CASE CONSULTATION:
WORKING WITH INDIVIDUALS WITH BEHAVIORAL HEALTH CHALLENGES
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HOUSEKEEPING

• Ground Rules
• Bike Rack
• Restrooms
• Electronic Devices

OBJECTIVES

• Review a case study to practice needs assessment and identification of presenting problems.
• Utilize risk assessment tools to establish and address immediate safety concerns.
• Implement strategies from evidence-based practices for clinical intervention with individuals who present with behavioral health challenges.
DO YOU SEE WHAT I SEE?

Instructions:
Partner A describes the image to Partner B.
Partner B cannot look at the original image, but can ask questions.
Partner B must draw the image, based on the description by Partner A.
Partner A cannot look at the image Partner B creates.
HOW ACCURATE ARE WE?

• Ability to describe what you see and know to others
• Pros and cons of making assumptions and filling in gaps of information
  • Importance of checking out the validity of our assumptions
• Asking questions to clarify understanding
• Communication styles of speaker and listener
  • Cultural influences
  • Stigmatizing language
• Complexity and nature of the circumstances
  • Trauma-informed assessment skills
• Limitations of capturing real life experience, second hand
GORDON’S MODEL OF COMMUNICATION

What the Listener Thinks the Speaker Means

Words the Speaker Says

Words the Listener Hears

What the Speaker Means

1

2

3

4

IMPORTANCE OF ASSESSMENT

• Who ...should be assessed? ...should do the assessment?

• What...are we assessing? ...is the best way to complete an assessment?

• Where ... should the assessment be completed?

• When ...is the best time to complete an assessment?

• Why...is it important? ...is it necessary?
MULTIDISCIPLINARY ASSESSMENT PROFILE (MAP)

- Organizing structure for assessing multiple areas of an individual's life
- Helps avoid oversimplification of complex circumstances
- Acknowledges the interactions among different factors
- Promotes holistic assessment and development of many directions for treatment
  - If an individual seems “stuck” in one area, offers other options for consideration and attention
- Need for ongoing assessment
Problems with substances AND the experience of using substances are the result of interactions.

**DRUG**
- Substances used (effect, potency, purity)
  - Includes prescription medications
  - Route of administration
  - Legality of substances

**SET**
- Person’s unique physiology
- Physical health
- Mental health or emotional state
- Cultural identity
- Expectation of drug and reasons for use

**SETTING**
- Stressors (social, economic, environmental, legal)
- Supports
- Where and with whom drug use occurs
- Social and cultural attitudes toward drug use

**DRUG**
- Substance use diagnoses
- American Society of Addiction Medicine (ASAM) Program 1: Withdrawal and acute intoxication potential
  - Risk of overdose, hospitalization, legal involvement

- Substance(s) used
  - Frequency, amount, pattern of use
  - Potency, purity, effect
  - Route of administration
  - Includes prescription medications and patterns of adherence
CASE EXAMPLE: JESSICA

DRUG
• Severe alcohol use disorder
• Near-daily alcohol use, often begins drinking in the morning, then stops in the evening, physical dependence at times, drives under the influence. Typically consumes ~ 1 bottle of wine/day; binge drinking on weekends; denies blackout.
• Very infrequent use of marijuana, opiate pain pills; sporadic Xanax use; overdose risk increased with polysubstance use.
• Prazosin, Geodon, Naltrexone, Trileptal, forgets to take meds ~1x/week; hx of medication noncompliance

SET
• Individual’s goals
• ASAM 2: Biomedical conditions, complications
• ASAM 3: Emotional, behavioral, cognitive conditions
• ASAM 4: Readiness for change
  ➢Motivation, insight, confidence, self-efficacy
• ASAM 5: Continued use/relapse potential
  ➢Reasons and expectations of use
CASE EXAMPLE: JESSICA

SET
• Goals: stop using alcohol, go back to school, manage mental health (MH) symptoms
• 27 year old, biracial cisgender, heterosexual female; born with cocaine dependency; adopted
• No biomedical conditions; sexually active with 1 partner, uses condoms
• Depression, Post Traumatic Stress Disorder (PTSD); previous diagnosis: Schizoaffective, Borderline Personality Disorder; significant trauma history, shame about trauma and mental health symptoms; ongoing suicidal ideation
• Ambivalent about alcohol use; use varies; motivated to manage MH symptoms
• Drinks to manage PTSD symptoms, drinks in moderation with friends and family; binge drinks with partner; Xanax helps with sleep

SETTING
• ASAM 3: Ongoing emotional stressors
  • Unemployment, financial distress
  • Child or elder care
• ASAM 6: Recovery environment
  • Support system (social, professional)
  • Stressors (social, economic, environmental, legal)
  • Where and with whom drug use occurs
  • Social and cultural attitudes toward the individual’s community and surrounding culture
  • Community violence and/or resources
CASE EXAMPLE: JESSICA

SETTING

- Connected to many professional supports; well engaged; trusts therapist
- Significant social network; childhood best friend positive influence; current partner respectful of boundaries, but engages in heavy alcohol use.
- Living independently for first time; was living in nursing home for 1 year; receives Supplemental Security Income (SSI)
  - Friends from nursing home with substance use, mental health concerns; one friend provides Xanax and opiate pain pills, threatens suicide
- Complicated relationship with mother; father deceased; many siblings (adopted and biological); suspected history of sexual abuse by brother
- Alcohol use occurs at home, alone or with others; at friends’ homes
- Unemployed; recently re-enrolled in school

CASE SCENARIO: CREATING A MAP

- Work in groups.
- Complete Juan’s MAP, including drug, set, and setting.
- Write your MAP on the paper provided.
DRUG
- Substance(s) used (frequency, amount, route, pattern of use)
- Substance use diagnoses
- Prescription medications and compliance
- ASAM 1: Withdrawal and acute intoxication potential (risk of overdose, hospitalization, legal involvement)

SET
- Individual’s goals
- ASAM 2: Biomedical conditions, complications, considerations
- ASAM 3: Emotional, behavioral, cognitive conditions
- ASAM 4: Readiness for change
- ASAM 5: Continued use/relapse potential (reasons & expectations of use)

SETTING
- ASAM 3: Ongoing emotional stressors
- ASAM 6: Recovery environment
  - Stressors and supports (social, economic, environmental, legal, professional)
  - Where and with whom drug use occurs

JUAN’S MAP
- How do Juan’s drug, set, setting influence each other?
- What strengths does Juan demonstrate?
- What needs would you focus on first?
- What interventions would you implement?
- Other ideas for resources or support?

Utilizing the MAP
- What questions came up?
- How can you implement this in your work?
ASSESSING FOR SAFETY

Drug Overdose  Homicide  Suicide

OVERDOSE PREVENTION AND RESPONSE

WE NEED TO TALK ABOUT OVERDOSE.

OVERDOSE DEATH IS PREVENTABLE. KNOW WHAT TO DO.

OVERDOSE CAN AFFECT ANYONE.
KEY GROUPS AT RISK OF OVERDOSE

• People experiencing homelessness
  • #1 cause of death (Baggett, 2012)

• People experiencing incarceration
  • #1 cause of death (Binswanger, 2013)

• People entering & exiting treatment for Opioid Use Disorder
  • Detox riskier than AMA or nothing (Strang, 2003)

• People living with Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) 74% higher if HIV+ (Green, 2012)

OVERDOSE RISK FACTORS

• Polysubstance use
• Tolerance changes
• Quality
  ➢ Variation in strength and content of street drugs (e.g., purity, additives)
  ➢ Variation in strength and action of prescription opioids (e.g., Vicodin is not Dilaudid)
  ➢ Unknown pill content
• Using alone
• Physical health (e.g., liver disease, weight loss, asthma, immune system problems, dehydration, malnutrition)
• Mode of administration
• Previous overdose
FENTANYLS IN ILLICIT OPIOID SUPPLY

Fentanyl and analogs are mostly found mixed with or sold as heroin. Fentanyls also found mixed with (less common)

- Cocaine
- Methamphetamine
- Counterfeit prescription opioids and benzodiazepines

TALKING ABOUT OVERDOSE IN SU TREATMENT

- Impact of past overdose events
  - Individuals who have experienced overdose
  - Loved ones lost to overdose
  - Communities impacted by overdose
  - Trauma and grief associated with overdose
  - Impact on recovery efforts and outcomes

- Preventing potential future overdoses
  - Individuals in our programs
  - People in their lives
WHY DO WE HAVE TO TALK ABOUT OVERDOSE?

- Increase likelihood of survival and health among people served
- Improve relationship between individuals served and their providers
- Affirm individuals as valuable community members who are able to save lives within communities
- Enhance a holistic prevention, treatment, and recovery system’s capacity to address trauma
- Support treatment providers by expanding skills and addressing vicarious trauma

WHAT ARE THE SIGNS OF A POSSIBLE OPIOID OVERDOSE?

- Pupils small - “pinned”
- Unresponsive
- Not speaking
- Breathing slow or stopped
- Less than 8 times per minute
- May hear choking sounds or a gurgling/snoring noise
- Blue or purple lips/fingertips
- Gray, cold, clammy skin
**REALLY HIGH OR OVERDOSE?**

**Really High**
- Pupils small - “pinned”
- Nodding, but arousable
  - Responds to sternal rub
- Speech is slurred
- Sleepy, intoxicated, but breathing
  - 8 or more times per minute

**Overdose**
- Pupils small - “pinned”
- Not arousable
  - No response to sternal rub
- Not speaking
- Breathing slow or stopped
  - Less than 8 times per minute
  - May hear choking sounds or a gurgling/snoring noise
  - Blue or purple lips/fingertips
  - Gray, cold, clammy skin

>> Stimulate and observe

>> Call for help + rescue breathe + give naloxone

**WHAT DO YOU KNOW ABOUT NALOXONE?**
- Naloxone is an opioid overdose antidote.
- Naloxone counteracts the effects of prescription opioids like hydrocodone, oxycodone, morphine, methadone and fentanyl and illegal opioids like heroin.
- Naloxone is very safe.
- If a person has not taken opioids, naloxone will not hurt them, but if something else is wrong, it will not help, either.
OPIOIDS AND OPIOID RECEPTORS

OPIOIDS, OPIOID RECEPTORS & NALOXONE
EVALUATIONS OF OVERDOSE EDUCATION AND NALOXONE DISTRIBUTION (OEND) TO LAYPERSONS

Feasibility
- Piper et al. Subst Use Misuse 2008; 43; 858-70.
- Erent et al. J Urban Health 2010; 87; 931-41.
- Walley et al. JSAT 2013; 44:241-7. (Methadone and detox programs)

Increased knowledge and skills

No increase in use, increase in drug treatment

Reduction in overdose in communities

Cost-effective
$438 (best)
$14,000 (worst) per quality-adjusted life year gained

Should focus on people who use drugs
- Rowe et al. Addiction 2015; 1360-0443

RESPONDING TO AN OVERDOSE

1: Call 9-1-1 (or) 2: Administer naloxone (whichever fastest) 3: Rescue Breathing
THE RECOVERY POSITION

• If you must leave the overdose victim for any reason, put them in the recovery position.
• Lay the person slightly on the left side so that the body is supported by a bent knee, with the person’s face turned to the side and bottom arm reaching out to stabilize the position.

WHAT NOT TO DO DURING AN OVERDOSE

• Don’t leave someone who is overdosing alone (except if you absolutely must leave the area to call for help).
  • Risk: they could stop breathing and die.
• Don’t put them in a bath.
  • Risk: they could drown or go into shock.
• Don’t give them anything to drink or induce vomiting.
  • Risk: they could choke.
THE OVERDOSE-TREATMENT PARADOX

Engagement in substance use treatment can *decrease* risk of overdose by eliminating or reducing drug use…which results in changes to an individual’s tolerance, in turn *increasing* risk of overdose due to:

- Cycles of opioid abstinence and use
- Withdrawal management (detox) often includes use of benzodiazepines
- Discharge from treatment means lowered tolerance, decreased structure and support, and increased access to substances

CASE STUDY: NATHAN

Nathan is a 66 year-old man, who began using heroin at age 18. His pattern of use has varied, but for the majority of his life, he has used heroin daily, via inhalation. He has been to treatment over 10 times, and is now participating in outpatient treatment.

You have connected him to Medical Assisted Treatment (MAT), and with the use of Suboxone and counseling, he has been abstinent for 5 months, his longest period of sobriety ever. He is extremely proud and determined, and has made significant changes to many areas of his life.
CASE STUDY: NATHAN

Nathan has a new doctor and is preparing for 12 weeks of treatment for Hepatitis C, for which he must remain abstinent from heroin.

Nathan has a couple of friends who use heroin on occasion, but he has drawn clear boundaries with them, which they do respect: they don’t use in his presence, discuss their use with him, or come around when they’re intoxicated.

When you try to give Nathan Naloxone and talk about overdose prevention, he says he doesn’t need it because he isn’t going to use.

DISCUSSION QUESTIONS

• What overdose risk factors are present?
• How would you address them with Nathan?
• What overdose prevention plans would you attempt to put in place?
• How can you talk to him about Naloxone?
Billy comes in for an intake to begin Substance Use Treatment. He is a 42 year-old African American cisgender, heterosexual male with long history of involvement with the criminal legal system.

He has spent over 20 years incarcerated throughout his life, and has been out of prison for 4 years, the longest period of time he has ever been free. Billy experienced significant abuse and emotional neglect as a child. He began using heroin at age 12, and found a sense of belonging in gang involvement.
SERVING INDIVIDUALS WITH A HISTORY OF VIOLENCE: BILLY’S CASE

Billy is highly motivated to stay out of prison and really wants to do things differently. He still engages in violent behavior toward others (fighting), but sees it as justified and a way of protecting his loved ones.

He believes that if he doesn’t respond with violence when he or his loved ones are threatened or disrespected, he will be seen as weak and become a target.

DISCUSSION QUESTIONS

• What are your initial thoughts about working with Billy?
• Who may you want to consult for guidance?
• What protocol(s) may need to be implemented or reinforced?
• What other information would you want to collect?
• Would you admit Billy to your program?
• What steps would you take to balance staff safety, program member’s safety, and Billy’s need for treatment services?
SAFETY ASSESSMENTS UPON ENTRY

• Safety review at administrative and clinical levels
• Collected releases of information for previous treatment providers
• Obtained background check to verify his reports
• Established plan for individual counseling with multiple staff
• Agreed on hours and location for Billy’s services
• Collaborated with Billy to safety plan for anger management

BILLY’S CASE

Billy comes in for an appointment and reports that a very close friend of his died last week via overdose. He had known this friend since they were 8 years old, and this was one of the few people who stuck by Billy through thick and thin.
BILLY’S CASE

The people who were using with him didn’t take any steps to try to help. Instead, they robbed him and ran. After a few minutes of discussing this recent loss, Billy discloses to his counselor that he is thinking about seeking revenge on them and believes that killing them would be justified.

DISCUSSION QUESTIONS

• What other information do you need?
• How would you collect that information from Billy?
• Who do you consult for assistance?
• How do you respond to Billy?
ASSESSING HOMICIDAL IDEATION

Homicide assessment:

- Intent
- Plan
- Means
- Access to Means
- Specific Individual
- Duty to Warn

ALWAYS CONSULT WITH YOUR SUPERVISOR!

CRISIS RESPONSE

SAFETY FIRST!

- Ask for help
- Maintain calm posture and voice
- Provide additional space
- Avoid intense eye contact
- Let person know what you are going to do

- Allow person to ‘save face’ if possible
- Be aware of your surroundings
- Don’t threaten, direct, over-promise
- Don’t try to be a hero
**BILLY’S CASE: CRISIS INTERVENTION**

- Thank Billy for sharing his concern, elicited that he wants help thinking this through.
- Empathize with underlying emotions.
- Play out the tape: What do you think will happen if you go through with this?
- Value-based focus
  - What would your friend say about your plan?
  - How will this affect your long term goals?
- Collaborative safety plan written, signed, and provided to Billy

**IF THE DECISION IS NOT TO HOSPITALIZE**

- Review coping strategies with person and practice with them
- Write down names and phone numbers of supports
- Develop plan or routine to follow that will help with managing symptoms including natural supports when possible
- Explore medication: taken consistently, side effects, understand purpose?
- Schedule follow up appointments
- Establish other case management plans to get concrete needs met
- Follow up with team
BILLY’S CASE: DEBRIEFING

Billy misses his next appointment, but when you call him, he agrees to schedule another session. When he comes in, he quickly starts talking about issues he is having with his benefits and wants to focus on a lot of case management tasks.

• How do you respond?
• What do you say to debrief the previous session with him?
• Where do you go from here?

MYTHS ABOUT SUICIDE

Myth: Asking about suicide will plant the idea in someone’s head.

Reality: Asking how someone feels doesn’t create suicidal thoughts any more than asking how someone’s chest feels would cause pains.

Myth: There are talkers and there are doers.

Reality: Most people who die by suicide have communicated some intent. Someone who talks about suicide offers opportunity to intervene before suicidal behaviors occur.

Myth: If someone really wants to die by suicide, there is nothing you can do about it.

Reality: Providing a safe environment for treatment of the underlying causes of suicidal ideas can save lives.
SMALL GROUP DISCUSSION: SARA’S CASE

Sara is a 38 year-old Latina woman with a history of self-injury. She has been hospitalized two times in the past, most recently one year ago. She is currently employed and has been in a relationship with Alex for 3 years. Overall, she has a strong support system which consists of her mother, extended family, 2 close friends, Alex, and colleagues at work. She lives alone in a studio apartment. She uses cocaine and alcohol, which is what brought her to Substance Use Treatment. She states that she is depressed and doesn’t want to live any longer.

SMALL GROUP DISCUSSION: SARA’S CASE

Discussion Questions:
What else do you want to know?
How do you keep yourself and Sara safe?
What do you plan to do to help Sara? What informs your clinical decision?
**SARA’S CASE: PART 2**

With staff support, Sara was brought to the hospital and received a crisis evaluation, but they did not keep her there. She is going to be discharged on Friday morning.

**Discussion Questions:**
- What do you plan to do to help Sara?
- How will your team follow up with Sara?
- What information informs your clinical decision?

**SAFETY TIPS**

- *Exercise* vigilance and attentiveness; learn to be a “good detective”
- *Maintain* a visual grasp of your surroundings
- *Establish* a culture of respect and safety
- *Monitor* for potential indications that someone or something is not right
- *Practice* good self care
- *Develop* a crisis or emergency plan
- *Train* staff on ‘what if’s’
- *Check in* with each other on a regular basis

Adapted from Thresholds Workforce Development Department
BE PROACTIVE

One of the most effective methods for enhancing safe practices is to encourage and make time for regular, ongoing, candid discussions about safety concerns amongst your staff.
MOTIVATIONAL INTERVIEWING AND STAGES OF CHANGE

1. NO, NOT ME.
   Pre-contemplation

2. Well, maybe.
   Contemplation

3. SO, OK. What do I do now?
   Preparation

4. OK. Let’s do this.
   Action

5. IT IS POSSIBLE.
   Maintenance

6. LET’S TRY AGAIN!
   Relapse and Recycling

6. LET’S TRY AGAIN!
   Relapse and Recycling

Let’s try again!
### CLINICIAN’S TASKS AT EACH STAGE OF CHANGE

<table>
<thead>
<tr>
<th>Stage</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Precontemplation</strong></td>
<td>Build relationship, provide practice assistance. Explore what the individual wants, understand their motivation and perspective. Identify strengths.</td>
</tr>
<tr>
<td><strong>Contemplation</strong></td>
<td>Explore benefits of status quo, clarify values, develop discrepancy, normalize and explore ambivalence, assess confidence and expectations of change. Assess resources, develop options, build commitment, identify and reduce barriers, assess for past success, develop and troubleshoot plan.</td>
</tr>
<tr>
<td><strong>Preparation</strong></td>
<td>Help implement plan, normalize missteps, problem solve and adjust plan as needed, build self-efficacy.</td>
</tr>
<tr>
<td><strong>Action</strong></td>
<td>Develop and implement strategies to maintain gains; continue assessing how well the plan is working.</td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
<td>Blame the plan, re-cycle through previous stages; avoid getting caught in shame spiral; re-assess, adjust, and try again</td>
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“RESISTANCE” IS ACTUALLY EITHER

**SUSTAIN TALK** – About target behavior

*I really don’t want to stop.*
*I have to have it.*

**DISCORD** – About your relationship

*You can’t make me.*
*You don’t understand how hard it is.*

BOTH ARE HIGHLY RESPONSIVE TO COUNSELOR STYLE

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**SUSTAIN TALK: THE OTHER SIDE OF AMBIVALENCE**

- Desire for status quo
- Inability to change
- Reasons for sustaining status quo
- Need for status quo
- Commitment to status quo

When sustain talk outweighs change talk, we need to *slow down* and consider stage of change the person is exhibiting.
DISCORD
Interpersonal and requires two people
- Interrupting
- Arguing, challenging
- Discounting, hostility
- Withdrawing, ignoring, changing topic

Means there’s something that we are not hearing.
Slow down, focus on relationship, embody the spirit of MI, and remain present.
CONSIDERATIONS FOR DANCING WITH DISCORD

- Avoid the natural impulse to rebut or debate it.
- Sometimes the goal is simply reducing discord.
- Avoid excessively affirming or negative responses.
  
  - Understand the person’s subjective experience by asking an open ended question or offering a neutral reflection and then responding in a manner congruent with member affect.
- We can change our style in ways that will decrease discord and make collaboration and agreement more likely.
OPEN ENDED QUESTIONS

Instead of a statement, a question can be used to seek a better understanding of the individual’s perspective.

**EXAMPLE:**

*Individual:* “I know that I made a mistake, but the hoops that they are making me jump through are getting ridiculous.”

*Staff:* “Sounds like you’re pretty frustrated. What do you think is the best way forward?”

EMPHASIZING PERSONAL CHOICE AND CONTROL

People ultimately have the choice to take action or not. Acknowledging this may help the individual recognize that they have the right to make a choice.

**EXAMPLE:**

*Individual:* “I know I made a mistake, but the hoops that they are making me jump through are getting ridiculous.”

*Staff:* “You have tried even though you haven’t liked what they are asking you to do. Sounds like you are reconsidering whether you can or want to continue . . .”
SHIFTING FOCUS
Attempts to get around a contentious or defensive issue by *side-stepping* it. Staff validates the individual’s experience and asks for clarification instead.

**EXAMPLE:**

*Individual:* “I know I made a mistake, but the hoops they are making me jump through are getting ridiculous.”
*Staff:* “You’re upset by all of these hoops. What mistake are you talking about?”

Adapted from Thresholds Workforce Development Department

COMING ALONGSIDE
Allows the helper to align and join with the individual. It demonstrates empathy and support and invites the person to modify the original statement or agree with it.

**EXAMPLE:**

*Individual:* “I know I made a mistake, but the hoops they are making me jump through are getting ridiculous.”
*Staff:* “You may be at your limit and might not be able to keep up with all this.”

Adapted from Thresholds Workforce Development Department
REFRAMING

This technique takes a member communication and gives it a twist. It may be useful in providing a positive spin to a seemingly negative assertion.

EXAMPLE:

*Individual:* “I know that I made a mistake, but the hoops they are making me jump through are getting ridiculous.”

*Staff:* “You are not happy about others having so much control, but so far you’ve been able to keep up with all the expectations and have been quite successful!”

Adapted from Thresholds Workforce Development Department

AGREEMENT WITH A TWIST

This is a technique that combines a reflection with a reframe. It gives confirmation of being “heard” and then offers another perspective.

EXAMPLE:

*Individual:* “I know that I made a mistake, but the hoops that they are making me jump through are getting ridiculous.”

*Staff:* “You’re feeling frustrated with all these expectations. It’s clear, though, you are also committed to moving forward and being successful.”

Adapted from Thresholds Workforce Development Department
MI SELF CHECK FOR PRACTITIONERS

Individuals and families with whom I meet would say that I …

- Believe that *they* know what’s best for themselves
- Help them to recognize their own strengths
- Am interested in helping them solve their problems in their own way
- Am curious about their thoughts and feelings
- Help guide them to make good decisions for themselves
- Help them look at both sides of a problem
- Help them feel empowered by my interactions with them

(Hohman & Matulich, 2008)

INTENTION SETTING

- What will you bring back to your workplace?
- What are you excited to try out?
- How will you continue your growth?

*Thank you for all that you do!*
QUESTIONS? COMMENTS?

THANK YOU!

REFERENCES AND RESOURCES

Chicago Recovery Alliance: www.AnyPositiveChange.org


REFERENCES AND RESOURCES


Harm Reduction Coalition: [http://HarmReduction.org](http://HarmReduction.org)


REFERENCES AND RESOURCES


Motivational Interviewing Network of Trainers: [http://www.motivationalinterviewing.org/](http://www.motivationalinterviewing.org/)

REFERENCES AND RESOURCES


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Thomas Gordon, Parent Effectiveness Training: http://www.gordontraining.com/

Thresholds Workforce Development Department: http://www.thresholds.org/our-work/workforce-development/