



INTRODUCTION TO CRISIS PREVENTION STRATEGIES

Provincial Summer Institute 2010

Presenter

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Sponsored by
Education
Services



Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale



CRISIS... *“An opportunity riding on a dangerous wind...”* (poetic interpretation)

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CORE PROGRAM BELIEFS

“There is only one corner of the universe you can be certain of improving and that’s your own self.”

Aldous Huxley

“Crisis intervention with others, despite what it often feels like, is a privilege. The greater the struggle, the greater the potential exists for truly making a difference.”

Philip E. Perry



OVERVIEW OF THE SEMINAR

- This session will provide an overview of the Prevention and Management of Aggressive Behaviour (PMAB) program at the Centre for Addiction and Mental Health (CAMH). Participants who attend this session will be introduced to concepts and strategies that comprise the PMAB program, including the following



AGENDA

- introduction to the seminar
- impact of personal triggers and self management in high stress encounters with angry, aggressive and physically violent clients
- several theoretical frameworks related to anger, aggression, crisis and de-escalation of aggressive behaviours.
- de-escalating interventions that reflect best practice, appropriate to each stage



AGENDA cont'n

- PMAB principles and Trauma Informed Care or Practice.
- roles and responsibilities of staff in planning and conducting a team or Code White crisis intervention
- work related post crisis issues
- a pathway of self-mastery toward maximizing professional competency, resiliency and well-being with respect to crisis intervention work



ENERGY AND STRESS

- Find a partner and “check-in” on your relative levels of:
 - ENERGY
 - STRESS
 - DISTRACTION
 - MOTIVATION
- Use the Thermometer to gauge from 1-10, where you are at right now.
 - 10 minutes



DAILY CHECKING IN AND CHECKING OUT PRACTICES

- A short briefing and venting sessions directly related to maintain professional accountability, enhancing trust and team communication, and balance between work and home
- A Check-in and out process is not a group or individual counselling or therapy



GROUND RULES FOR MUTUAL RESPECT, CONFIDENTIALITY AND CREATING SAFETY DURING OUR WORKSHOP

- everyone participates in his/her own way
- confidentiality is maintained
- we value and honour diversity
- everyone has the right to pass
- everyone brings wisdom and experience

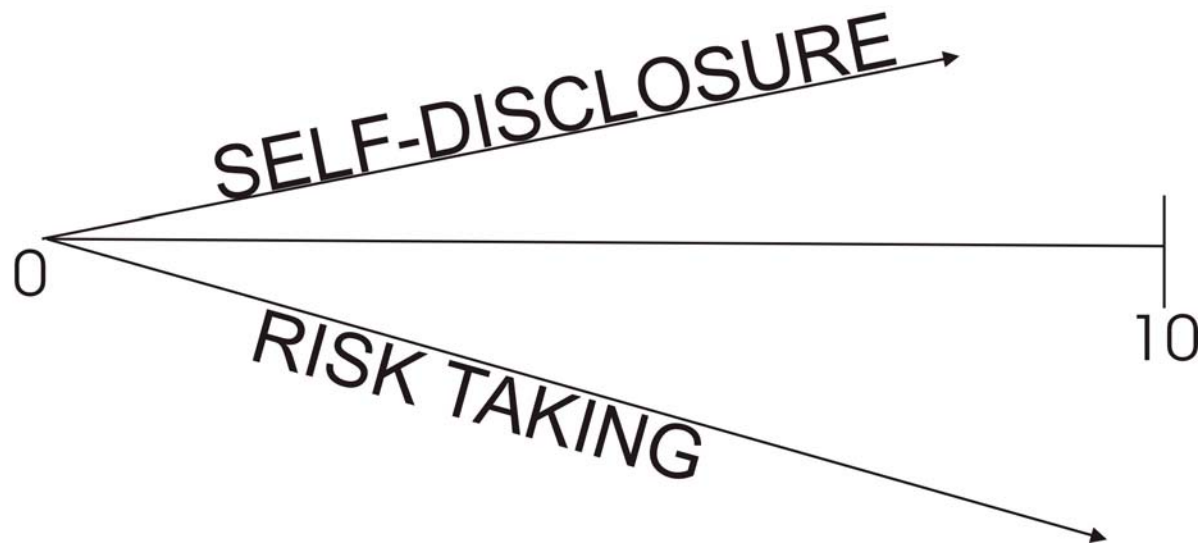


GROUND RULES FOR MUTUAL RESPECT, CONFIDENTIALITY AND CREATING SAFETY DURING OUR WORKSHOP

- facilitator(s) stay in a position of respect
- we commit not to violate each other
- we are encouraged to speak for themselves
- everyone is responsible for his/her own learning
- jargon watch
- fun

SUBJECTIVE UNITS OF DISCLOSURE

S.U.D.S.





SELF AWARENESS

“KNOW THYSELF”

- Socrates, 469-399 BCE



SELF AWARENESS

- ***“Defuse yourself before you attempt to defuse others.”***
 - Dale Tremble and Fred Van Fleet

- ***“Anger is a tool for change when it challenges us to become more of an expert on the self and less of an expert on others.”***
 - Harriet Lerner



PERSONAL TRIGGERS AND PROVOCATIONS

- In your small group of 3-4 people, discuss:
 1. What are your Volcano, Heart String, and/or Panic triggers?
 2. When or how do you know you have been triggered?
 3. What strategies have you developed to successfully manage your own triggers?
 4. Your self-awareness plan to enhance your ability to manage your personal triggers?

(15 – 20 minutes)



NON-VERBAL COMMUNICATION

THE ATTENDING PRESENTATION

- Body Language is non-threatening and demonstrates support and confidence
 - An “interviewers” presentation
- Personal Space is respectful and does not violate the others space
- Eye Contact is a “soft gaze” with the “eyes of an eagle, not the glare of a hawk” (Elder Vern Harper)



NON-VERBAL COMMUNICATION

THE ATTENDING PRESENTATION

Cont'n

- Responsiveness to verbal and non-verbal cues, critical distance, and balance
- Hands are open and visible
- Can use the “wrist clutch” to assist in self management and biofeedback



FIGHT-FLIGHT REVISITED

- Fear and Survival Intuition
- Fear: Stop, Look and Listen
- Flight: Defuse and/or Disengage
- Fight: Defuse and/or Self Protect
- Freeze: Use of Silence and Time
- **Panic:** Immobilized and Overwhelmed by threat – No plan of action



OUR THREAT ALERT SYSTEM IN ACTION

A. "Here it comes!!!!!" (i.e. Child running with gum ball in their mouth)

B. Oh! _ _ _ _ (it is happening now!)

- Plan of action in place, now...I ACT
- Process experience and prepare for next event or situation

BUT, if I have No plan, no preparation, no practice.....

C. PANIC:

- I have no plan!! (Therefore, I need to create plans)
- I have no experience!! (Therefore, I need to simulate the experience to gain experience)
- I have know idea of how I might react!! (Therefore, I need practice to my fears, and gain a sense of my own reactions)

Holistic Intervention and Self-Management Model



Rigid thinking

Discounting

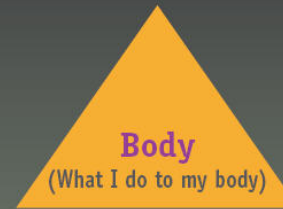
Attack thoughts



Validating

Assessing

Coping thoughts



Headache

Muscle tension

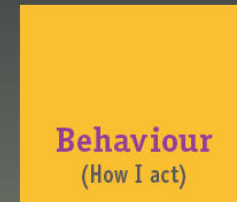
Heart rate



Centering

Relaxing

Positive activity



Clamming up

Avoiding

Attacking



Defusing

Disengaging

Problem solving



MANAGING ANGER, TRIGGERS AND PERSONAL PROVOCATIONS: Summary

- Know what triggers you and why
- Thinking before speaking
- Listen – Empathically and Actively
- Identify your “triggers” and try to “own them” vs. blaming the client or yourself
- Count to ten in your head
- Ask questions – what is the real problem here
- Turn away; breathing; talk to myself; talk to the client; name and own your feelings
- Knowing in advance your sensitivities, boundaries and limits.
- Reframe the problem
- Don’t personalize the trigger
- Seek supervision for support
- “Seek to understand – not to be understood” (S. Covey)
- Keep stress levels lower on a daily basis – self-care – e.g. regular exercise, meditation,
- Disengage from the encounter – give both people time and space when possible



INTERPERSONAL AWARENESS

- *"Violent acts are often the outcome of poor staff – client interactions, rather than client pathology per se."*

- Rice, Harris, Varney & Quinsey (Mental Health Centre, Penetanguishene)

Factors Influencing Crisis and Anger

Beliefs

Mad/Bad/Sad

Environment

Micro/Macro

Communication Skills

Empathy,
Active Listening,
Limit Setting and
Assertive Expression



Self-Talk

Inner Scripts
and Dialogues

History

Past Actions
and Beliefs

Stress Arousal

Chronic
and Traumatic



ENVIRONMENT: Macro Factors

- the larger context in which we engage in assisting people in crisis.
- is reflected in the Impact of the Social Environment model
- has a direct effect on broader issues such as poverty, racism, sexism, and homophobia, which brings with it stigmatization, isolation and increased stress

Impact of the Social Environment

Qualities of the Human Environment

Powerlessness
(Out of control)

Empowerment
(In charge of self)

Confusion
(Unclear messages and limits)

Clarity
(Clear communication and limits)



Isolation
(Alone, unsupported)

Coalition
(Involved, supported)

Increased angry feelings

Decreased angry feelings

Increased fear/insecurity

Increased confidence

Passive/aggressive behaviour

Assertive/cooperative behaviour

Reactive behaviour

Responsive behaviour

Increased stress

Decreased stress

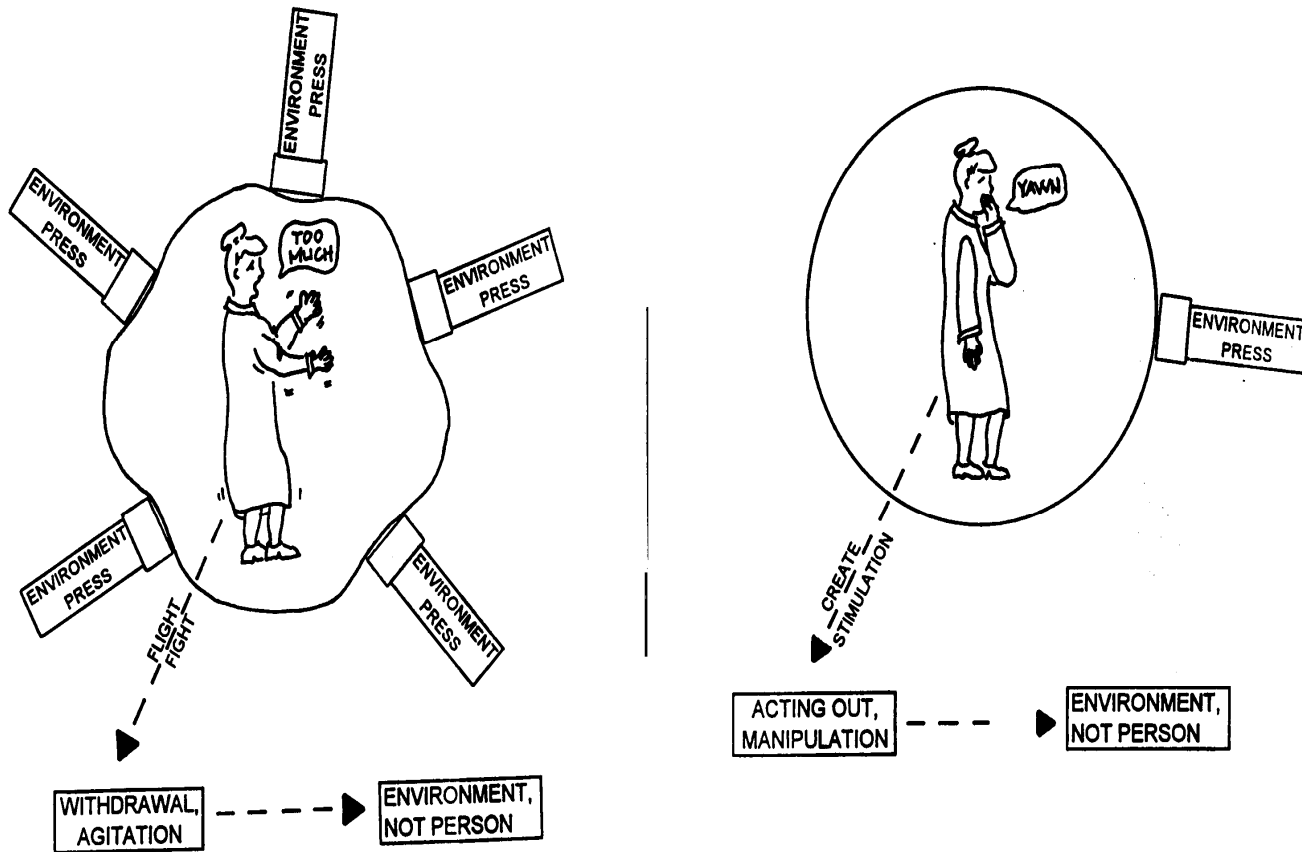


ENVIRONMENT:

Micro Factors

- micro environmental factors relate to the context in which the interpersonal interactions occur.
- can include time of day, effects of audiences, place in which the conflict occurs, power centres, thresholds
- a guiding rule for intervening with clients in care is to preserve their dignity and respect.

MICRO: Environmental Press





PERSONAL HISTORY FACTORS

- Trauma will affect physiological, emotional and cognitive functioning
- the development of self regulation skills
- our ability to form relationships
- our perceptions of selves as good/bad, as capable/incapable



PHYSIOLOGICAL AROUSAL FACTORS

- physiological arousal states can be influenced by personal histories.
- For individuals who have experienced trauma within their lives, their baseline state of arousal may be “re-set”.
- increased baseline level of arousal can contribute to increased reactivity in response to perceived threat (for clients and staff members alike)



BELIEFS FACTORS

- our beliefs are shaped by our history.
- some individuals have a fundamental belief that they are a bad person.
- some believe that adults in authority are always trying to punish them.
- beliefs of individuals who feel threatened are rigid and restricted.
- many experience anger as a win-lose



SELF TALK FACTORS

- inner dialogues, old scripts or tape recorded messages that we carry around.
- self talk can be positive i.e. the world is a good place, I am a good person .
- it can be negative, i.e. the world sucks, I am a failure.
- self talk can become a way of coping, informing us of our reactions and thus influencing our response.



COMMUNICATION SKILLS FACTORS

- the ability to communicate what is going on with ourselves, what we are perceiving and to disclose what we need from others around us.
- For many clients, the most frequent skill deficit is the lack of assertive and direct communication skills
- All staff need to be aware of cross-cultural communication and clinical cultural competence skills



THE MIND AND BODY ARE ONE

Mindfulness activities

- Box Breathing
- Stack Breathing
- Body Scan
- Shake it out



UNDERSTANDING TRAUMA INFORMED CARE AND SERVICES

A brief overview and introduction



TRAUMA-INFORMED CARE

- Care that is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and violence on humans and is informed by knowledge of the prevalence of these experiences in persons who receive mental health services.
 - (National Association of State Mental Health Program Directors-
[\(NASMHPD, 2004\)](#))



WHAT PERCENTAGES OF MENTAL HEALTH CLIENTS HAVE HISTORIES OF TRAUMA?

- 90% of public mental health clients have been exposed to (and most have actually experienced multiple experiences of trauma (Goodman, Rosenberg et al., 1997; Mueser et al., 1998))



WHAT PERCENTAGES OF MENTAL HEALTH CLIENTS HAVE HISTORIES OF TRAUMA?

- 75% of women and men in substance abuse treatment report abuse and trauma histories (SAMHSA/CSAT, 2000)
- 97% of homeless women with mental illness experienced severe physical and/or sexual abuse, (Goodman, Dutton et al., 1997)



RELATIONSHIP TO CAMH VISION AND MODELS OF CARE

- Seclusion/Restraint reduction needs to be congruent with principles of recovery
- We are building a **trauma informed** system of care; creating violence free and coercion free environments; assuring safe environments for staff and clients; and facilitating a return to the community or improved quality of life



TRAUMA INFORMED SERVICES

What are they?

Trauma specific services – are designed to treat the long-term effects of past sexual, physical or emotional trauma.

Trauma Informed Services – are NOT designed to treat the specific symptoms related to the past trauma or abuse. Rather they are providers of care whose primary mission is not the treatment of trauma. They treat the “person” who has special needs due to their trauma history in a sensitive, caring and welcoming way.



TRAUMA INFORMED SERVICES

Understanding “Trauma”

Traditional – Trauma is understood as a single event that took place in the patient’s past and has no relationship to the current problem begin presented. We expect that the patient will have an ongoing reaction but we expect it to be closely linked to the actual event. Example: Someone who sustained major injuries from a car accident would be expected to be afraid to ride in or drive a car.

Trauma Informed – Serious trauma makes the survivor question all that they knew to be true about life. They have trouble making sense of what happened and why. They develop a new belief system to make sense of the trauma which effects all of their choices going forward.



TRAUMA INFORMED SERVICES

Another Understanding of “The Client”

Trauma Informed – The clinician looks at the whole person and tries to make sense of the problem in the context of the present and past trauma history. They may need to be referred to someone who can help them acquire new coping strategies that are more appropriate for their current place in life.



TRAUMA INFORMED SERVICES

Why in my Department, Unit or area?

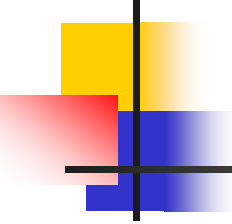
What are some of the outcomes you can expect?

- Reduced use of coercion
- Reduced use of force
- Reduced use of seclusion
- Reduced use of restraint
- Reduced staff time by eliminating unnecessary seclusion and restraint



RECOMMENDATION

Universal precautions. Because not all clients/patients feel comfortable reporting a history of trauma, and because practices that benefit patients with trauma histories benefit all patients, staff should adopt trauma-informed practices toward all clients



THE CRISIS ESCALATION SPIRAL MODEL

- A dynamic and responsive resource for:
- assessing the level of escalation based on observed behaviours and clinical intuition
 - self management
 - matching interventions appropriate and effective at the corresponding levels of escalation



BEFORE THE CRISIS BEGINS

- Check-in
- 360 degree presence and awareness
- Observe and Prepare
- Breathe
- Read shift log
- Enquire about prior shift
- Plan to be proactive
- Body Language that promotes calm and confidence



THE SKILLS OF ENGAGING INDIVIDUALS IN CRISIS

- Self Awareness
- Empathy and Active Listening
- Assertive Communication and Limit Setting
- Coalition Building and Win-Win Problem Solving
- Self Care Strategies in managing body stress
- Simulation Training

EMPATHIC LISTENING: Poetic Chinese Interpretation





ACTIVE LISTENING

- Attending Body Language
- Reflection of feelings
- Paraphrasing of content
- Summarizing: feelings and content
- Feedback and impact on others
attending body language



THE SCRIPTING EXERCISE

Journal Notes:

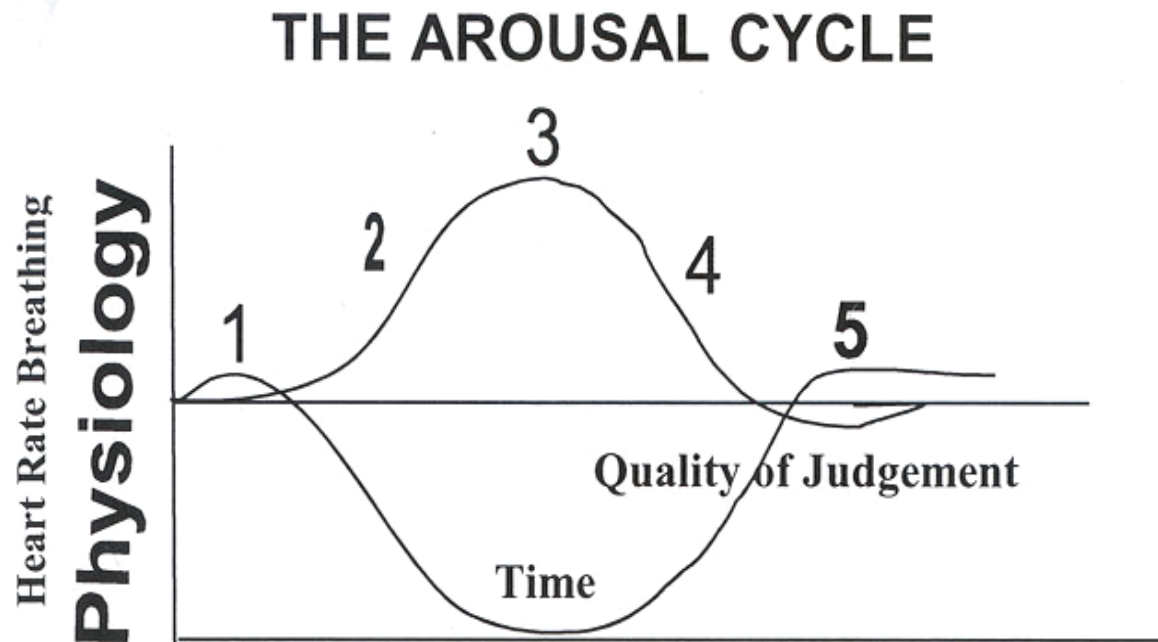


DEALING WITH RESISTANCE OR REFUSAL TO COMPLY WITH REASONABLE REQUESTS

ASSERTIVE COMMUNICATION AND LIMIT SETTING

- Key Principles in Setting Limits:
 - Understand that the “client” is under stress or distress (be understanding not “right”)
 - Set positive limits, never negative
 - Seek the “yes” solution.... Always!!
 - Win-Win Problem Solving if an immediate solution is not possible
 - Help the client “save face”, and maintain their dignity and self respect

THE AROUSAL CYCLE



Source: Smith, Paul. (1983). Professional Assault Response Training (PART) manual, p 12.



THE ART OF CRISIS INTERVENTION

"Clearly, most crisis intervention training formulas, when applied prescriptively or methodically, diminish our brilliance and restrict our creativity"

- Philip Perry, 1990

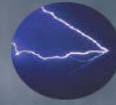
GENERAL PRINCIPLES

FOR DEFUSING HOSTILITY

- **Defuse Yourself first (Centre or Ground)**
- **Consider Trauma**
- **Observe, prepare and be Proactive**
- **Deal With Person's Feelings First**
- **Look To What You Can Agree With, and What You Can Say “Yes” To**
- **Be Assertive, Not Manipulative, Passive, or Aggressive**
- **Focus on “Being Effective” vs. “Being Right**
- **Be mindful of your body language, facial expression, distance and the environment**

The Crisis Escalation Spiral

Check-In



Triggering Event
Psychomotor
Agitation

Manage Triggers

Challenging for
Information

Empathic Approach

Breathe

Power Struggles

Information

Positive Self-Talk

Refusal

Reframing

Step Back

Venting

Setting Limits/Offering Choices

Mobilize Team

Threatening and
Intimidation

Monitoring Risk

Mobilize Self

VIOLENCE

Disengaging/Team Intervention

Self Care

Post Crisis

Self Protection and Team Containment

Client Follow-Up



THE CRISIS DE-ESCALATION SPIRAL MODEL

A dynamic and responsive resource for:

- assessing the level of escalation based on observed behaviours and clinical intuition
- self management
- matching interventions appropriate and effective at the corresponding levels of escalation



TEAM SIMULATION GROUND RULES

- simulations are about PRACTICE not Performance
- simulations are “real” (colleagues are taking risks in front of their peers)
- time Out? OK!
- coaching? OK, but invited, and not advice or critique
- “client” in role(s) must not fake resistance
- must be debriefed



DEBRIEFING SIMULATIONS

- Finally, ask the Staff Members:
 - What did you do well, or that was successful?
 - What skill did you focus on as a priority for yourself?
 - What stands out as the most significant part of the experience for you?
 - If you were to do this again, what (if anything) would you do differently?



CENTERING AND MANAGING BODY STRESS

- The 3 Minute Breathing Space

TEAM INTERVENTIONS



“It is amazing how much you can accomplish when it doesn't matter who gets the credit.”

- Unknown

”There is no "I" in "TEAMWORK".”

- Unknown

”Teamwork: Simply stated, it is less me and more we.”

- Unknown



SUCCESSFUL CRISIS TEAMS

- Have been trained and practice skills together
- Trust each other and have transparent communication
- Leave ego's out of the process, and the focus on *being effective* together vs.
 - who is right or wrong,
 - who wins or loses,
 - what should or shouldn't be happening
- Excellence in practice knows no defensiveness



TEAM INTERVENTIONS

- The Need for Team Interventions
- Getting the Team to the Crisis
- The Team Intervention Leaders in a Crisis
- Designating the Team Intervention Leaders

TEAM INTERVENTION:

CRISIS OR CODE WHITE ROLES AND RESPONSIBILITIES

- Intervention Leader and Back-up or Second to Intervention Leader
- Code Manager
- Role of Security
- Roles of Physicians and Managers
- Roles of Supporting Team Members
- Roles of arriving team members (code white)
- Roles of new staff, students and volunteers



THE “TAG” TEAM AND TRIANGULATION APPROACH

- The switching of roles can be used, with the “touch-in and “tap-out”, if
 - the client escalates and *targets the intervention leader as “their problem or*
 - if the staff member becomes triggered by the client
- Triangulation means that staff supporting the Intervention Leader are behind her/him, not beside or in front.



INTERVENTION LEADER

- Communicates directly with the individual in crisis or client
- Is only staff to speak directly to client
- Is prepared to disengage to another staff should they:
 - Become the target of the aggression
 - Become triggered
 - If a staff with a stronger rapport come to the scene



THE BACK-UP, SECOND TO THE INTERVENTION LEADER

- Advise the Team Leader and other team members they are the “2nd” or Code Manager. Communicate with Team Leader.
- Be prepared to assume the role of Team Leader as required using the “Switch”.
- Coordinate other team tasks (i.e., remove onlookers, call code for 911, assess number of team members necessary).



CODE OR CRISIS MANAGER

Coordinates and directs the overall response
maintains the role of oversight during the entire
crisis event

- Is responsible for doing or delegating the following:
 - briefs staff coming to the code or crisis
 - coordinates the team and delegates tasks
 - assesses the situation and develops a plan of intervention with the assistance and input of the intervention leader and responding staff
 - preparing medication as ordered
 - clearing the area of potentially dangerous objects or weapons of opportunity
 - ensuring patient/clients and visitors are cleared from the immediate area



CODE OR CRISIS MANAGER

- re-directing staff back to their work areas once the intervention team has been formed
- documentation on the Code White Monitoring Form
- once the situation is under control, the Code White Manager or designate instructs Switchboard/Security/Reception/Admitting to announce “Code White all clear”
- conducts a Post Incident Review with all staff involved
- Conducts Post Incident Review with other patients/clients in the area
- may be the back-up the Intervention Leader and is prepared to switch roles to become the Intervention Leader (if there is a shortage of staff available such as night shifts etc.)



ROLE OF OTHER SUPPORTING STAFF

- Seek and Accept direction give by the Code Manager
- Be prepared to play a leadership role with the Client, if appropriate
- Remove or direct any on-lookers
- Scan and Remove any potential hazards in the environment
- Assist in the restraint process as needed
- Assisting with crowd control



ROLE OF SECURITY STAFF

- Seek and Accept direction give by the Code Manager or another clinical staff
- Remove or direct any on-lookers
- Scan and Remove any potential hazards in the environment
- Assist in the restraint process as needed
- Assisting with crowd control



ROLES OF PHYSICIANS AND MANAGERS

- Seek and Accept direction give by the Code Manager
- Be prepared to play a leadership role with the Client if relevant to your role as a physician or manger, and the situation
- Remove or direct any on-lookers
- Scan and Remove any potential hazards in the environment
- Assist in the restraint process as needed
- Assisting with crowd control



ROLE OF NEW STAFF

- Tracks their reactions and questions that they have for future supervision
- Seek and Accept direction give by the Code Manager
- Remove or direct any on-lookers
- Scan and Remove any potential hazards in the environment
- Assisting with crowd control
- Monitor exist and entrances
- If not needed, leave the scene



ROLE OF STUDENTS AND VOLUNTEERS

- Seek and Accept direction give by the Code Manager
- If not needed, leave the scene



PERSONAL SAFETY AND DISENGAGING

- *“Never meet force with force, verbal or physical.... it will only escalate the situation, you may use excessive force, and the bigger force always wins.”*

Butch Snider (CTI Canadian
Training Institute)



ASSESSING THE RISK FOR IMMINENT VIOLENCE

- **Anger or aggression may lead to violence often when:**
 - An immovable threat is perceived
 - a strong sense of powerlessness occurs
 - communication fails
 - the system is felt to be profoundly unresponsive to individual needs
- **Focus of Anger**
- **Level of Cognitive Impairment**
- **Level of Anti-social Behaviour**
- **History of Violence**



WHO GETS HIT?

- Stayed too long.....got too close
- Where the worker denies the potential for violence in a situation (heart string triggers)
- Those who set too many limits or not enough limits
- Those who use untimely interpretations, it is important not to demonstrate too much insight (especially with paranoid clients) and instead to behave as though you and the client are working it out together
- Those who do not listen to the client's threats
- Those who refuse to meet a client's reasonable request
- Those who behave in an overly kind or motherly/fatherly manner
- Where there are negative transference reactions
- Those who force clients to confront upsetting material
- The inexperienced



THE DECISION TO DISENGAGE

- If you are alone and are confronted with physical aggression, immediately leave the scene, and engage the crisis team
- If you can not leave as you are trapped or under assault, self protect and immediately leave the scene

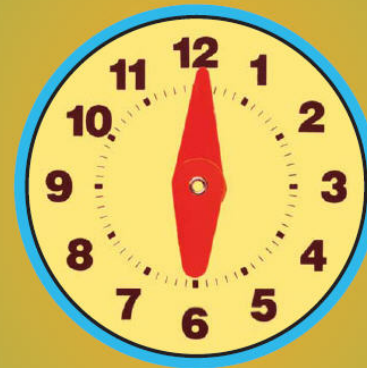
This symbol expresses the movements of entrance and exit in Aikido



Evasion and the Clock Model

The Red Zone

Green Zones



Green Zones

Green Zones

Green Zones

The Red Zone



THE KEY PRINCIPLES OF SELF-PROTECTION vs SELF-DEFENSE

- Congruency with Organizational Values
- Evasion, Distraction, Escape: and the Clock Model
- The Mind And Body Are One: Trained Reactions
- Never Meet Force With Force, Verbal or Physical
- Never support the use of pain compliance, pressure points or impact stuns
- Neutralize the Aggression not the Aggressor
- Defend yourself twice
- Environmental Awareness



POST CRISIS TOPICS: Post-crisis reactions response

- The staff and clients should not be left alone immediately following the incident
- Staff should always be alert to:
 - the individual's confusion or depression about what has happened
 - fears of retaliation by staff
 - the need to find a way of making reparation



POST CRISIS OR CODE WHITE PROCESSES

- Daily Check-in and Check-out
- Immediate “Debriefing” psycho-educational intervention
- Critical Incident or Traumatic Stress Debriefing Resources
- Client Debriefing Processes
- Weekly Incident Review Processes
- Employee Assistance Program (EAP)



THE GOALS OF DEBRIEFING

- To prevent the future use of seclusion and restraint.
- To reverse or minimize the negative effects of the use of seclusion and restraint.
- To address organizational problems and make appropriate changes.



CLIENT DEBRIEFING: Defined

- A Client-centred, Recovery informed, mindful conversation with a client who has experienced a Restraint event while in our care. (inclusive of mechanical, seclusion, or chemical restraint)
- A framework for staff to work within to support the prevention of future events



THE CLIENT DEBRIEFING PROCESS

- At the earliest time possible, and/or within 3 hours of release from restraint (or the administration of medication), a debriefing must be offered to the client/patient
- If the client does not wish to complete it initially, it should be re-offered again, *whenever clinically appropriate*, but within a 24 hour time frame



IMMEDIATE POST EVENT DEBRIEFING FOR STAFF

- After every restraint event (chemical /seclusion/mechanical), an Immediate Post-Event Debriefing will be occur (policy)
- After all crisis events, near misses and successfully managed events



THE GOALS OF THE POST EVENT DEBRIEFING

- to provide an immediate process to ensure that everyone is safe and supported
- to “check-in” with involved staff, clients/patients and witnesses to the event, and return the unit or area and activities to pre-crisis milieu
- to ensure that the client/patient in restraint/seclusion is safe and being monitored appropriately
- that documentation is sufficient to be helpful with later analysis



SELF CARE STRATEGIES

- Sleep
- Nutrition
- Exercise
- Personal Time
- What strategies do you currently use to maintain your vitality, resiliency and zest, in working with people in crisis?



CAMH RESOURCES AND SUPPORTS FOR STAFF

- Clinical Supervisors
- Employee Assistance Program (EAP)
- Spiritual and Religious Care Services
- Staff Development/Continuing Professional Education
- Organizational Development
- Employee Wellness Committee



RETAINING NEW LEARNING

“Friends, colleagues, and family members often want you for what you are... not for what you are becoming.”

- Charles Seashore



LINKING NEW LEARNINGS

Find a partner and discuss:

- What part of this seminar has had meaning for you? Can you explain why?
- How will these conceptual skills and new self-awareness assist you in (a) your work and (b) your life?



CLOSING ACTIVITY

- Guided imagery exercise



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