and tolerance and dependence through neuroadaptation — and how the brain heals in recovery: neuroplasticity, gradual recovery of dopamine function and executive function over sustained abstinence, improving sleep, mood, and stress regulation, and the supports that give healing its best conditions. Frame the whole hour with hope: the brain can heal. No outcome and no timeline is promised to any client.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant. Especially valuable for participants who blame themselves for struggling to stop, who have returned to use and believe they are permanently broken, or who want to understand why treatment, skills, and support — and not willpower alone — are part of recovery. No participant is asked to describe their own drug history in detail. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip

	chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: this is brain science as education, not a diagnosis of any person in the room — and the hour ends with hope, not with a verdict.
5–30 min	Teaching	The teaching points below, in order, on the board: the reward circuitry; the three stages; the prefrontal cortex; stress systems; tolerance and dependence; then neuroplasticity and what supports healing.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to recount their own use in detail.
45–55 min	Practice — my brain-healing plan	Clients write one personal page: the stage pattern they recognize, one everyday reward to rebuild, and one healing support for each part of the plan. Writing stays with the client.
55–60 min	Close	Takeaways, and one healing support each client will actually do this week.

Teaching points

- **A brain built to learn.** The brain is built to learn what matters. Deep in the brain sits a reward circuit — dopamine pathways running through the basal ganglia, including the nucleus accumbens — that evolved to teach survival: food, water, connection, safety. When something important happens, dopamine signals salience — this matters, remember it, do it again — and motivation follows. That system is not a flaw. It is how every person learns. Addiction does not invent a new brain. It takes this learning system over.
- **How substances hijack the circuit.** Addictive substances flood that circuit. Alcohol and other drugs drive dopamine far beyond what everyday rewards produce, and the brain tags the substance, the place, the people, and the ritual with outsized importance. Over time the wanting grows louder than the liking: a person can want the substance fiercely while enjoying

it less and less. Cues — a street, a song, a feeling, a time of day — start firing the circuit before the substance even arrives. That is incentive salience: the brain has learned, deeply, that this matters most.

- **The three-stage cycle.** Koob and Volkow describe addiction as a cycle in three stages, each with its own brain circuitry. Stage one is binge and intoxication: the rewarding effects of the substance, the building of incentive salience, and the forming of drug-seeking habits, driven by changes in dopamine and opioid peptides in the basal ganglia. Use becomes faster, more automatic, and more habitual — less a decision each time, more a well-worn path. Stage two is withdrawal and negative affect: as use continues, the reward system itself weakens, everyday pleasures flatten, and negative emotional states grow — anxiety, irritability, low mood, dysphoria — while the brain's stress systems are recruited. Use shifts from seeking a high to escaping a low: not feeling good, but feeling normal, or feeling less bad. Stage three is preoccupation and anticipation: craving, and the struggle to hold a decision against it, as the prefrontal cortex and the insula send dysregulated signals — including glutamate — back to the reward and stress circuitry. The cycle feeds itself: each stage makes the next one easier to enter.
- **The prefrontal cortex — the brake gets quieter.** The prefrontal cortex is the brain's brake and steering: planning, decision-making, weighing consequences, inhibiting an impulse, holding a long-term goal in mind while a short-term urge shouts. In addiction, the balance shifts. Volkow, Koob, and McLellan describe weakened executive function alongside desensitized reward circuits and strengthened conditioned responses: the brake gets quieter while the accelerator — cues, craving, habit — gets louder. That is impaired control, and it is visible in brain imaging, not invented as an excuse. A person can know, clearly, what use is costing them, and still use — because knowing lives in the prefrontal cortex and the decision is being outvoted by circuitry that learned faster and louder. Understanding this does not remove responsibility. It tells a person where the work has to go: strengthening the brake takes practice, support, and time, and this program is built to give all three.
- **Stress systems — the alarm gets louder.** Stress is not background noise in addiction; it is part of the machinery. In the withdrawal and negative-affect stage, the brain recruits its own stress neurotransmitters — including corticotropin-releasing factor and dynorphin — in the extended amygdala, producing a stress surfeit: more stress reactivity, more negative emotion when cravings are not sated, and a lower threshold for the next trigger. Stressful events, and even the memory of them, can then reactivate craving through conditioned responses. That is why a hard day, a conflict, or an anniversary can feel like a physical pull toward use, and why stress regulation — sleep, steadiness, support, practiced skills — is not soft extra work. It is work on the circuit itself.
- **Tolerance and dependence — the brain adapts.** With repeated exposure, the brain adapts — that adaptation is neuroadaptation. Receptors desensitize and their numbers and sensitivity shift; the reward system down-regulates, so more of the substance is needed for the same effect: tolerance. When the substance clears, the adapted system is left out of balance: withdrawal. Dependence is that adaptation — the brain now expects the substance to feel normal. Addiction is more than dependence: dependence plus compulsive use, impaired control, and continued use despite harm. Naming the difference matters in this room. A person can be dependent on a prescribed medication taken exactly as directed and not be addicted; a person can be addicted and need medical support to stop safely. Facilitators do not

sort any client's situation in group — medical questions go to medical staff — but every client deserves the honest language: adaptation is what the brain does. It is not a moral verdict.

- **Neuroplasticity — the brain that learned can relearn.** Here is the hope, and it is science, not sentiment: the same property that made addiction possible makes recovery possible. Neuroplasticity is the brain's ability to change its structure and function in response to experience — to strengthen the pathways that get used and let unused pathways weaken. The brain learned addiction by repetition: cue, use, relief, repeated until the path was a highway. It learns recovery the same way: new responses, repeated until they hold. Healing is gradual and uneven. Brain-imaging studies have reported partial recovery of dopamine markers during protracted abstinence in people who had used methamphetamine — one small study, partial recovery, and no promise attached — and the wider literature describes the same direction: with sustained abstinence, dopamine function and reward sensitivity to everyday life can gradually recover, and executive function can strengthen as the prefrontal cortex gets practice doing its job again. Sleep, mood, and stress regulation commonly improve as the stress systems settle and the reward system rebalances. No timeline is promised in this group, to anyone. Brains differ, histories differ, and healing does not run on a schedule a facilitator can hand out. What can be said honestly is the direction, and the direction is toward healing.
- **What supports healing.** Sustained abstinence gives the brain the time and the quiet to readjust; every additional stretch of abstinence is more practice for the new pathways. Sleep rebuilds the basics the reward and stress systems run on — a tired brain craves harder and decides worse, so protecting sleep is brain work. Exercise moves the body and steadies mood and stress, and gives the reward system a natural, repeated signal it can learn from. Nutrition restores what chaotic use neglected; regular meals steady energy and mood across the day. Connection rewires belonging: relationships, peer support, and being genuinely needed give the brain everyday rewards worth pursuing and people worth staying present for. Support — counseling referrals, skills training, and the groups in this packet — is cognitive engagement with a purpose: every skill practiced, every trigger plan written, every craving ridden out is a rep for the prefrontal cortex. Medication, where indicated and decided with a medical provider, can steady the chemistry while the learning happens; it is a support for healing, never a substitute for it, and never a shame. None of these is a cure on its own. Together, repeated, they are the conditions under which a brain heals.

Cut points — teaching (25 minutes): teach the points in order. If time runs short, compress the stress-systems and tolerance-and-dependence points to one sentence each — never cut the three-stage cycle, the prefrontal-cortex point, neuroplasticity, or the practice. Cut teaching, never skill practice.

- **The warrior's reading.** So the warrior's reading of the science, said plainly: you are not weak, and you are not permanently broken. A brain that learned its way into addiction, cue by cue and day by day, can learn its way out the same way — rep by rep, support by support, day by day. The learning that hurt you is the proof that learning still works in you. The brain can heal. What it cannot do is heal on wishing alone. It heals on abstinence sustained, sleep protected, body moved and fed, people kept close, treatment worked, and skills practiced until the brake is strong again. That is the work this program asks of you, and it is work worth doing — because the brain doing it is yours, and it is still yours to train.

See also Session 4: The Addiction Cycle: Brain, Body, and Behavior.

Discussion prompts

- “Which stage of the cycle do you recognize most in your own story — the pull of the high, the escape from feeling bad, or the craving that will not stop planning? Name the stage, not the details.”
- “What everyday rewards went flat for you while the substance took the circuit over — and which one would you most want to matter again?”
- “When stress hits, what does your brain reach for first — and what could your plan reach for instead, in that same minute?”
- “Which healing support do you already use, and which one do you resist — and what would make the resisted one easier to start this week?”

Practice — my brain-healing plan (10 minutes, your page stays with you)

1. Name your pattern: the stage that grabs you hardest, and the cue — place, person, feeling, or time of day — that fires it. One sentence each.
2. Name one everyday reward to rebuild: something ordinary that used to matter, or that you want to matter — a meal, a walk, music, a person, a task done well — and when this week you will do it on purpose.
3. Choose one basics step for this week: one sleep step, one movement step, or one regular-meals step. Write the day and the time.
4. Name your people and your care: one person you will stay connected to this week, and whether you want a referral to medical or clinical staff about treatment or medication — a question to ask, not a decision made in group.
5. Choose one cognitive rep for this week: one skill from Coping Skills, one trigger plan from Relapse Prevention, or one page of your WRAP to work. Write what you will practice, and when. Keep your page. It is yours.

Facilitator boundaries — Brain Science of Addiction and How It Heals in Recovery

- **Education, not diagnosis.** This group teaches brain science as recovery education. It does not diagnose any client, does not interpret any client's brain or history, and does not tell any client that their brain is damaged, permanently damaged, or healed. No brain scan, test, or image is discussed as if it described a person in the room. If a client asks what their own brain looks like or what their recovery will look like, answer honestly: this group teaches the general science; personal questions go to clinical and medical staff.
- **No determinism, no verdict.** Brain science explains; it never excuses and never condemns. Do not let the science become a verdict in either direction — neither “my brain made me do it, so nothing is my responsibility” nor “my brain is broken, so there is no point trying.” Hold both truths: the circuitry is real, and the conduct, the supports, and the daily reps are the client's work, with help.

- **Medication affirmed; decisions referred.** Medication is discussed only as education, and only in the terms of this packet's standard: a medical decision between a client and their prescriber. Facilitators affirm clients who use medication as prescribed, never advise a client to start, stop, or change any medication, and refer every medication question to medical staff the same day. A client who asks about medication for addiction treatment, for sleep, or for mood is connected to medical staff, not answered in group.
- **Care is never replaced; no outcome is promised.** Healing is described by direction only. Never promise a client a timeline, a result, or a level of recovery, and never present one study — including the imaging study named in the Sources & Evidence box — as a guarantee for any person. If a client is in withdrawal, is medically unwell, or discloses a medical or psychiatric concern, follow program procedure and connect them to medical and clinical staff the same day. Group education never replaces medical evaluation or care.
- **Warrior close:** Close with the hope, honestly held: “Your brain learned its way here, and learning is still in it. The healing is gradual, it is uneven, and it is real — and it runs on the reps you do this week. Sleep, move, eat, stay close to your people, work your treatment, practice one skill until the brake holds. The brain can heal. You are the one who trains it.”

Sources & Evidence

Clinical evidence: Koob, G. F., & Volkow, N. D. “Neurobiology of Addiction: A Neurocircuitry Analysis.” The Lancet Psychiatry, 3(8), 760–773 (2016) — addiction as dysregulation of motivational circuits in three stages: binge/intoxication, with changes in dopamine and opioid peptides in the basal ganglia; withdrawal/negative affect, with decreased dopamine reward function and recruitment of brain stress neurotransmitters, including corticotropin-releasing factor and dynorphin, in the extended amygdala; and preoccupation/anticipation, with dysregulation of projections from the prefrontal cortex and insula, including glutamate, to the basal ganglia and extended amygdala. Volkow, N. D., Koob, G. F., & McLellan, A. T. “Neurobiologic Advances from the Brain Disease Model of Addiction.” The New England Journal of Medicine, 374(4), 363–371 (2016) — desensitization of reward circuits, increasing strength of conditioned responses and stress reactivity, and weakening of executive-function regions involved in decision-making, inhibitory control, and self-regulation. National Institute on Drug Abuse (NIDA). Drugs, Brains, and Behavior: The Science of Addiction — the brain's reward circuitry, dopamine and the nucleus accumbens, how drugs change the brain, and how treatment helps the brain recover. Peer-reviewed brain-imaging literature: Volkow, N. D., and colleagues, positron emission tomography (PET) imaging of dopamine transporter availability in people who had used methamphetamine — partial recovery of dopamine transporter binding during protracted abstinence in a small studied group. This outline reports that finding as partial and preliminary, with no timeline and no outcome promised to any participant.

Recovery-support evidence: Substance Abuse and Mental Health Services Administration (SAMHSA) — the four dimensions of recovery: health, home, purpose, and community, and recovery supports including treatment, peer and community support, and the everyday conditions that sustain recovery. National Institute on Drug Abuse (NIDA) — treatment as a combination of behavioral therapies, medications where indicated and decided with a medical provider, and recovery support, with sustained abstinence and continued engagement giving the brain the conditions to recover. This outline teaches these ideas as recovery education in one group hour; it does not reproduce any treatment protocol, and, like every group in this packet, it promises no outcome.

Note: No outcome is promised for any group in this packet.

Breakout 11 — Building and Maintaining Healthy Relationships — Boundaries, Honesty, and Trust Rebuilt

One sentence for the board: Healthy relationships are built on purpose — with clear boundaries, honest words, and trust earned back one kept promise at a time.

Purpose	Teach clients to build and maintain healthy relationships in recovery: setting and holding boundaries, communicating honestly and kindly, resolving conflict without combat, and rebuilding trust through sustained changed conduct — while keeping safety first and never turning a group into couples work.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who wants stronger relationships — with family, a partner, friends, children, or coworkers — whether they are rebuilding a relationship, starting fresh, or learning to choose healthier connections. No participant is asked to name another person or describe a private relationship in detail. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: no one is asked to share private relationship details, and this group never works on a couple together.
5–30 min	Teaching	The teaching points below, in order, on the board: trust rebuilt in kept promises, boundaries, honest communication, conflict without combat, forgiveness and amends, safety before repair, and choosing a circle on purpose.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to describe their own relationships in detail.
45–55 min	Practice — one boundary, one repair step	Clients draft one boundary in writing and one small repair step for this week. Writing stays with the client.
55–60 min	Close	Takeaways, and one boundary or repair step each client will actually carry out this week.

Teaching points

- **Trust is rebuilt in small kept promises.** Addiction breaks trust in specific ways: promises made and missed, money gone, words said that cannot be unsaid, presence withdrawn. Trust is not rebuilt by one big apology or one good week. It is rebuilt the way it was broken — in daily conduct, over time: showing up when promised, telling the truth when it costs something, and doing the next right thing whether anyone is watching or not.
- **Boundaries are care, not punishment.** A boundary is a clear statement of what you will and will not do, stated plainly and held kindly. Boundaries protect recovery and protect the relationship at the same time: they stop resentment from building, they keep a client out of situations that threaten sobriety, and they give the other person something honest to count on. A boundary held without anger is not rejection. It is the condition under which closeness stays safe.
- **Say it straight, say it kind.** Healthy communication has a shape: state the facts without blame, name what you need, listen fully before answering, and confirm what was agreed. Use words about your own experience — what happened, how it affected you, what you are asking for — rather than labels about the other person. Timing matters: do not hold a hard conversation

when either person is exhausted, hungry, or flooded. If voices rise, pause and return later; a conversation postponed is not a conversation refused.

- **Conflict without combat.** Conflict itself is not the problem; contempt is. Work one issue at a time, keep the issue separate from the person, and refuse the weapons that end relationships: name-calling, bringing up old grievances as ammunition, threats, and the silent treatment used as punishment. Agree a time-out signal in advance for hard conversations — either person may call it, and the conversation resumes at a named time. After a conflict, repair it: name what went wrong on your side, apologize without excuses, and state what you will do differently.
- **Forgiveness and amends are different jobs.** Forgiveness is personal and cannot be demanded, scheduled, or used as a test of recovery — by a client, by family, or by a facilitator. An apology is words; an amend is sustained changed conduct, and in Twelve Step tradition amends are made directly wherever possible, except where doing so would injure the other person or others. This group does not direct any client to contact a particular person or to make a particular amend. Decisions about contact and amends belong with the client, their sponsor or counselor, and program staff — and where there has been harm or danger, safety decides first.
- **Safety comes before repair.** Where a relationship has involved coercion, control, or violence, repair never requires contact, and no exercise in this group works on a couple together. A client who wants to rebuild a relationship after harm does that work through appropriate separate support and program procedure, never by being placed in joint work with the other person in this room. If a client discloses current danger, tell the Program Director or on-call supervisor the same hour and connect them to staff and an advocate the same day. See the escalation box at the front of this packet.. The Domestic Violence outline governs whenever safety is in question.
- **Choose your circle on purpose.** Recovery changes who a person spends time with, and that change is not disloyalty — it is protection. Support people are the ones who respect boundaries, tell the truth kindly, and show up steadily. High-risk relationships are the ones that pull a person back toward old places, old people, and old patterns. Clients are not asked to cut ties dramatically in group; they are asked to notice honestly which relationships steady them and which ones cost them their footing, and to invest time accordingly.
- **Support grows where honesty lives.** Family and social support strengthen recovery when the support is honest and steady — and strained or dishonest support can add risk. The work of this group is therefore two-sided: become a person others can rely on, and build a circle you can rely on. Both sides run on the same habits: keep small promises, say what you mean, repair quickly, and ask for help before a hard moment becomes a decision.
- **The warrior's reading.** So the warrior's reading, said plainly: nobody rebuilds a relationship by wishing it whole. You rebuild it by holding a boundary calmly, speaking honestly, fighting fair, and keeping the next promise — and the next, and the next. That is how trust comes back: not all at once, and not by accident, but by conduct other people can count on.

Discussion prompts

- “What is the difference between a boundary and a wall — and how can a person tell which one they just built?”

- “What does honest communication sound like, word for word, when the truth is hard to say?”
- “Where does conflict usually go wrong: the words used, the timing, or what happens after? What helps each one?”
- “What is one small kept promise that would mean the most to someone you care about — and what would it cost you to keep it this week?”

Practice — one boundary, one repair step (10 minutes, your writing stays with you)

1. Choose one relationship where a boundary would protect both your recovery and the relationship. Write the situation in general terms — no names are needed.
2. Draft the boundary in plain words: what you will do, what you will not do, and what you will do if the boundary is crossed. Keep it short enough to say calmly.
3. Choose one repair step for this week: one small, specific act of changed conduct — a kept promise, a call made on time, help given without being asked — with the day you will do it.
4. Before acting on either draft, name who you will check it with — staff, a sponsor, or a counselor — especially where safety, a court matter, or a fragile relationship is involved. Do not use group time to send messages or make contact.
5. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Building and Maintaining Healthy Relationships

- **No couples work, ever.** Never run conjoint or joint exercises in this group, carry messages between partners or family members, or mediate a disagreement between two clients in the room. Relationship repair after harm is separate work through program procedure.
- **Do not direct contact or amends.** Facilitators do not tell a client to contact, apologize to, forgive, or reconcile with any particular person. Refer decisions about contact, amends, and family involvement to the client's sponsor, counselor, and program staff.
- **Safety decides first.** If a client discloses current danger, coercion, or a plan that would put anyone at risk, follow program procedure and connect them to staff and an advocate the same day. Do not investigate, confront another person, or attempt a rescue yourself.
- **General learning is complete participation.** No client is pressed to name a person, describe a private relationship, or share anything they wrote. Facilitators never repeat a client's private relationship details outside the room, beyond program procedure and any reporting duty that applies.
- **Warrior close:** Close with the steady standard: “Boundaries held calmly, words spoken honestly, promises kept small and kept well — that is how a warrior rebuilds a life other people can trust. Start with one boundary and one kept promise this week.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. Substance Use Disorder Treatment and Family Therapy. Treatment Improvement Protocol (TIP) Series 39 — family involvement in

treatment, communication-skills training, conflict-resolution skills, and the daily trust discussion in behavioral family counseling, as the background for the boundary, communication, and trust-rebuilding approach in this outline. This group teaches those skills as recovery education; it does not provide family therapy.

Recovery-support evidence: Alcoholics Anonymous, Twelve Steps — Step Nine, making direct amends wherever possible except when doing so would injure others, cited here as recovery-support tradition, clearly distinct from clinical evidence. This group presents that tradition as background only and does not direct any amend. Substance Abuse and Mental Health Services Administration — the four dimensions of recovery: health, home, purpose, and community — with family and social support as part of the community dimension that sustains recovery. No outcome is promised for this group.

Note: No outcome is promised for any group in this packet.

Breakout 12 — Managing Co-Occurring Mental Health Conditions — The Whole Person, Held Steady

One sentence for the board: Recovery and mental health walk together — this group teaches, in plain language, how to steady both, and how to get the right help, early, for each.

Purpose	Teach recovery education, in plain language, about living with both a substance use disorder and a mental health condition: how the two can travel together, what steadies daily life across anxiety, low mood, trauma responses, and anger, and how to stay connected to the counselor and to medical care — the group itself diagnoses no one, treats no one, and provides no clinical care.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who lives with, or wonders whether they live with, both substance use and mental health struggles, and any participant supporting someone who does. No participant is asked to name a diagnosis, describe symptoms in detail, or share anything about their own care in group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, the topic resources named in this outline, and the program's current crisis and referral information

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: this group is recovery education only — it does not diagnose or treat anyone, and help is available the same day for anyone who needs it.
5–30 min	Teaching	The teaching points below, in order, on the board: two struggles in one person, why they travel together, anxiety, low mood, trauma responses, and anger in plain language, what helps across all four, and staying with care.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to describe their own symptoms, diagnosis, or care.
45–55 min	Practice — my steady-days plan	Clients write a personal steady-days plan: early signs, one steadying skill for each area that applies, their care connections, and a same-day help plan. Writing stays with the client.
55–60 min	Close	Takeaways, the same-day help path restated, and one steadying step each client will actually do this week.

Teaching points

- **Two struggles, one person.** A co-occurring disorder means a substance use disorder and a mental health condition are present in the same person at the same time. That is common, not unusual, and it is not a character flaw or a sign of weak recovery. Each struggle can make the other harder: mental distress can drive a person toward use for relief, and use can deepen distress as it wears off or as consequences pile up. Neither struggle is treated as the only real one here. Both are taken seriously, and both are addressed — in care, together — because treating only one while the other goes unaddressed leaves the person carrying half the load alone.

- **Why the two travel together.** Researchers describe three broad pathways, and more than one can be true for the same person: shared risk factors can contribute to both; a mental health condition can contribute to substance use, as a person reaches for relief; and substance use can contribute to the development of a mental health condition. Symptoms also overlap — poor sleep, low mood, restlessness, and trouble concentrating can belong to either struggle, or to withdrawal, or to an ordinary hard week. Sorting that out takes a proper assessment by qualified clinicians over time, including time in abstinence. This group never sorts it in the room. What it teaches is steadiness and help-seeking while assessment and care do their work.
- **Anxiety, in plain language.** Anxiety is often described as worry that will not switch off, restlessness, a racing heart, tightness in the chest, dread before ordinary things, and avoidance of the places and people that stir it. It can drive use when a substance seems to quiet it for an hour. Steadying skills taught here are general and educational: name what is happening, slow the breathing, ground in the senses, keep a steady routine, and reach a support person early rather than waiting until the worry peaks. If worry is frequent, intense, or interfering with daily life, that is a same-day conversation with staff about a referral to the counselor — not a problem to white-knuckle through group skills alone.
- **Low mood, in plain language.** Low mood is often described as persistent sadness or emptiness, loss of interest or pleasure in things that used to matter, exhaustion, sleep and appetite changes, and hopeless thoughts. Substances can deepen low mood as their effects wear off, and low mood can make recovery feel pointless — which is why the group names it plainly instead of treating it as bad attitude. Steadying skills are small and concrete: a fixed wake time, one planned activity a day, movement, daylight, connection with one trusted person, and honest contact with the care team. A client who describes hopelessness, thoughts of harming themselves, or an inability to carry out daily life is connected to staff the same day, through program procedure, and the crisis path in this outline is followed without delay.
- **Trauma responses, in plain language.** After frightening or overwhelming events, people often describe intrusive memories or nightmares, feeling constantly on guard, being easily startled, avoiding reminders, and feeling numb or cut off. Those responses are the mind and body trying to protect themselves, and they can persist long after danger has passed. This group teaches trauma-informed steadiness only: safety, choice, and control stay with the client; no one is asked to retell what happened; grounding and routine are practiced; and triggers are handled with the client's own plan. Trauma is never processed in this group. A participant who wants trauma-focused care from the counselor is connected to staff the same day, and the facilitator follows program procedure for any disclosure of current danger.
- **Anger, in plain language.** Anger is a signal, not a verdict. It often arrives with body cues — heat, tightness, a clenched jaw, a raised voice — and with a story about unfairness or threat. The skill is to catch the signal early: pause, name the body cue, step back before speaking, and return when the surge has passed. Agreeing a time-out in advance — with family, housemates, and staff — makes the pause a plan instead of a walkout. Repair follows: own your part plainly, without excuses. Anger paired with substance use raises risk sharply, which is why anger skills belong in relapse prevention too. Anger that feels uncontrollable, or that has led to harm or threats, is a same-day staff conversation about care from the counselor.
- **What helps across all four.** The same foundations steady every area in this group: regular sleep, regular meals, daily movement, a steady routine, honest contact with support people, and staying engaged with treatment and peer support. Skills from Coping Skills — noticing,

breathing and grounding, reframing, riding out a surge, and reaching out — are the daily reps. A written plan helps most: the client's WRAP, their relapse-prevention plan, and the steady-days plan written in this session, kept where the client can find them on a hard day. No single skill is presented as a treatment, and no combination of skills is presented as a substitute for care.

- **Staying with care, for both.** Care for co-occurring disorders works best when it is integrated: mental health and substance use care considered together, in one coordinated plan, with screening for each whenever a person seeks help for the other. Skills in this group support care and connection to care; they are never a substitute for care. The facilitator's job is connection, not provision: help the participant name what they need, get to the right staff the same day, and keep appointments and medication decisions with their prescriber. Care from the counselor may include talking therapies and, where a prescriber decides it is appropriate, medication. Facilitators never name a therapy or a medication as right for a particular client, and never advise starting, stopping, or changing any medication.
- **The warrior's reading.** So the warrior's reading, said plainly: carrying two struggles does not make you two kinds of broken. It makes you a whole person whose care must be whole, too. Ask early, stay with your care team, use your skills daily, and tell someone the same day it gets hard. Warriors do not win by carrying everything alone. They win by holding the line together — with help, on purpose, one steady day at a time.

Cut points — teaching (25 minutes): teach the four conditions briefly and in order — anxiety, low mood, trauma responses, anger — then “What helps across all four” and “Staying with care.” If time runs short, compress the “why the two travel together” point to one sentence and shorten one condition's examples — never cut the same-day referral triggers, the crisis protocol, or the practice. Cut teaching, never skill practice.

Discussion prompts

- “What makes it hard to ask for help when two struggles are tangled together — and what would make asking easier?”
- “Which steadying foundation — sleep, routine, movement, or connection — slips first for most people, and what is the earliest sign it is slipping?”
- “What is the difference between a hard week that skills can steady and a situation that needs same-day help from staff?”
- “Who is one person you could reach the same day things get hard — and what words would you use to open that conversation?”

Practice — my steady-days plan (10 minutes, your plan stays with you)

1. In general terms, name the pattern you recognize: which areas in this group feel most present for you right now, and the earliest signs that tell you a hard stretch is starting. No detail is required, and nothing here is shared aloud.
2. Choose one steadying skill for each area that applies to you — from Coping Skills, from this session, or from your own experience — and write when this week you will use each one.

3. Name your care connections: the staff member, counselor, prescriber, or support person you will contact, and the question you want to ask them. If you do not yet have a connection for one struggle, write that you will ask staff for a referral the same day.
4. Write your same-day help plan: who you will tell, how you will reach them, and that you will call or text 988 in a crisis, or call 911 if anyone is in immediate danger. Keep the program's crisis and referral information with this plan.
5. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Managing Co-Occurring Mental Health Conditions

- **Recovery education only — no diagnosis, no treatment.** This group teaches general information and steadiness skills. Facilitators do not assess, diagnose, label, or interpret any client's condition, symptoms, or history, and do not use clinical language about any individual. Do not ask clients to describe symptoms or name diagnoses. A client who asks what they have, or what treatment they need, is connected to clinical and medical staff the same day.
- **Same-day referral, every time.** Any disclosure of worsening mental distress, hopelessness, trauma material needing care from the counselor, uncontrollable anger, or a medication concern is routed to staff the same day through program procedure. The facilitator stays with the client, steadies the room, and makes the connection — the group does not become the treatment.
- **Crisis protocol, stated plainly.** If a client expresses thoughts of suicide or self-harm, or describes a plan or intent, follow the Facilitator Guide crisis protocol immediately: stay with the person, do not leave them alone, alert the Program Director or on-call supervisor at once, and use the crisis resources — call or text 988 for the Suicide and Crisis Lifeline, and call 911 if anyone is in immediate danger. Do not promise secrecy, do not minimize what was said, and do not attempt to assess risk yourself. See the escalation box at the front of this packet.
- **Medication affirmed; decisions referred.** Facilitators affirm clients who use medication exactly as prescribed, never advise a client to start, stop, or change any medication, and refer every medication question to medical staff the same day. Skills support care; they never replace it, and a client is never told that skills alone are enough when care from the counselor or medical providers is needed.
- **Warrior close:** Close with steadiness and the open door: “Two struggles, one whole person, one coordinated plan — and help the same day you ask for it. Use your skills, stay with your care, and reach out early. That is how warriors hold the line.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. Substance Use Disorder Treatment for People With Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series 42 — integrated treatment of co-occurring substance use and mental disorders, phased treatment, and the principle that both disorders are addressed together in a coordinated plan. National Institute on Drug Abuse. Common Comorbidities with Substance Use Disorders Research Report — the three pathways linking substance use disorders and mental illness: shared risk factors, mental illness contributing to substance use, and substance use contributing to mental illness; and the need for an integrated approach

that evaluates each disorder concurrently.

Recovery-support evidence: Substance Abuse and Mental Health Services Administration. Co-Occurring Disorders — integrated treatment and the “no wrong door” principle: a person seeking help for a mental disorder is routinely screened for substance use disorder, and a person seeking help for substance use disorder is screened for mental disorders, with treatment provided directly or through appropriate referral. Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57 (2014) — trauma-informed principles of safety, choice, and avoiding re-traumatization, as the background for how this group handles trauma responses. No outcome is promised for this group.

Note: No outcome is promised for any group in this packet.

Breakout 13 — Financial Recovery & Credit Rebuilding — Freedom Built One Step at a Time

One sentence for the board: Debt is a math problem with a plan attached — this group maps the debts, the credit file, and the next steps, without shame and without advice about any one person's money.

Purpose	Teach, as recovery education, the practical steps beyond basic budgeting: mapping debts honestly, working a payoff order, reading and correcting a credit report, building credit slowly and safely, and creating the small buffer and systems that protect financial independence. Basic budgeting stays in Life Skills; this outline goes deeper into debt, credit, and independence.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who carries debt, has a thin or damaged credit file, or wants a steadier financial footing after treatment. No participant is asked to state any amount, account, or personal financial detail in group, and no personal financial document is reviewed in the room. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens

0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: this group is education only, no personal figures are shared aloud, and nothing here is advice about any one person's money.
5–30 min	Teaching	The teaching points below, in order, on the board: the true picture, essentials first, talking to creditors, reading a credit report, building credit slowly, a buffer, independence as systems, and qualified help.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one states amounts, accounts, or personal financial details.
45–55 min	Practice — my money map	Clients privately map their debts, choose a payoff order, draft one creditor contact, and plan one credit-report step. Writing stays with the client, and no figures are shared aloud.
55–60 min	Close	Takeaways, the referral path to qualified help restated, and one money step each client will actually take this week.

Teaching points

- **Start with the true picture.** Financial recovery starts with a complete, private inventory: every debt listed from statements, not from memory — who is owed, how much, what it costs to carry, the minimum payment, and the due date. Add the accounts that are in collections and the ones being ignored, because an ignored debt still grows. Writing it down is not a confession and not a verdict. It is a map. Until the whole picture is on one page, every plan is guesswork; once it is there, the next step can be chosen on purpose.
- **Essentials first, then a plan for the rest.** Order matters. Essentials come first — housing, food, utilities, transport to work and care, and any court or program obligation with a deadline. Then pay at least the minimum on every debt, on time, every time, because on-time payment is the foundation everything else builds on. Any extra money then goes to one debt at a time, in an order the client chooses with qualified help: the highest-cost debt first, which saves the most over time, or the smallest balance first, which clears whole debts fastest and builds momentum. Both are sound methods. The wrong choice is no order at all.

- **Talk to the creditor before the collector talks to you.** Creditors and collectors are easier to deal with before an account is far behind than after. Clients are taught to contact creditors early, ask about hardship programs, payment plans, and reduced payments, and to get any agreement in writing before paying on it. Keep copies of every letter, every payment, and every agreement. Debt collectors must follow the law: a client may ask for written validation of a debt, may dispute what is wrong, and may tell a collector to stop contacting them in certain ways. This group teaches those general rights and routes individual situations to qualified help through staff.
- **What a credit report is — and how to read yours.** A credit report is the record lenders, landlords, and sometimes employers consult: identity information, accounts, payment history, balances, and public records, held by the three nationwide credit reporting companies. Every person may request their reports free from AnnualCreditReport.com, the federally authorized source. Read each report line by line: names, addresses, accounts you do not recognize, balances that look wrong, and negative items that should no longer be reported. Errors are disputed in writing, at no cost, with both the credit reporting company and the company that supplied the information, keeping copies of everything sent. No one in this group is promised a particular score or a particular result, and no company that promises to erase accurate history for a fee is to be trusted.
- **What builds credit, slowly.** Credit is built the same way trust is built: steadily, in public, over time. The habits that build it are unglamorous — pay on time, keep balances low compared with credit limits, keep older accounts open where it costs nothing to do so, and open new credit sparingly and only when there is a real need. A secured card or a small credit-builder account, used for one regular purchase and paid in full, is one common route clients discuss with qualified counselors; this group names the route and refers the decision. Accurate negative history cannot be wished or paid away, and rebuilding takes time. Anyone who promises a fast score is selling something, not helping.
- **A buffer before a breakthrough.** The difference between a setback and a new debt is usually a small amount of money set aside. Clients build a starter buffer — a modest sum in a separate account, added to automatically in small amounts — before attacking the largest debt with everything they have. One car repair, one medical bill, or one missed shift then bends the plan instead of breaking it. The buffer is not savings for a goal and not spending money in disguise. It is the wall between an ordinary emergency and a return to borrowing.
- **Independence is systems, not willpower.** Financial independence is not a personality trait. It is a set of systems that run whether motivation is high or not: paydays mapped to due dates, minimum payments automated, a calendar that shows every bill, documents and passwords kept safe, and a rule against co-signing or lending money on impulse. Protect personal information fiercely: never share account numbers, Social Security numbers, or passwords by phone, text, or email with anyone who called you first. People in recovery are targeted by scams precisely because a fresh start is being built. When an offer sounds urgent, secret, or too good to be true, the plan is to stop, check with staff or a qualified counselor, and decide later.
- **Help exists — use qualified help.** No one has to untangle debt and credit alone, and no one in this room has to become their own expert. Nonprofit credit counselors help people build budgets, negotiate with creditors, and set up structured repayment plans; program staff can connect any client to qualified, nonprofit help and to the free public guidance published by the

Consumer Financial Protection Bureau and the Federal Trade Commission. Bring statements and questions to that appointment, and bring a support person if it helps. A counselor's job is to look at the whole picture without judgment and to help choose the next step. Asking for that help is financial recovery, not failure.

- **The warrior's reading.** So the warrior's reading, said plainly: debt is not who you are. It is a number, a list, and a plan — and numbers move when a plan is worked, one payment, one letter, one on-time month at a time. Map it, order it, work it, protect it. Freedom is not bought in a day. It is built, step by step, until the debts are smaller than the life being built around them.

Discussion prompts

- "What keeps people from looking at the full debt picture — and what makes the first look easier?"
- "Between paying the highest-cost debt first and clearing the smallest balance first, what would matter most to you, and why?"
- "What is one scam, fee, or 'quick fix' offer to watch for — and how can a person check whether help is legitimate?"
- "What is one system — a calendar, an automatic payment, a separate buffer account — that would protect your plan on a hard week?"

Practice — my money map (10 minutes, your page stays with you)

1. On your own paper, list every debt you carry, from statements where you have them: who is owed, the balance, the minimum, and the due date. No figures are shared aloud, and no one sees this page but you.
2. Choose your payoff order: the highest-cost debt first, or the smallest balance first. Write the order and the first extra payment you will make, with the date.
3. Draft one creditor contact for this week: who you will call or write, what you will ask for, and what written agreement you will request before paying. Do not send anything from group; check the draft with staff or a qualified counselor first.
4. Choose one credit-report step: request your free reports from AnnualCreditReport.com, review one report line by line, or draft a written dispute for one error you can evidence. Write the step and the day you will do it.
5. Choose one buffer step: the amount you will set aside, where it will sit, and the day the first transfer happens. Keep your page. It is yours.

Facilitator boundaries — Financial Recovery & Credit Rebuilding

- **Education only — never personal financial advice.** This group teaches general information about debt, credit, and financial systems. Facilitators do not review any client's debts,

accounts, benefits, taxes, or legal documents, and do not recommend any specific financial product, creditor action, or legal decision for any individual. Every personal decision is referred to qualified help through program staff.

- **No personal figures in the room.** Clients are never asked to state amounts, account details, or personal financial information aloud, and facilitators never repeat anything a client volunteers. The practice writing stays with the client, and no document is collected, copied, or kept.
- **No promises about scores or debts.** Never promise a credit score, a debt outcome, a settlement, or a timeline. Do not present any method, product, or service as guaranteed to improve a score or erase a debt. Clients who are contacted by collectors, sued over a debt, or facing garnishment are connected to staff and qualified legal or financial help the same day.
- **Warn against scams, plainly.** Name the warning signs: fees paid in advance for credit repair, promises to erase accurate history, pressure to act immediately, and requests for account or Social Security numbers. A client who may have shared sensitive information or paid a fee is connected to staff the same day for help and reporting guidance.
- **Warrior close:** Close with the plan in hand: “You have a map, an order, and one step dated this week. Debt shrinks the same way it grew — one decision at a time, in the open, with help. Work the map. That is how warriors buy back their freedom.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. SAMHSA's working definition of recovery and its four major dimensions — health, home, purpose, and community — which frame financial stability, housing, and purposeful work as conditions that sustain recovery. This outline applies that framework as group education; it makes no outcome claim and gives no personal financial advice.

Recovery-support evidence: Consumer Financial Protection Bureau. Your Money, Your Goals — a financial empowerment toolkit for frontline staff and the people they serve, covering setting goals, managing money, managing debt, understanding credit, choosing financial products, and protecting money from scams. Federal Trade Commission — consumer guidance on free credit reports through AnnualCreditReport.com and on disputing errors on credit reports in writing, at no cost, with the credit reporting company and the company that supplied the information. No outcome is promised for this group.

Note: No outcome is promised for any group in this packet.

Breakout 14 — Physical Health in Recovery — Tend the Body That Carries Recovery

One sentence for the board: Recovery lives in a body — this group teaches, in plain language, how food, movement, sleep, and medical care steady the recovery the mind is fighting for.

Purpose	Teach, as recovery education, how physical health supports sustained recovery: regular nourishing food, everyday movement, protective sleep, and timely medical and dental care — in general terms only, with every personal health decision referred to the client's own medical providers.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who wants a steadier body for the recovery they are building, including participants catching up on care they postponed during active use. No participant is asked to share any health condition, measurement, or medical history in group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, the topic resources named in this outline, and the program's current medical-referral information

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly

		at the start: this group is education, not medical advice — personal health questions go to medical providers, and medical concerns are referred the same day.
5–30 min	Teaching	The teaching points below, in order, on the board: recovery as physical, food, movement, sleep, catching up on medical care, warning signs, and the body still healing.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to share any health condition or history.
45–55 min	Practice — my body plan for this week	Clients write one food step, one movement step, one sleep step, and one medical step, each dated. Writing stays with the client.
55–60 min	Close	Takeaways, the medical referral path restated, and one body step each client will actually do this week.

Teaching points

- **Recovery is physical, not only mental.** The body carried the cost of active use: missed meals, broken sleep, untreated illness, injuries ignored, teeth and health postponed until later. Recovery asks the body to do hard work — to steady its rhythms, to tolerate discomfort without a substance, to show up daily — and a body that is fed, rested, and cared for does that work better. Physical health is one of the four dimensions of recovery. Tending the body is therefore not vanity and not a reward for later. It supports the plan the licensed counselor completed before the first group; it does not replace that plan or any care the participant receives, and it starts with small, ordinary steps, not with an overhaul.
- **Food as repair, without rules that shame.** Regular meals steady mood, energy, and cravings better than any single food choice. The general pattern taught here is simple: eat regularly, build meals around a variety of foods — vegetables, fruits, whole grains, and protein foods — drink water through the day, and keep sugary drinks and heavily processed foods occasional rather than constant. No meal plan is prescribed, no calorie target is set, and no food is forbidden in this group. Clients with diabetes, allergies, eating concerns, or any medical nutrition need take their questions to medical staff or a dietitian, and facilitators never comment on any client's weight, body, or eating in the room.

- **Movement: start small, build steady.** Movement steadies mood and stress, improves sleep, and gives the reward system a natural signal it can use again. The national guideline for adults is 150 to 300 minutes a week of moderate-intensity aerobic activity, or 75 to 150 minutes of vigorous-intensity activity, or an equivalent combination, spread through the week, plus muscle-strengthening activities on two or more days a week. The guideline's first principle matters most in early recovery: some activity is better than none, and moving more while sitting less already helps. Start where the client actually is — a daily walk, stairs, stretching, work that uses the body — and build gradually. Anyone with a heart condition, injury, or other health concern checks with a medical provider before starting a vigorous or new exercise program.
- **Sleep: the foundation the rest stands on.** Adults need seven or more hours of sleep a night on a regular basis. In recovery, sleep is not a luxury: short sleep sharpens cravings, weakens decision-making, and deepens low mood, while steady sleep steadies all three. The habits taught here are general and practical: a fixed wake time, even on rest days; a wind-down routine with dimmer light; caffeine ended well before bed; screens out of the bed; and the bed kept for sleep. If sleep problems persist — trouble falling or staying asleep, loud snoring with pauses in breathing, or exhaustion despite long nights in bed — that is a medical conversation, and the facilitator connects the client to medical staff the same day. Sleep aids, including anything bought over the counter, are medication questions for a provider, never group advice.
- **Medical care: catch up, do not catch shame.** Many clients arrive with years of postponed care: no primary care provider, untreated dental pain, unfilled prescriptions, screenings missed, vaccinations behind. Catching up is part of recovery, and shame has no place in it. Clients are taught to establish primary care, to bring a current list of medicines and questions to appointments, to ask what screenings and preventive care apply to them, and to keep dental and vision care in the same plan. Medical decisions — including whether any test, treatment, or medicine is right for a particular person — belong to the client and their providers. The facilitator's job is to help the client name the appointment they need and get connected to staff who can arrange it.
- **Know the warning signs that need same-day help.** This group teaches recognition, not diagnosis. Some signs need medical attention the same day: chest pain or pressure, trouble breathing, sudden severe headache, sudden weakness or speech difficulty, a wound that is worsening, fever with confusion, severe pain, or thoughts of harming oneself. In an emergency, call 911 or call or text 988; otherwise, alert staff and medical providers the same day and do not wait for the next group. A client who is in withdrawal, is medically unwell, or discloses a medical or psychiatric concern in group is connected to medical staff through program procedure immediately. Waiting it out is never the plan taught here.
- **The body, still healing.** Healing in the body, like healing in the brain, is gradual and uneven. Energy returns in fits and starts, sleep settles slowly, appetite and weight shift, and old aches announce themselves as the numbing wears off. None of that is failure, and no timeline is promised to any client in this group. What the group teaches is the direction: regular food, daily movement, protected sleep, care kept current, and honesty with providers about symptoms and history. Tobacco and alcohol use continue to tax the body during recovery, and the Nicotine Cessation and Brain Science outlines carry that work in depth. Tending the body daily is how a warrior keeps the ground already taken.

- **Protect the basics on a hard day.** On the hardest days, the plan shrinks to its smallest faithful form: one regular meal, one short walk or stretch, one fixed wake time, and one honest contact with a support person or staff member. A hard day is not a failed day when the basics were kept. Clients choose steps small enough to keep on a hard day when they write their body plan below, so a bad day has a plan already made instead of a decision to make while depleted. If the basics cannot be kept for several days running, that is information for the care team, shared the same day — not a private failure to hide.
- **The warrior's reading.** So the warrior's reading, said plainly: the body carried you through the worst of it, and it is still carrying you. Feed it regularly, move it daily, guard its sleep, and take it to the care it needs without apology. Small reps, kept faithfully, are how a body becomes trustworthy ground again — ground a whole recovery can stand on.

Discussion prompts

- "Which part of physical health — food, movement, sleep, or medical care — has been hardest to keep steady, and what gets in the way?"
- "What is one small movement or food step that would actually fit a real day here, not an ideal one?"
- "What makes it hard to ask for medical help after years of postponing it — and what would make the first appointment easier to keep?"
- "What is one warning sign every person in this room should act on the same day, without waiting?"

Practice — my body plan for this week (10 minutes, your page stays with you)

1. Choose one food step for this week: a regular meal time, a food you will add, or water you will carry. Write what, and on which days.
2. Choose one movement step: what you will do, for how long, and on which days — starting where you are, not where the guideline ends.
3. Choose one sleep step: a fixed wake time, a wind-down start time, or a caffeine cutoff. Write the time and the first night you will try it.
4. Choose one medical step: the appointment you need, the question you want to ask a provider, or the referral you will ask staff about. Write who you will ask, and when.
5. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Physical Health in Recovery

- **Education only — no medical advice.** This group teaches general health information. Facilitators do not diagnose, interpret symptoms, recommend treatments, diets, supplements, or exercise programs for any individual, and do not comment on any client's body, weight, or eating. Every personal health question is referred to medical staff or the client's own providers the same day.

- **Medication affirmed; decisions referred.** Facilitators affirm clients who use medication exactly as prescribed, never advise a client to start, stop, or change any medication — including sleep aids and over-the-counter products — and refer every medication question to medical staff the same day.
- **Medical concerns go the same day.** A client who reports pain, illness, withdrawal, a worsening condition, or a psychiatric concern is connected to medical staff through program procedure immediately. In an emergency, call 911 or call or text 988. The group never waits, watches, or treats the concern with group skills. See the escalation box at the front of this packet and the Facilitator Guide crisis protocol.
- **No shame about bodies or care.** No client is singled out for their health, habits, or history of postponed care. Facilitators correct shaming language in the room, directly and kindly, and keep every discussion at the level of general education and personal planning, never personal examination.
- **Warrior close:** Close with the body's work: “Feed it, move it, rest it, and take it to the care it needs — one dated step this week, kept like a promise. That is how warriors hold ground: by tending the ground they stand on.”

Sources & Evidence

Clinical evidence: U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition (2018) — adults should move more and sit less; for substantial health benefits, 150 to 300 minutes a week of moderate-intensity, or 75 to 150 minutes a week of vigorous-intensity aerobic activity, or an equivalent combination, spread through the week, plus muscle-strengthening activities on two or more days a week. Centers for Disease Control and Prevention. About Sleep — adults aged 18 to 60 need seven or more hours of sleep per night on a regular basis, and insufficient sleep is linked with poorer health outcomes.

Recovery-support evidence: Substance Abuse and Mental Health Services Administration — the four dimensions of recovery: health, home, purpose, and community, with health as the dimension that includes physical well-being and the everyday conditions that sustain recovery. National Institute on Drug Abuse. Drugs, Brains, and Behavior: The Science of Addiction — treatment as a combination of behavioral therapies, medications where indicated and decided with a medical provider, and recovery support, with the everyday conditions of health, sleep, and routine supporting the brain's recovery. No outcome or timeline is promised for this group.

Note: No outcome is promised for any group in this packet.

Breakout 15 — Health and Wellness Basics — Sleep, Food, Movement, Hygiene, and When to Seek Care

One sentence for the board: Taught by LPN staff, this group teaches general health and wellness basics in plain language — sleep, food, movement, hygiene, and how the body works day to day — and when a health question needs a private conversation with staff or a provider, not advice in group.

Purpose	Teach general health and wellness education, taught by LPN staff, in plain language: sleep, food, movement, hygiene, body basics, and when to seek care — in general terms only, with every personal health concern taken private to staff or a clinician and no personal health advice, diagnosis, or medication advice in group.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who wants plain, general health and wellness education taught by LPN staff. No participant is asked to share any health condition, measurement, or medical history in group. A participant who shares a personal health concern is taken private to staff or a clinician the same day. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria. This group is taught by LPN staff.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, the topic resources

	named in this outline, and the program's current medical-referral information, one-page picture/word sheet of the same-day warning signs, posted on the board

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: this group is general health and wellness education taught by LPN staff, not personal health advice — personal health concerns go private to staff or a clinician the same day.
5–30 min	Teaching	The teaching points below, in order, on the board: health basics, sleep, food, movement, hygiene, when to seek care, the private path, and keeping the basics on a hard day.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to share any health condition or history.
45–55 min	Practice — my wellness basics plan	Clients write one sleep step, one food step, one movement step, and one hygiene step, each dated, and name the private path for a health question. Writing stays with the client.
55–60 min	Close	Takeaways, the private path and medical referral path restated, and one basics step each client will actually do this week.

Teaching points

- **Health basics, taught plainly.** LPN staff teach this group as general health and wellness education — what the body does day to day, in plain words: the heart moves blood around the body, the lungs move air in and out, digestion turns food into energy, the skin protects the body, and teeth and mouth need daily care to stay sound. General information is taught to everyone in the room. Nothing in this group is advice for one person's health, and no one is examined, measured, or diagnosed here. A question about one person's health goes private to staff or a clinician the same day.
- **Sleep: the steady base.** Sleep steadies mood, decision-making, and cravings, and steady sleep is built on steady habits: a fixed wake time, even on rest days; a wind-down routine with dimmer light; caffeine ended well before bed; screens out of the bed; and the bed kept for sleep. Adults need seven or more hours of sleep a night on a regular basis. If sleep problems persist — trouble falling or staying asleep, loud snoring with pauses in breathing, or exhaustion despite long nights in bed — that is a medical conversation, and the facilitator connects the client to medical staff the same day. Sleep aids, including anything bought over the counter, are medication questions for a provider, never group advice.
- **Food: regular and enough.** Regular meals steady mood, energy, and cravings better than any single food choice. The general pattern taught here is simple: eat regularly, build meals around a variety of foods — vegetables, fruits, whole grains, and protein foods — drink water through the day, and keep sugary drinks and heavily processed foods occasional rather than constant. No meal plan is prescribed, no calorie target is set, and no food is forbidden in this group. Clients with diabetes, allergies, eating concerns, or any medical nutrition need take their questions to medical staff or a dietitian, and facilitators never comment on any client's weight, body, or eating in the room.
- **Movement: a little, every day.** Movement steadies mood and stress, improves sleep, and gives the body a daily signal it can use again. The first principle matters most: some activity is better than none, and moving more while sitting less already helps. Start where the client actually is — a daily walk, stairs, stretching, work that uses the body — and build gradually. Anyone with a heart condition, injury, including ongoing pain, or other health concern checks with a medical provider before starting a vigorous or new exercise program. Gentle, short movement — a short walk, gentle stretching — counts, in general terms; what fits one person's pain is a private conversation with a provider the same day.
- **Hygiene: small care, daily.** Daily hygiene is ordinary care that protects health and dignity: wash hands with soap, especially after using the bathroom and before eating; shower or bathe regularly; brush teeth and care for the mouth daily; keep skin clean and dry, care for feet, and change into clean clothes. Cuts, sores, rashes, or skin problems are not examined or treated in group — a client with a skin, foot, dental, or other personal care concern is taken private to staff the same day. No one is singled out for their hygiene, habits, or history in this room.
- **When to seek care — and how.** This group teaches recognition, not diagnosis. Some signs need medical attention the same day: chest pain or pressure, trouble breathing, sudden severe headache, sudden weakness or speech difficulty, a wound that is worsening, fever with confusion, severe pain, or thoughts of harming oneself. Teach this list from the picture/word sheet posted on the board, pointing as each sign is named. In an emergency, call 911 or call or text 988; otherwise, alert staff and medical providers the same day and do not wait for the

next group. Routine care is part of the same teaching: establish primary care, bring a current list of medicines and questions to appointments, and keep dental and vision care in the same plan. The facilitator's job is to help the client name the appointment they need and get connected to staff who can arrange it.

- **The private path for personal concerns.** If a participant shares a personal health concern in group, the facilitator thanks them, does not advise in the group, and takes the concern private to staff or a clinician the same day. The group never examines, diagnoses, or advises on a person's health, and no plan or diagnosis detail is discussed in the room. The facilitator confirms the counselor plan is in place, without reading clinical detail. Asking for private help is a success in this group, never a disruption.
- **Keep the basics on a hard day.** On the hardest days, the plan shrinks to its smallest faithful form: one regular meal, one short walk or stretch, one fixed wake time, one hygiene step, and one honest contact with a support person or staff member. A hard day is not a failed day when the basics were kept. Clients choose steps small enough to keep on a hard day when they write their wellness basics plan below. If the basics cannot be kept for several days running, that is information for the care team, shared the same day — not a private failure to hide.

Discussion prompts

- "Which basic — sleep, food, movement, or hygiene — is hardest to keep steady here, and what gets in the way?"
- "What is one small sleep or hygiene step that would actually fit a real day here, not an ideal one?"
- "What makes it hard to ask for medical help, and what would make asking easier — in private, with staff?"
- "What is one sign every person in this room should act on the same day, without waiting for the next group?"

Practice — my wellness basics plan (10 minutes, your page stays with you)

1. Choose one sleep step for this week: a fixed wake time, a wind-down start time, or a caffeine cutoff. Write the time and the first night you will try it.
2. Choose one food step for this week: a regular meal time, a food you will add, or water you will carry. Write what, and on which days.
3. Choose one movement step: what you will do, for how long, and on which days — starting where you are, not where a guideline ends.
4. Choose one hygiene step: handwashing, dental care, showering, or foot care. Write what, and when in the day you will do it.
5. Name the private path: who you will ask privately if a health question comes up, and when you will ask them. Write the name and the day.
6. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

REDIRECT SCRIPT — MEDICATION QUESTION (say word-for-word)

Thank you for asking. This group teaches general health information only — I cannot advise on your medication here, even though I am LPN staff. I will take this private with [staff/clinician] today at [time/place], and they will answer it with you. Let us go back to the general teaching.

Second press — say: "I hear this matters now. The private conversation today is the fastest safe way to get you a real answer. I will make sure it happens today."

Facilitator boundaries — Health and Wellness Basics

- **Education only — LPN staff teach; no personal advice.** This group teaches general health and wellness information, taught by LPN staff. Facilitators do not diagnose, interpret symptoms, recommend treatments, diets, supplements, or exercise programs for any individual, and do not comment on any client's body, weight, or eating. Every personal health question is taken private to medical staff or the client's own providers the same day.
- **A personal concern goes private — never advised in group.** If a participant shares a personal health concern, the facilitator does not advise in the group, takes the concern private to staff or a clinician the same day, and returns the group to general education. No personal health detail is discussed, examined, or recorded in the group.
- **Counselor plan confirmed in place, no detail.** The facilitator confirms the counselor plan is in place, without reading clinical detail. No plan goal, diagnosis, or clinical detail is recorded or discussed in group, and no facilitator advises on any client's plan.
- **Medication affirmed; decisions referred.** Facilitators affirm clients who use medication exactly as prescribed, never advise a client to start, stop, or change any medication — including sleep aids and over-the-counter products — and refer every medication question to medical staff the same day.
- **Medical concerns go the same day.** A client who reports pain, illness, withdrawal, a worsening condition, or a psychiatric concern is connected to medical staff through program procedure immediately. In an emergency, call 911 or call or text 988. The group never waits, watches, or treats the concern with group skills. See the escalation box at the front of this packet and the Facilitator Guide crisis protocol.
- **No shame; warrior close.** No client is singled out for their health, habits, or history of postponed care. Facilitators correct shaming language in the room, directly and kindly, and keep every discussion at the level of general education and personal planning, never personal examination. Close with the basics kept: "Sleep, food, movement, and clean daily care — one dated step this week, kept like a promise. That is how warriors hold ground: by tending the ground they stand on."

Sources & Evidence

Clinical evidence: U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans, 2nd edition (2018) — adults should move more and sit less; for substantial health benefits, 150 to 300 minutes a week of moderate-intensity, or 75 to 150 minutes a week of vigorous-intensity aerobic activity, or an equivalent combination, spread through the week, plus muscle-strengthening activities on two or more days a week. Centers for Disease Control and Prevention. About Sleep — adults aged 18 to 60 need seven or more hours of sleep per night on a regular basis,

and insufficient sleep is linked with poorer health outcomes.

Recovery-support evidence: Substance Abuse and Mental Health Services Administration — the four dimensions of recovery: health, home, purpose, and community, with health as the dimension that includes physical well-being and the everyday conditions that sustain recovery. General hygiene and everyday body care are taught here as part of the health dimension's everyday conditions, in general terms only. National Institute on Drug Abuse. Drugs, Brains, and Behavior: The Science of Addiction — treatment as a combination of behavioral therapies, medications where indicated and decided with a medical provider, and recovery support, with the everyday conditions of health, sleep, and routine supporting the brain's recovery. No outcome or timeline is promised for this group.

Note: No outcome is promised for any group in this packet.

Breakout 16 — Trigger & Warning Sign Mapping — Map Your Own Triggers and Warning Signs

One sentence for the board: This group maps the personal triggers and warning signs each client already knows from their own life — what comes before use, and what shows up first — so the map can be written down and used.

Purpose	Teach clients to map their own triggers and warning signs — the people, places, feelings, times, and situations that come before use, and the early signs that trouble is starting — as a personal, written map they keep and use. This is mapping only: it is not crisis planning, which WRAP teaches on Thursday, and not a full prevention plan, which Relapse Prevention teaches.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who

	wants a clear, written picture of what comes before use for them. No participant is asked to share anything from their map aloud. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: maps stay with their owners — nothing is collected or read aloud.
5–30 min	Teaching	The teaching points below, in order, on the board: triggers, warning signs, the map as yours, mapping before planning, order, and using the map.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to share anything from their map aloud.
45–55 min	Practice — my trigger and warning-sign map	Clients map their own triggers and warning signs in order, and choose where the map will live. Writing stays with the client.
55–60 min	Close	Takeaways, the WRAP Thursday and Relapse Prevention next steps named, and one map step each client will actually do this week.

Teaching points

- **A trigger is what comes before.** A trigger is a person, place, feeling, time, or situation that has come before use in your own life — not a theory about triggers in general. This group maps only what the client recognizes from their own experience.
- **Warning signs are what shows up first.** Warning signs are the early changes — in thoughts, feelings, sleep, appetite, routine, or contact with support — that show up before a high-risk situation turns into a decision point. Naming them early is the point of the map.
- **Your map is yours, not a copy.** Two people in the same room can have different triggers and different warning signs. Borrowing someone else's map does not work; the map has to match the life it will be used in.
- **Mapping is not planning — yet.** This group draws the map: what the triggers are, what the warning signs are, and in what order they usually appear. The plan for what to do about each one is built in Relapse Prevention and in the WRAP Thursday sitting, not here. Do not turn this hour into a crisis plan.
- **Order matters.** Triggers and warning signs usually arrive in a sequence — one thing, then the next. Writing them in the order they usually appear makes the map usable: the first sign is the place to act.
- **A map is used, not memorized.** A map kept in a drawer helps no one. Clients leave with the map on paper they keep, and with one named place they will keep it where they can see it.

Discussion prompts

- "What is one trigger you already know from your own life — not one you were told about, one you have lived?"
- "What is the earliest warning sign you notice in yourself — the first small change, before things get loud?"
- "In what order do your triggers and warning signs usually arrive? What comes first, and what comes next?"
- "Where will your map live so you can actually use it — and who, if anyone, will you show it to?"

Practice — my trigger and warning-sign map (10 minutes, your page stays with you)

1. List your triggers in three columns: people and places; feelings and times of day; situations and anniversaries. Write only what you recognize from your own life.
2. List your warning signs in the order they usually appear, from the earliest small change to the last sign before a high-risk situation.
3. Draw one line from the trigger that comes first to the warning sign that follows it. That line is the sequence your map is built on.
4. Write where this map will live — pocket, notebook, wall — and the first date you will look at it again.
5. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Trigger & Warning Sign Mapping

- **Mapping only — no crisis planning in this room.** This group maps triggers and warning signs. It does not write crisis plans, safety plans, or prevention plans; those belong in WRAP Thursday and Relapse Prevention. A client in crisis now is connected to staff the same day — the group does not plan around them.
- **No one shares their map aloud.** Maps are personal. No participant is asked to read their map, name a trigger in front of the room, or describe a high-risk situation in detail. General answers are complete answers.
- **No diagnosing, no treatment planning.** Facilitators teach mapping as education. They do not assess any participant's risk, do not score danger, and do not complete a plan for anyone in the room.
- **Warrior close:** Close with the map kept: "You cannot watch for what you have never named. Name it, write it down, keep it where you can see it — that is how warriors hold ground: by knowing the ground."

Sources & Evidence

Clinical evidence: Marlatt, G. A., and Gordon, J. R. (Eds.). Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors (1985) — the foundational relapse-prevention model: high-risk situations, warning signs, and coping planning. This outline teaches the mapping part of that model only — triggers and warning signs as the client recognizes them — and does not teach a full prevention plan.

Recovery-support evidence: Written personal prevention plans and peer practice — standard recovery-support practices reflected in SAMHSA recovery-support guidance. The written map in this outline is kept by the participant and is never collected. No outcome is promised for this group.

Note: No outcome is promised for any group in this packet.

Breakout 17 — Healthy Stress Management — Practical Skills for Stress

One sentence for the board: This group practices healthy ways to steady stress — in the body, in the day, and in contact with other people — so stress has somewhere to go besides use.

Purpose	Teach practical, healthy stress-management skills clients can use the same day: steadying the body, steadying the day, and reaching out

	— practiced in the room, not just described. This is skills practice, not the grounding practice of Coping Skills and not teaching about the brain's stress systems from Brain Science.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant who wants practical ways to steady stress without using. No participant is asked to share what is stressing them. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: no one is asked to share what is stressing them.
5–30 min	Teaching	The teaching points below, in order, on the board: stress as a load, steadying the body, steadying the day, reaching out, steadying versus numbing, and the hard day.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to name what is stressing them.
45–55 min	Practice — my stress-	Clients practice one body skill,

	steadying plan	shape tomorrow in three steps, and name one person and one sentence. Writing stays with the client.
55–60 min	Close	Takeaways, the same-day path for a medical concern restated, and one steadying step each client will actually do this week.

Teaching points

- **Stress is a load, not a verdict.** Stress is the body's response to a load — too much to carry, too fast, for too long. Feeling stressed does not mean recovery is failing; it means the load needs a way down.
- **Steady the body first.** Stress lives in the body before it lives in words: tight shoulders, shallow breathing, a racing heart. The first skills are physical and small — slow breathing out, unclenching hands and jaw, a short walk, water — and they are practiced in the room until they are familiar.
- **Steady the day next.** Stress grows when a day has no shape. A short list of what must happen today, one thing at a time, in order, with rest built in, keeps a hard day from becoming a formless one. Small, finished steps lower the load more than big plans announced and abandoned.
- **Reach out before the load peaks.** Stress handled alone grows; stress spoken to one trusted person shrinks. Naming the load to a support person, a peer, or staff — early, before the peak — is a skill, not a weakness, and it is practiced here as a sentence clients can actually say.
- **Know the difference between steadying and numbing.** Healthy stress management steadies the load so it can be carried. Numbing — with a substance, with sleep that swallows the day, with shutting everyone out — postpones the load and adds to it. This group practices the steadying kind only.
- **A hard day still counts.** On the hardest days the plan shrinks to its smallest form: one slow breath, one finished step, one honest contact. A hard day is not a failed day when the small steps were kept.

Discussion prompts

- “What does stress feel like in your body first — before you have words for it?”
- “Which of the three — body, day, or reaching out — is hardest for you, and what gets in the way?”
- “What is one healthy way you have already steadied stress, even once, that actually worked?”
- “What sentence could you say to one trusted person when the load is rising — word for word?”

Practice — my stress-steadying plan (10 minutes, your page stays with you)

1. Practice one body skill in the room: three slow breaths out, shoulders down, hands unclenched. Write the one you will use first.
2. Write tomorrow as three steps, in order, each small enough to finish — and one rest built in between them.
3. Write the name of one person you will contact when the load rises, and the sentence you will say: “I am stressed, and I need…”
4. Name one numbing habit you will not use to steady stress this week, and the steadying step that replaces it.
5. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Healthy Stress Management

- **Skills practice, not therapy.** Facilitators teach and practice stress-management skills as education. They do not counsel any participant's stress, diagnose anxiety, or advise on any individual's situation.
- **No medical advice.** Stress that comes with chest pain, trouble breathing, or thoughts of harming oneself is a same-day medical concern, not a group skill. Connect the client to medical staff through program procedure immediately; in an emergency, call 911 or call or text 988.
- **No one shares their stress aloud.** No participant is asked to name what is stressing them or to describe a stressful situation in detail. General answers are complete answers.
- **Medication affirmed; decisions referred.** Facilitators affirm clients who use medication exactly as prescribed, never advise a client to start, stop, or change any medication, and refer every medication question to medical staff the same day.
- **Warrior close:** Close with the load steadied: “Stress is a load, and a load can be steadied — one breath, one finished step, one honest word. That is how warriors hold ground: by setting the load down in pieces, not all at once.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. Trauma-Informed Care in Behavioral Health Services (TIP 57, 2014) — grounding, self-regulation, and coping-skills education in behavioral health settings. Cognitive behavioral and dialectical behavior therapy skills literatures are the broader clinical background for reframing, grounding, and distress-tolerance skills; named generally here, with no specific outcome claimed for this group.

Recovery-support evidence: Written personal coping plans, in-session guided practice, and peer rehearsal — standard recovery-support practices. SAMHSA National Helpline, 1-800-662-4357, for referrals when a client needs support beyond this group. No outcome is promised for this group.

Note: No outcome is promised for any group in this packet.

Breakout 18 — Life Skills for Stability — Housing Readiness and Employment Readiness

One sentence for the board: This group builds the two kinds of readiness recovery stands on after the basics hold — a place to live that stays, and work that pays and keeps.

Purpose	Teach housing readiness and employment readiness as practical planning: what a stable place to live requires, what steady work requires, and the dated steps that move each one forward. This is new ground beyond Life Skills, which teaches money and time; nothing here repeats the money and time material. This group plans; it does not place anyone in housing or a job, and it promises no placement.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant working toward stable housing, steady work, or both. No participant is asked to share their housing situation, income, or employment history in group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline, and the program's current local resource sheet

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: this group plans — it does not place anyone in housing or a job.
5–30 min	Teaching	The teaching points below, in order, on the board: two foundations, housing readiness, keeping the place, employment readiness, naming what you can do, and dated steps.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to share their housing situation, income, or work history.
45–55 min	Practice — my housing and work steps	Clients choose housing or work and write three dated steps, what step one needs, and an if–then plan. Writing stays with the client.
55–60 min	Close	Takeaways, the staff referral path for housing and work questions restated, and one dated step each client will actually do this week.

Teaching points

- **Stability is two foundations.** Recovery stands on daily systems — money, time, home, work — and this group works the two that reach beyond the week: a place to live that stays, and work that pays and keeps. Both are built in steps, not found in a single leap.
- **Housing readiness: know what a landlord needs.** A stable place to live asks for the same things in the same order: identification and documents in one folder, a way to show income or support, references who will answer, and a record kept clean from here on. This group teaches what to gather and in what order — it does not find housing for anyone.
- **Housing readiness: keep the place once it is yours.** Rent paid on time, the place kept clean and in repair, neighbors treated with respect, and problems reported early instead of hidden — the same small systems from Life Skills, aimed at keeping a home, not just finding one.

- **Employment readiness: show up ready.** Steady work asks for documents in one folder, a way to be reached, clean clothes and a way to get there, and the habit of arriving early and communicating before a lateness, not after. Prepare the night before; that habit alone rebuilds a reputation.
- **Employment readiness: name what you can do.** A short, honest list of what a person can do — tasks, skills, experience, willingness — written down, practiced aloud in general terms, and kept where it can be used for an application or a conversation. No participant is asked to perform their history for the room.
- **Steps, dated, one at a time.** Housing and work each get three dated steps — gather, ask, follow up — small enough to finish this week. A step without a date is a wish; this group writes dates.

Discussion prompts

- "What is one housing or work step you have already finished — and what made it possible?"
- "What gets in the way most often: missing documents, no way to be reached, transport, or something else?"
- "What is one thing you can do, honestly and plainly, that an employer or landlord would value?"
- "Who on staff or in your supports can help with one step this week — and what exactly will you ask them?"

Practice — my housing and work steps (10 minutes, your page stays with you)

1. Choose housing or work — the one that needs a step this week. Write which one and why.
2. Write three steps for it — gather, ask, follow up — each small enough to finish, with the day you will do each one.
3. Write what you need for step one: the document, the number, the ride, the person to ask.
4. Name the obstacle most likely to appear and your if–then plan for it: "If ___ happens, then I will ___."
5. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Life Skills for Stability

- **Planning, not placement.** Facilitators teach readiness and planning. They do not find housing, do not find jobs, do not contact landlords or employers for a client, and do not promise any placement or outcome. Referrals go through program staff.
- **No personal advice on any client's situation.** Facilitators do not advise on any individual's housing, benefits, legal, or employment matter. Questions about a client's own situation go to program staff and the client's own contacts.
- **No one shares their situation aloud.** No participant is asked to share housing status, income, benefits, or work history in group. General answers are complete answers.

- **Warrior close:** Close with the steps dated: “A place that stays and work that keeps are built one dated step at a time — gather, ask, follow up. That is how warriors hold ground: by building the ground they will stand on.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. SAMHSA's working definition of recovery and its four major dimensions — health, home, purpose, and community — which frame housing and purposeful work as conditions that sustain recovery. This outline applies that framework as group education; it makes no outcome claim and promises no placement.

Recovery-support evidence: Casey Life Skills (Casey Family Programs) — a widely used framework for assessing and building practical life skills, named here as the framework background for the readiness domains covered. Recovery-support application in this packet: peer practice, written weekly steps, and accountability in group. No outcome is promised for this group.

Note: No outcome is promised for any group in this packet.

Breakout 19 — Identity Reconstruction & Purpose — Rebuilding Identity and Finding Purpose

One sentence for the board: This group does the work of becoming someone new on purpose — setting down the old name addiction gave, and building a life aimed at something worth doing.

Purpose	Teach identity reconstruction and purpose as recovery work: separating the person from the addiction, naming who the person is becoming, and aiming daily life at a purpose worth keeping. This is rebuilding, not the re-authoring of labels from the Labels group and not the service and vocation work of Giving Back — it is the wider work of who a person is and what their life is for.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for

	participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant doing the work of becoming someone new in recovery. No participant is asked to share their past, their record, or their story in group. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: no one is asked to share their past or their story.
5–30 min	Teaching	The teaching points below, in order, on the board: the person is not the addiction, identity by conduct, purpose as direction, grief, old chapters, and purpose kept by routine.
30–45 min	Discussion	Prompts below. General answers are always complete answers — no one is asked to share their past, their record, or their story.
45–55 min	Practice — my identity line and my purpose	Clients write one identity line, one purpose, one daily act, and one kept promise. Writing stays with the client.
55–60 min	Close	Takeaways, the counselor path for anyone who needs it restated, and one daily act

		each client will actually do this week.

Teaching points

- **You are not your addiction.** Addiction handed out a name — addict, failure, lost cause — and the name stuck because it was repeated. This group starts from a separation the whole program stands on: the person is not the problem; the problem is the problem. The name can be set down.
- **Identity is built by conduct, not by announcement.** A new identity is not declared once and finished; it is built by kept promises, day after day — showing up, finishing small steps, treating people steadily. Conduct writes the new name; words alone do not.
- **Purpose is a direction, not a job title.** Purpose is what a day is aimed at: caring for family, learning a trade, keeping a home, helping one other person, making something that lasts. It can be small and still be purpose — what matters is that the day has somewhere to go.
- **Grief belongs in this work.** Rebuilding an identity means grieving what addiction cost — years, relationships, chances — without letting grief become the new name. Grief named honestly, in general terms, is part of the rebuild; grief carried alone becomes a weight that pulls back.
- **The old chapters stay written.** Rebuilding does not pretend the past never happened. The record, the harm, the lost years — they are part of the story, not the whole of it. A person who has done harm owns it through the program's own processes; this group does not rehearse it and does not excuse it.
- **Purpose is kept by routine.** A purpose with no daily shape fades. One daily act aimed at the purpose — a call kept, a skill practiced, an hour given — keeps the direction alive on ordinary days, not only on good ones.

Discussion prompts

- “What name did addiction hand you — and what name are you building instead, in plain words?”
- “What is one kept promise, however small, that already says something true about who you are becoming?”
- “What is your life aimed at right now — not a job title, a direction? What does a day aimed that way look like?”
- “What grief from the old life still needs naming — in general terms — before the rebuild can hold?”

Practice — my identity line and my purpose (10 minutes, your page stays with you)

1. Write one line about who you are becoming, in your own words, in person-first language: “I am a person who…”
2. Write one purpose for this season of your life — a direction, not a job title — in one sentence.

3. Write one daily act that aims at that purpose, small enough to do tomorrow.
4. Write one kept promise from this week that already proves the new line true.
5. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Identity Reconstruction & Purpose

- **No life stories in the room.** No participant is asked to tell their history, name their past, or describe harm done or suffered. General learning is always a complete way to participate.
- **No clinical work.** Facilitators teach identity and purpose as recovery education. They do not diagnose, do not counsel any participant's past, and do not run any therapeutic process in group. A client who needs that help is connected to their counselor the same day.
- **No promises about outcomes.** No facilitator promises any participant a particular identity, result, or future. The work is the direction, practiced daily — nothing more is claimed.
- **Warrior close:** Close with the line kept: "You are not the name addiction gave you. You are the kept promises, the daily acts, the direction you walk — one day at a time. That is how warriors hold ground: by becoming, on purpose, the person they mean to be."

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. SAMHSA's working definition of recovery and its four major dimensions — health, home, purpose, and community — which frame purpose as a condition that sustains recovery. This outline applies that framework as group education; it makes no outcome claim.

Recovery-support evidence: Substance Abuse and Mental Health Services Administration — peer recovery support and recovery-community frameworks, in which helping others and community participation are core dimensions of recovery support. This outline applies that framework as group education; it makes no outcome claim. No outcome is promised for this group.

Note: No outcome is promised for any group in this packet.

Breakout 20 — Community Re-Engagement — Re-Entering Community Life

One sentence for the board: This group practices coming back into community life — relationships, supports, and ordinary belonging — one step, one person, one room at a time.

Purpose	Teach community re-engagement as recovery

	work: re-entering community life, rebuilding relationships and supports, and taking a place in ordinary belonging again. This is re-entry, not the service and volunteering of Giving Back and not the avoidance of high-risk situations from Relapse Prevention — it is the work of belonging again.
Who chooses this group	Curriculum groups meet separately for men and for women. Breakout groups are coed unless otherwise specified. Placement for participants who do not fit a men/women split follows the participant's stated preference, confirmed with staff for safety and privacy. Nothing about a participant's placement is disclosed to the group. Any participant ready to take a step back into community life — a relationship, a group, a support, a room. No participant is asked to name anyone they have harmed or been harmed by, or to describe any relationship in detail. The stated preference stands unless a stated safety reason requires a private conversation. Safety and privacy are the only criteria.
Length	60 minutes
Materials	Paper and pens for every client, whiteboard or flip chart and markers, and the topic resources named in this outline

Time	Segment	What happens
0–5 min	Welcome	Ground rules, confidentiality limits, right to pass. State plainly at the start: no one is asked to name anyone in their life.
5–30 min	Teaching	The teaching points below, in order, on the board: community as recovery, one safe connection, trust by conduct, the network, ordinary belonging, and boundaries.
30–45 min	Discussion	Prompts below. General

		answers are always complete answers — no one is asked to name anyone in their life or describe any relationship.
45–55 min	Practice — my community map	Clients map the supports they have, name one safe connection and one ordinary place, and one protecting boundary. Writing stays with the client.
55–60 min	Close	Takeaways, the staff path for any unsafe relationship restated, and one community step each client will actually do this week.

Teaching points

- **Recovery happens in community, not alone.** Addiction isolates: people, rooms, and ordinary life all narrow down to one thing. Recovery widens them again — one person, one room, one ordinary day at a time. Belonging is not a reward for later; it is part of the work now.
- **Start with one safe connection.** Re-entry does not begin with a crowd. It begins with one safe connection — a support person, a peer, a family member where that is safe, a group that welcomes newcomers — and one concrete next step toward them.
- **Relationships are rebuilt by conduct.** Trust is not rebuilt by explanation or apology alone; it is rebuilt by sustained, changed conduct — showing up when promised, telling the truth plainly, keeping small commitments. This group teaches the conduct; it does not rehearse conversations with real people.
- **Supports are a network, not a single person.** One person cannot carry a whole recovery. A network — peers, support people, staff, community groups, and, where it fits, family — spreads the load so no single relationship breaks under it. Clients map the network they have and the one gap they will fill next.
- **Ordinary belonging counts.** A shared meal, a regular group, a morning greeting, a place where your name is known — ordinary belonging is recovery work, not a break from it. Clients name one ordinary place or group they will enter or re-enter this week.
- **Boundaries protect re-entry.** Re-entering community life does not mean re-entering every old room. Some people, places, and situations stay closed — Relapse Prevention teaches which ones and why. Boundaries are what make re-entry safe enough to keep.

Discussion prompts

- “What is one safe connection you already have — and what makes it safe?”

- “What is one ordinary place or group where you would like to belong again — or belong for the first time?”
- “What is the one gap in your network right now — and who could fill it, even partly?”
- “What conduct rebuilds trust fastest, in your experience — showing up, telling the truth, or keeping small promises?”

Practice — my community map (10 minutes, your page stays with you)

1. List the supports you have now: people, groups, staff, and community connections — one line each.
2. Circle the one safe connection you will lean on most this week, and write the next step toward them, with a day.
3. Name one ordinary place or group you will enter or re-enter this week, and the day you will go.
4. Name one boundary that protects your re-entry — a person, place, or situation that stays closed — and write it as a plain sentence.
5. Keep your page. It is yours. Nothing written in this practice is collected, copied, or kept by the facilitator or the program.

Facilitator boundaries — Community Re-Engagement

- **No rehearsing real relationships.** Facilitators do not role-play conversations with real people, do not advise on any specific relationship, and do not contact any family member or support person for a client. Questions about a specific relationship go to program staff and the client's own counselor.
- **Safety first in every reconnection.** A client who names a relationship that may be unsafe is connected to staff the same day. No reconnection is ever presented as required, and no one is pressed to reconcile with anyone.
- **No one shares relationship detail.** No participant is asked to name anyone, describe a relationship, or tell a story about a person in their life. General answers are complete answers.
- **Warrior close:** Close with the step taken: “Belonging is not a reward for later — it is the work now. One safe connection, one ordinary room, one kept promise at a time. That is how warriors hold ground: by standing it together.”

Sources & Evidence

Clinical evidence: Substance Abuse and Mental Health Services Administration. SAMHSA's working definition of recovery and its four major dimensions — health, home, purpose, and community — which frame community as a condition that sustains recovery. This outline applies that framework as group education; it makes no outcome claim.

Recovery-support evidence: Substance Abuse and Mental Health Services Administration — peer recovery support and recovery-community frameworks, in which helping others and community participation are core dimensions of recovery support. This outline applies that framework as group education; it makes no outcome claim. No outcome is promised for this group.

Note: No outcome is promised for any group in this packet.

Resources and adding topics

National resources — verified, for every group

These national resources may be read aloud and handed out in any group. They are printed here exactly as the services publish them:

Emergency	Call 911 if it is safe to do so.
National Domestic Violence Hotline	Call 1-800-799-7233 • Text START to 88788 • thehotline.org — confidential support and safety planning, 24 hours a day.
988 Suicide and Crisis Lifeline	Call or text 988 — 24 hours a day.
SAMHSA National Helpline	Call 1-800-662-4357 (1-800-662-HELP) — treatment referrals and information, in English and Spanish, 24 hours a day.

Local resources — Senath area (fill in by hand)

Local names and numbers change, and a wrong printed number helps no one. This packet therefore leaves local resources blank on purpose. The facilitator fills in the current information from the program's local resource sheet before group, and the Program Director reviews this page whenever that sheet changes.

Local domestic violence shelter / advocate	Name: _____ Phone: _____
Local crisis / mobile response	Name: _____ Phone: _____
Nearest hospital / emergency care	Name: _____ Phone: _____
Program on-call staff contact	Name: _____ Phone: _____
Other local resource	Name: _____ Phone: _____

Adding topics later

The twenty topics in this packet are the menu for breakout groups, with WRAP fixed twice weekly and the other nineteen topics rotating by current client needs. Additional topics can be added later as client needs and program capacity grow. A new topic joins the rotation only when it has a complete outline in this same format — purpose, a timed plan, teaching points, prompts, an in-room practice, facilitator boundaries, and a Sources & Evidence box that separates clinical evidence and recovery-support evidence. Any Scripture content for a new topic goes only in a separate Optional Scripture Handout in the appendix format (a new handout in the B-number sequence, following B-20), never in the outline itself — and when the Program Director has approved it. A new topic joins the rotation as a rotating topic; it does not displace WRAP's twice-weekly sittings, and the rotation flexes to make room for it.

No topic is added on the strength of a good title alone, and no outline is facilitated from memory or from an outside handout that has not been reviewed for this program's standards: an evidence-based core, grace and not shame, medication affirmed, needed care never replaced by group support, and every source real and checkable.

A closing word to facilitators

Two rooms, two topics, one choice. It sounds small. It is not. A client who can point at the work they most need — safety, family, a steadier daily life, a plan to stay free, a chance to give back, a skill for the hard hour, a written plan for staying well, a plan to break free from nicotine, the work of shedding labels and defining themselves, the science of how the brain was changed and how it heals, healthier relationships built on boundaries and repair, steadier footing when mental health and recovery meet, a way out of debt toward financial independence, a body tended with food, movement, sleep, and care, and general health and wellness basics taught by LPN staff, mapping their own triggers and warning signs, steadying stress in healthy ways, building housing and employment readiness, rebuilding identity and purpose, and re-entering community life — and walk into that room is practicing the exact thing recovery requires: honest self-knowledge, freely chosen, acted on today. Not every topic runs every week — the week's rotation is chosen for the clients in the house, WRAP fixed twice weekly, and the full menu returns over the rotation cycle as the nineteen rotating topics cycle through and more are added.

Run your room well. Prepare like it matters, teach like it is true, and hold the boundaries that keep the room safe and honest — because all three matter for what the hour produces.

Joshua Damon Brown, MS • Program Director, New Day Recovery, Senath, Missouri

Appendix — Optional Scripture Handouts

The twenty breakout outlines in this packet are evidence-based only. The faith content that was previously woven through each outline — the Scripture passages in the King James Version and the framing written for each topic — is preserved in this appendix as twenty separate handouts, one for each topic: B-1 Domestic Violence; B-2 Parenting Skills; B-3 Life Skills; B-4 Relapse Prevention; B-5 Giving Back (A Spirit of Service); B-6 Coping Skills (Development and Practice); B-7 WRAP (Wellness Recovery Action Plan); B-8 Nicotine Cessation; B-9 Labels and the Power of Words; B-10 Brain Science of Addiction and How It Heals in Recovery; B-11 Building and Maintaining Healthy Relationships; B-12 Managing Co-Occurring Mental Health Conditions; B-13 Financial Recovery & Credit Rebuilding; B-14 Physical Health in Recovery; B-15 Health and Wellness Basics; B-16 Trigger & Warning Sign Mapping; B-17 Healthy Stress Management; B-18 Life Skills for Stability; B-19 Identity Reconstruction & Purpose; B-20 Community Re-Engagement.

Handouts B-7, B-8, B-9, B-10, B-11, B-12, B-13, B-14, B-15, B-16, B-17, B-18, B-19, and B-20 were written with their outlines, in the same format: one passage in the King James Version, thematically paired with the topic. The other six handouts are preserved in this appendix, unchanged.

These handouts are optional and separate from the groups. Faith-based lessons are never required, and faith content cannot be required — even in a faith-based program. Every handout in this appendix carries the same marking, and the marking governs how it is used:

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

How handouts are offered

- The facilitator mentions availability neutrally, in one line only, with no pressure: “Optional Scripture handouts for this topic are available on request outside group time.” No invitation to respond in the room, and no comment on who does or does not ask.
- A handout is given only to a participant who requests one, and it is given outside required session time. Handout content is never delivered, read aloud, taught, or discussed as part of the required group.
- Requests are never tracked in a way that affects services. A request is not recorded as a measure of participation, progress, or compliance, and declining a handout carries no consequence of any kind.
- If a client raises handout content during a group, acknowledge it briefly and return to the outline for that session. The group stays on its evidence-based outline.

Each handout begins on its own page so it can be printed or copied on its own, without the rest of the packet. All twenty handouts remain in the packet even though not every topic runs every week.

Print only the handouts for topics scheduled that week, and store them apart from the group outlines and sign-in materials.

Handout B-1 — Domestic Violence

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Psalm 34:18 (King James Version) — *"The LORD is nigh unto them that are of a broken heart; and saveth such as be of a contrite spirit."*

Isaiah 41:10 (King James Version) — *"Fear thou not; for I am with thee: be not dismayed; for I am thy God: I will strengthen thee; yea, I will help thee; yea, I will uphold thee with the right hand of my righteousness."*

Framing note (preserved as originally written for this topic):

God draws near to the brokenhearted. Nothing in these verses asks a survivor to stay in danger, stay silent, or reconcile on anyone else's timetable. Read them as nearness and strength for the person who has been harmed — never as an instruction to endure harm.

Handout B-2 — Parenting Skills

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Proverbs 22:6 (King James Version) — *"Train up a child in the way he should go: and when he is old, he will not depart from it."*

Ephesians 6:4 (King James Version) — *"And, ye fathers, provoke not your children to wrath: but bring them up in the nurture and admonition of the Lord."*

Framing note (preserved as originally written for this topic):

Training is daily and patient — nurture, not provocation. Proverbs 22:6 is a proverb about faithful training, not a guarantee to promise a parent or a verdict on a parent whose child is struggling. Say that plainly. Some parents in the room carry that grief.

Note on Ephesians 6:4: “ye fathers” addresses parents and caregivers — mothers included. This handout speaks to every parent and caregiver, whatever their family role.

Handout B-3 — Life Skills

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Proverbs 3:5–6 (King James Version) — *“Trust in the LORD with all thine heart; and lean not unto thine own understanding. In all thy ways acknowledge him, and he shall direct thy paths.”*

Colossians 3:23 (King James Version) — *“And whatsoever ye do, do it heartily, as to the Lord, and not unto men;”*

Framing note (preserved as originally written for this topic):

Trusting God and building a budget are not opposites. Faith directs the path; faithful hands do today's work on it — heartily, including the unglamorous parts.

Handout B-4 — Relapse Prevention

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

1 Corinthians 10:13 (King James Version) — *"There hath no temptation taken you but such as is common to man: but God is faithful, who will not suffer you to be tempted above that ye are able; but will with the temptation also make a way to escape, that ye may be able to bear it."*

James 4:7 (King James Version) — *"Submit yourselves therefore to God. Resist the devil, and he will flee from you."*

Framing note (preserved as originally written for this topic):

The way of escape is real — and it usually has to be found before the moment of pressure, not during it. That is what a plan is: the escape route, mapped in a clear head. These verses are foundation and encouragement, not a claim that willpower alone is a treatment plan.

Also preserved from the original outline:

- Teaching point, original wording in part: "Protect the basics that protect everything else: sleep, food, meetings and groups, prayer, honest contact with support people, and any medication taken exactly as prescribed."

Handout B-5 — Giving Back (A Spirit of Service)

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Acts 20:35 (King James Version) — *"I have shewed you all things, how that so labouring ye ought to support the weak, and to remember the words of the Lord Jesus, how he said, It is more blessed to give than to receive."*

Mark 10:45 (King James Version) — *"For even the Son of man came not to be ministered unto, but to minister, and to give his life a ransom for many."*

Galatians 6:9 (King James Version) — *"And let us not be weary in well doing: for in due season we shall reap, if we faint not."*

Framing note (preserved as originally written for this topic):

Service in the pattern of Christ is strength, not self-erasure. We serve from gratitude, in measure, with boundaries — and we do not keep score.

Also preserved from the original outline:

- Teaching point, original wording: "Service is offered, never owed as penance. No client earns forgiveness, standing, or God's love by serving. We serve because we have received — that order matters, and facilitators keep it straight."

Handout B-6 — Coping Skills (Development and Practice)

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Philippians 4:6–7 (King James Version) — *"Be careful for nothing; but in every thing by prayer and supplication with thanksgiving let your requests be made known unto God. And the peace of God, which passeth all understanding, shall keep your hearts and minds through Christ Jesus."*

Psalm 46:1 (King James Version) — *"God is our refuge and strength, a very present help in trouble."*

2 Timothy 1:7 (King James Version) — *"For God hath not given us the spirit of fear; but of power, and of love, and of a sound mind."*

Framing note (preserved as originally written for this topic):

Prayer and practice belong together in a person's own practice, outside group time. We bring requests to God — and we train the mind He gave us. A sound mind is both gift and discipline.

Also preserved from the original outline:

- Skill 3 — Reframe, original wording in part: "What is true instead — including what is true about God's nearness and my own progress?"
- Skill 4 — Ride the urge, original skill list in part: "walk, water, prayer, a call"
- Skill 5 — Reach out, original wording in part: "meeting, or place of prayer"

Handout B-7 — WRAP (Wellness Recovery Action Plan)

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Proverbs 16:3 (King James Version) — *"Commit thy works unto the LORD, and thy thoughts shall be established."*

Framing note (written for this topic):

A plan written in a clear head is a gift to a future self who may not have one. WRAP asks a person to commit their wellness to paper — what keeps them well, what warns them, who may help and how. This verse pairs with that work: the committing is the person's own, done deliberately, in their own words. The plan belongs to the person who wrote it. Monday and Thursday parts: the Monday sitting teaches the Wellness Toolbox and the Daily Maintenance Plan; the Thursday sitting teaches Triggers, Early Warning Signs, When Things Are Breaking Down, the Crisis Plan, and the Post-Crisis Plan. Either part may be requested on its own.

Handout B-8 — Nicotine Cessation

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

1 Corinthians 6:19–20 (King James Version) — *"What? know ye not that your body is the temple of the Holy Ghost which is in you, which ye have of God, and ye are not your own? For ye are bought with a price: therefore glorify God in your body, and in your spirit, which are God's."*

Framing note (written for this topic):

These verses are about care, not condemnation. The body is a gift held in trust, and breaking free from nicotine is one way of tending what was entrusted — breath by breath, day by day. A person still struggling with dependence is not a failed temple; they are a person mid-repair, and repair is holy work. Plans, support, and medical help are tools for the work, not substitutes for grace.

Handout B-9 — Labels and the Power of Words

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

2 Corinthians 5:17 (King James Version) — *"Therefore if any man be in Christ, he is a new creature: old things are passed away; behold, all things are become new."*

Framing note (written for this topic):

This verse is about who does the naming. The old creature was named by the old life — by other people's words, by the record, by the worst chapters. In Christ, the naming is new: old things passed away, all things become new. A person shedding a label is not pretending the old chapters were never written; they are refusing to live under a name God Himself has retired. The new name is received, and then it is walked out — day by day, choice by choice, under your own name.

Handout B-10 — Brain Science of Addiction and How It Heals in Recovery

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Romans 12:2 (King James Version) — *"And be not conformed to this world: but be ye transformed by the renewing of your mind, that ye may prove what is that good, and acceptable, and perfect, will of God."*

Framing note (written for this topic):

Renewal is the word this verse gives for what the brain-science group describes: a mind transformed, not frozen in the old pattern. The old shape was pressed in by the world and by repeated use, day after day. The renewing is pressed in the other way — by new thinking practiced, new company kept, new days walked out — until the renewed mind is the one a person lives from. No timeline is promised here, and no one is told their renewal is finished. The verse names the direction, and the direction is toward a mind made new.

Handout B-11 — Building and Maintaining Healthy Relationships

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Ephesians 4:32 (King James Version) — *"And be ye kind one to another, tenderhearted, forgiving one another, even as God for Christ's sake hath forgiven you."*

Framing note (written for this topic):

Kindness, tenderness, and forgiveness are the pattern this verse sets for how people treat one another — and the pattern holds alongside boundaries, not instead of them. Kindness does not require contact that is unsafe, forgiveness is never demanded on anyone else's timetable, and trust is rebuilt by conduct that matches the words. Read this verse as the manner of repair: gentle in tone, honest in word, steady in deed.

Handout B-12 — Managing Co-Occurring Mental Health Conditions

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Psalm 147:3 (King James Version) — *"He healeth the broken in heart, and bindeth up their wounds."*

Framing note (written for this topic):

This verse names nearness for a broken heart — not a promise that any particular wound heals on a particular day, and not a reason to wait for help instead of seeking it. Binding up wounds is careful, hands-on work, and in this program it includes clinical and medical care, support people, and daily steadiness. Read this verse as hope held honestly: the heart is tended, the wounds are bound, and asking for help is part of the tending.

Handout B-13 — Financial Recovery & Credit Rebuilding

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Proverbs 22:7 (King James Version) — *"The rich ruleth over the poor, and the borrower is servant to the lender."*

Framing note (written for this topic):

This proverb names debt plainly: owing money narrows a person's freedom to choose. Naming it is not shaming the person who owes — many debts were taken on in hard seasons, and some were inherited from the costs of addiction itself. The verse points the direction of the work: smaller debts, a clearer file, and a life less ruled by what is owed. Read it as the reason for the steady steps — map, order, work, protect — taken one at a time, with qualified help.

Handout B-14 — Physical Health in Recovery

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

1 Corinthians 10:31 (King James Version) — *"Whether therefore ye eat, or drink, or whatsoever ye do, do all to the glory of God."*

Framing note (written for this topic):

Eating, drinking, moving, resting — the ordinary acts of a day are named here as worthy work. Tending the body is not vanity and not punishment for past neglect; it is faithful care of what was entrusted, done in small daily acts. A person still struggling with health, sleep, or habits is not failing this verse. They are mid-repair, and repair done faithfully, one step at a time, is the work the verse blesses.

Handout B-15 — Health and Wellness Basics

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

3 John 1:2 (King James Version) — "Beloved, I wish above all things that thou mayest prosper and be in health, even as thy soul prospereth."

Framing note (written for this topic):

Health is wished for here, not promised and not earned by perfect habits. Sleep kept, food eaten regularly, a body moved a little each day, and small daily care — these ordinary acts are named as

worthy work, done one step at a time. A person still struggling with sleep, appetite, movement, or hygiene is not failing this verse. They are mid-repair, and repair done faithfully, one step at a time, is the work the verse blesses. A personal health question is never group advice: it goes private, to staff or a provider, the same day.

Handout B-16 — Trigger & Warning Sign Mapping

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Proverbs 4:23 (King James Version) — "Keep thy heart with all diligence; for out of it are the issues of life."

Framing note (written for this topic):

Watchfulness is the work this verse names: guard the heart — the place triggers and warning signs first show themselves — with diligence, because what comes out of a life follows what was watched over in it. A map is one way of watching: triggers named, warning signs ordered, the sequence written down. A person still learning their own triggers is not failing this verse. They are mid-map, and mapping done honestly, one sign at a time, is the work the verse blesses.

Handout B-17 — Healthy Stress Management

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Matthew 11:28 (King James Version) — "Come unto me, all ye that labour and are heavy laden, and I will give you rest."

Framing note (written for this topic):

Rest is offered here to people carrying a heavy load — not as a reward for managing stress well, and not as a promise that the load lifts on a particular day. The invitation is to come as you are, laden as you are. Healthy stress skills — a slow breath, a shaped day, an honest word to one trusted person — are small ways of answering that invitation, one step at a time. A person still overwhelmed by stress is not failing this verse. They are mid-repair, and repair done faithfully, one step at a time, is the work the verse blesses.

Handout B-18 — Life Skills for Stability

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Psalm 127:1 (King James Version) — "Except the LORD build the house, they labour in vain that build it: except the LORD keep the city, the watchman waketh but in vain."

Framing note (written for this topic):

Building is named here as work that needs more than effort alone: a house built, a life steadied, work kept — all of it raised one step at a time, with faithful hands doing today's part. Housing readiness and employment readiness are the steady steps — gather, ask, follow up — taken one at a time, with qualified help. A person still without stable housing or steady work is not failing this verse. They are mid-build, and building done faithfully, one step at a time, is the work the verse blesses.

Handout B-19 — Identity Reconstruction & Purpose

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Ephesians 2:10 (King James Version) — "For we are his workmanship, created in Christ Jesus unto good works, which God hath before ordained that we should walk in them."

Framing note (written for this topic):

Workmanship is the word this verse gives for a person made new: created for good works, prepared beforehand, walked out one step at a time. Identity is received and then walked — not announced once and finished, but lived daily, in kept promises and ordinary acts. A person still unsure who they are becoming is not failing this verse. They are mid-rebuild, and rebuilding done faithfully, one step at a time, is the work the verse blesses.

Handout B-20 — Community Re-Engagement

Optional — available on request only. Never required, never a condition of participation or services, and never delivered as part of required session time.

Optional Scripture Handout — New Day Recovery, Senath, Missouri. This handout is not part of any group outline. Keep printed copies separate from group materials, and give a copy only to a participant who asks for one, outside required session time.

Galatians 6:2 (King James Version) — "Bear ye one another's burdens, and so fulfil the law of Christ."

Framing note (written for this topic):

Burdens are carried together in this verse — not by one person alone, and not by a crowd all at once, but by neighbors bearing with one another, one load at a time. Re-entering community life is how that bearing happens: one safe connection, one ordinary room, one kept promise. A person still mostly alone is not failing this verse. They are mid-return, and returning done faithfully, one step at a time, is the work the verse blesses.