

ADVANCING PREVENTION PROJECT

Implementing a Comprehensive Approach to Suicide Prevention to Support the NYS Prevention Agenda

PRESENTED BY:

Erin Ray Pascaretti, Putnam County Department of Health

Garra Lloyd-Lester, Suicide Prevention Center of New York State

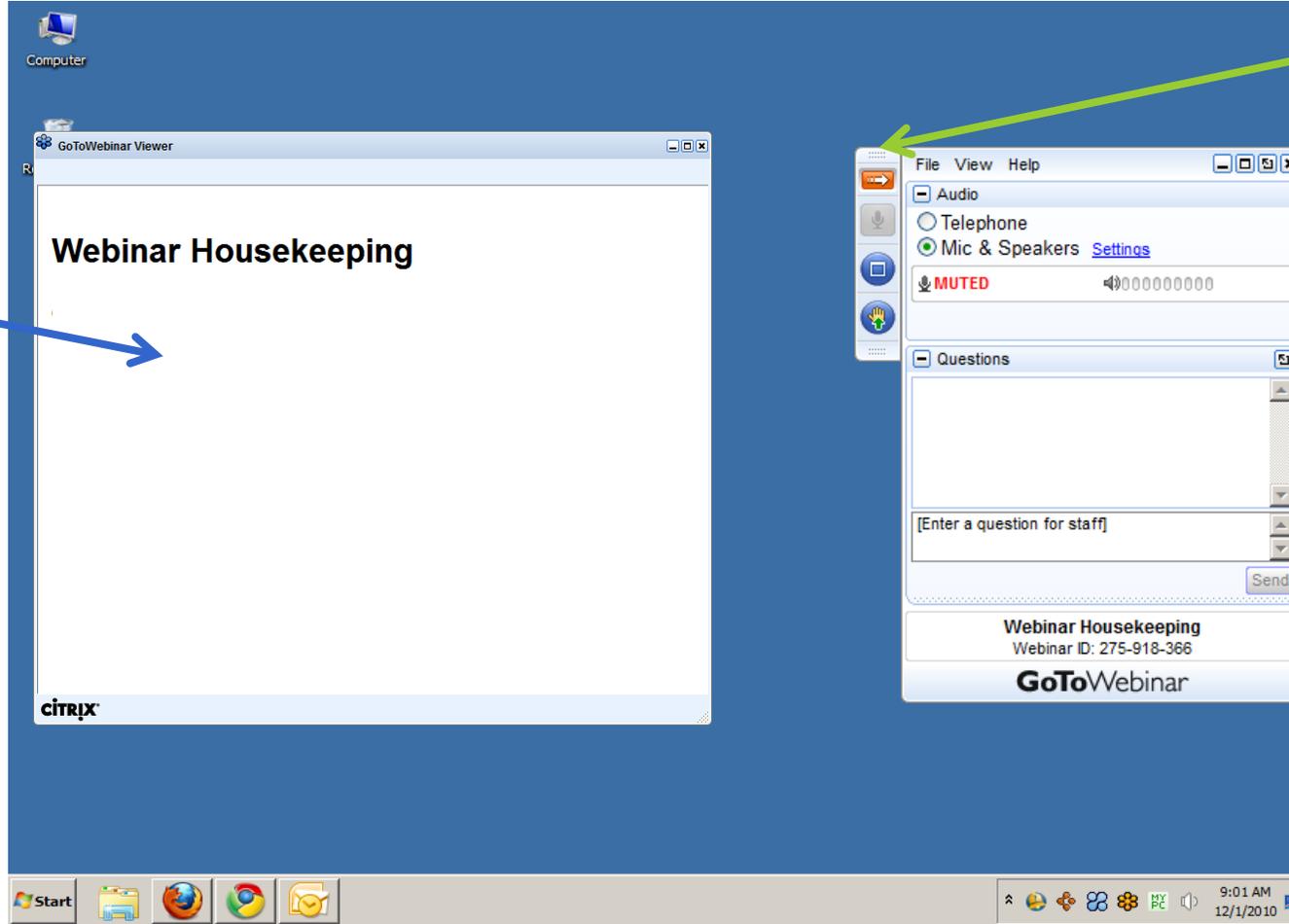
Dennis Ullman & Sarena Chisick, Putnam Hospital Center A Health-Quest Affiliate

FACILITATED BY: Michele Calvo, The New York Academy of Medicine

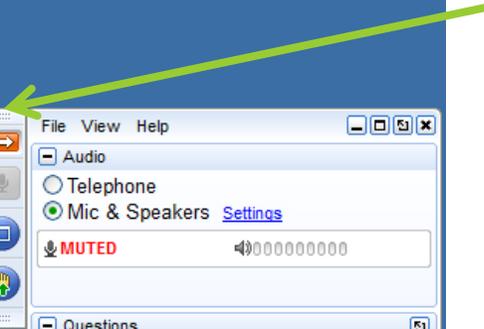


HOW TO USE GOTOWEBINAR

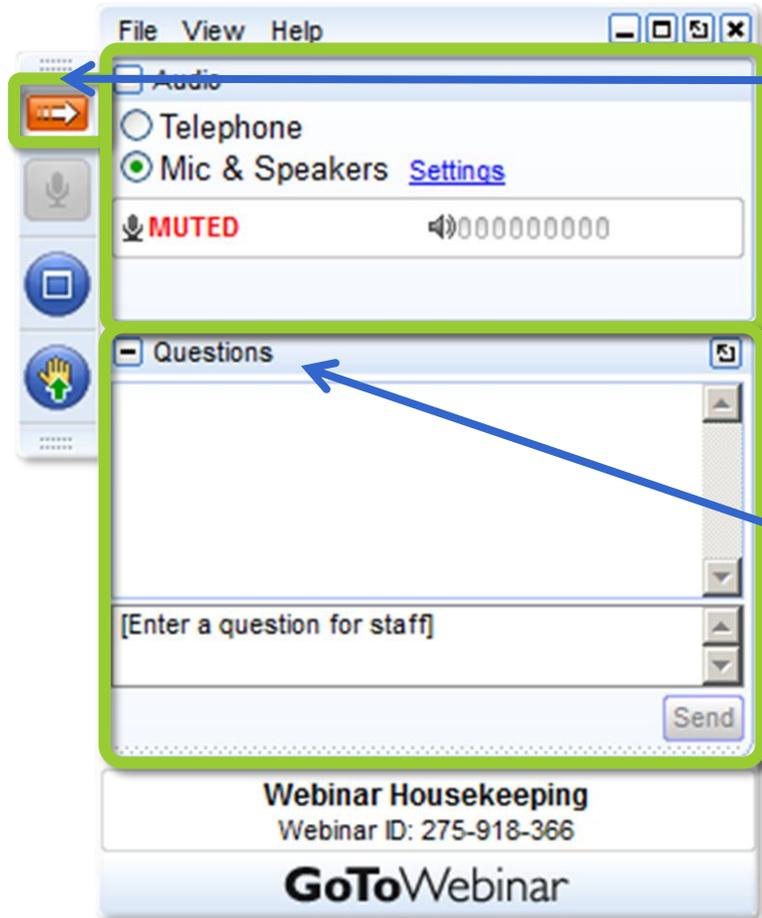
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HOW TO USE GOTOWEBINAR



Your Participation

Open and hide your control panel

Submit questions and comments via the **Questions panel**

Note: Today's presentation is being recorded and will be distributed at a later date.

If you have any technical questions or problems please contact:

Michele Calvo
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212-822-7245

AGENDA

- Project background
- Comprehensive Suicide Prevention in NYS Overview
- Suicide Prevention in Putnam County: A Collaborative Process
- Suicide Prevention in Putnam County: Suicide Screening in a Hospital EMR
- Q&A
- Upcoming Learning Opportunities

ABOUT THE NEW YORK ACADEMY OF MEDICINE

Priorities:

- Strengthen systems that prevent disease and promote the public's health
- Eliminate health disparities
- Support healthy aging
- Preserve and promote the heritage of Medicine and Public Health.



ADVANCING PREVENTION PROJECT



The New York
Academy of Medicine

At the heart of urban health since 1847

ADVANCING PREVENTION PROJECT (APP)

To support implementation of Prevention Agenda plans in the priority areas of:

- Prevent Chronic Disease
- Promote Mental Health/Prevent Substance Abuse

www.advancingpreventionproject.org

ADVANCING PREVENTION PROJECT

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The Advancing Prevention Project (APP) provides New York State local health departments with trainings, tools, and resources to collaboratively implement plans to advance the [New York State Prevention Agenda](#).

The [New York Academy of Medicine's](#) (NYAM) Advancing Prevention Project will provide local health departments with targeted technical assistance on the Prevent Chronic Disease and Promote Mental Health and Prevent Substance Abuse priorities, peer networking and collaborative learning opportunities, and a calendar of Prevention Agenda-specific trainings, events, and resources.



HIGHLIGHTS

Read about the impressive efforts and exciting programs of New York counties working to advance the Prevention Agenda.



EVENTS

Click here to identify state-wide events, webinars, conference calls, and other learning opportunities that are taking place to support your work.



SERVICES

NYAM is providing support to local health departments to implement the Prevention Agenda. Click here to find opportunities for collaboration and technical support.



RESOURCES

Research, articles, tools and best practices around Chronic Disease and Mental Health/Substance Abuse to support your work.

ADVANCING PREVENTION PROJECT



NYS PREVENTION AGENDA

- Priority Area: Promote Mental Health/Prevent Substance Abuse
 - Focus Area 2. Prevent Substance Abuse and other Mental Emotional Behavioral Disorders
 - **Goal 2.3: Prevent suicides among youth and adults.**
 - Objective 2.3.1: By December 31, 2017, reduce the percentage of adolescents (youth grades 9 - 12) who attempted suicide one or more times in the past year by 10% to no more than 6.4%
 - Objective 2.3.2: By December 31, 2017, reduce the age-adjusted suicide rate by 10% to 5.9 per 100,000
- NYSPA Tracking Indicators:
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard

What is a comprehensive approach to suicide prevention?

**Presented by: Garra Lloyd-Lester, Youth Suicide Prevention Specialist
Suicide Prevention Center of New York State (SPCNY)**

SUICIDE IN THE US

In the United States: (CDC Data)

- 41,149 suicide deaths in 2013
- National suicide rate is 13.0 per 100,000
- Suicide rate in U.S. has increased over the past decade
 - ~3/4 suicides are men
- Particularly concern over increased rate among 45-64 age cohort

SUICIDE IN NYS

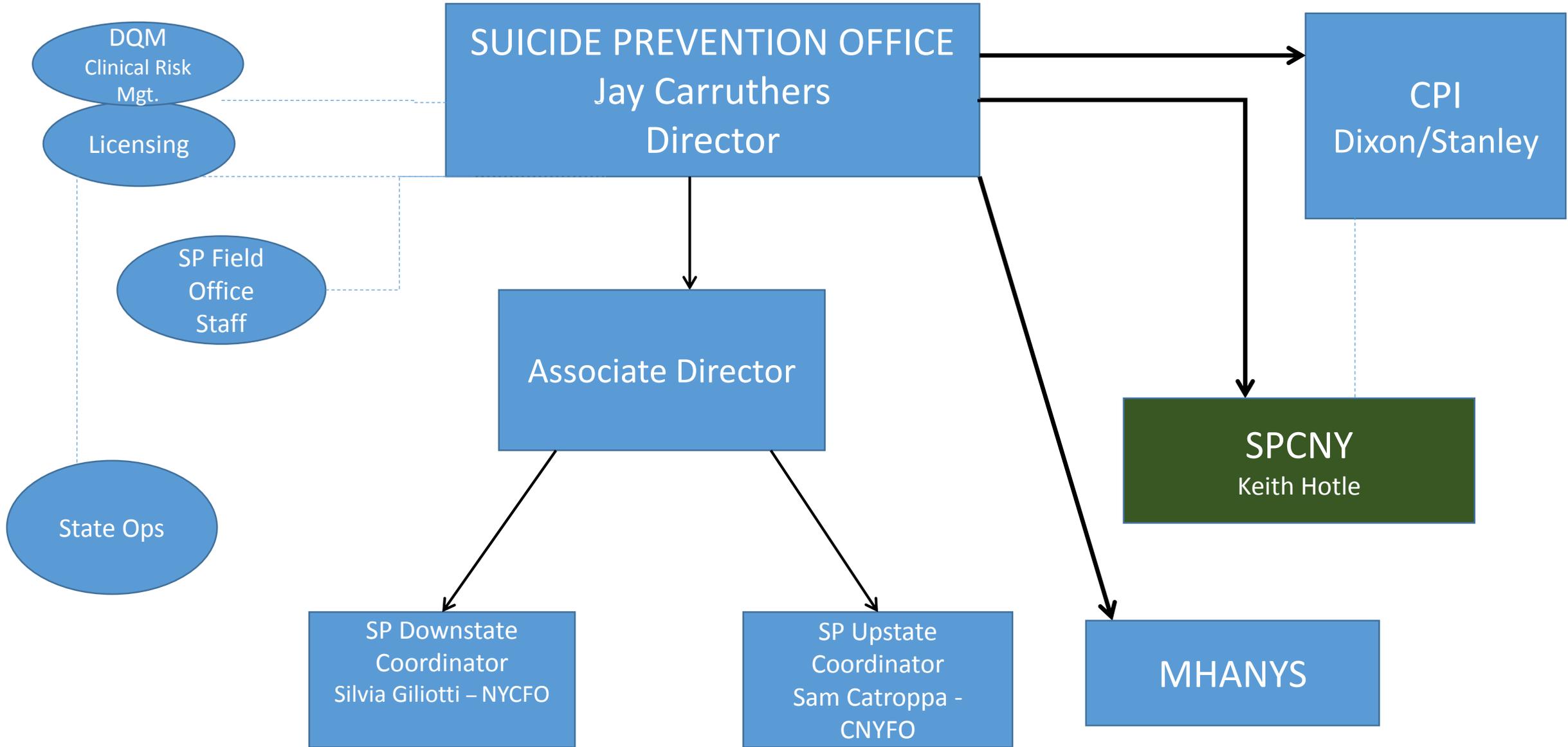
General NYS Population: (CDC Data)

- New York State 1687 suicide deaths (2013); suicide rate 8.6 per 100,000
- Only 4 states had more suicide deaths than NY

Public Mental Health System: (OMH 2012 Data)

- Suicide rate 38.8 per 100,000 (Nearly 5x rate of general population of New Yorkers)
- Rate of attempted suicides rose from 27.5 to 32.1 per 10,000 OMH service consumers
- 226 of 1656 (~14%) suicides in 2012 were OMH consumers

Suicide is a major public health problem and important priority in NY

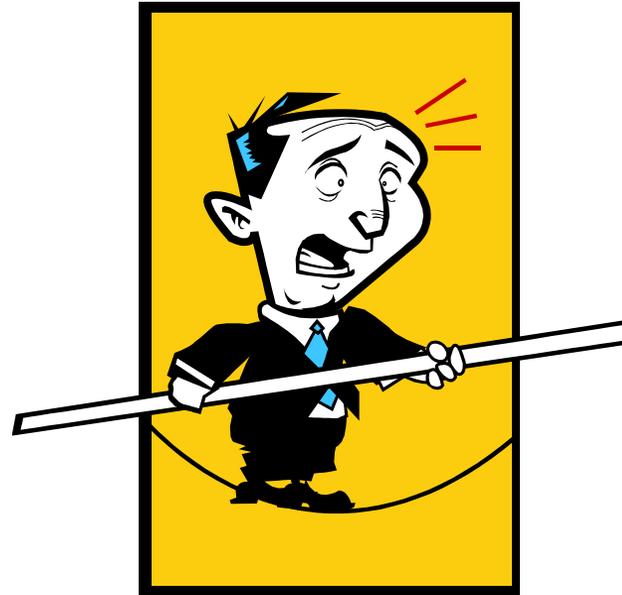


SUICIDE RISK FACTORS

- A risk factor is something that may make an individual more likely to attempt suicide.
- Risk factors are associated with suicidal behavior and ideation – they can't be said to predict that some particular individual actually will attempt suicide
- Risk factors may be fixed (permanent) or variable (subject to change)
- They can also be classified as proximal (close to the suicide event) or distal (farther in time from the suicide event)

SUICIDE RISK FACTORS (a non-exclusive list)

1. Mental health problems, particularly mood disorders, anxiety disorders (e.g., PTSD), and certain personality disorders.
2. Alcohol and other substance use disorders
3. Hopelessness
4. Impulsive and/or aggressive tendencies
5. History of trauma or abuse
6. Some major physical illnesses
7. Previous suicide attempts
8. Suicidal behaviors
9. Job or financial loss
10. Relational or social loss
11. Easy access to lethal means
12. Lack of social support and sense of isolation
13. Exposure to a range of suicidal behaviors
14. Stigma associated with help-seeking behavior
15. Barriers to accessing health care, especially mental health and substance abuse treatment
16. Certain cultural and religious beliefs (i.e., suicide is a noble resolution of a personal dilemma)



SUICIDE PROTECTIVE FACTORS

- A protective factor is a characteristic or attribute associated with a decreased likelihood of suicide
- Protective factors are those skills, strengths, or resources that help individuals deal more effectively with stressful life events
- Protective factors moderate a person's exposure to risk of suicide -- they enhance resiliency, and are important to healthy development

PROTECTIVE FACTORS

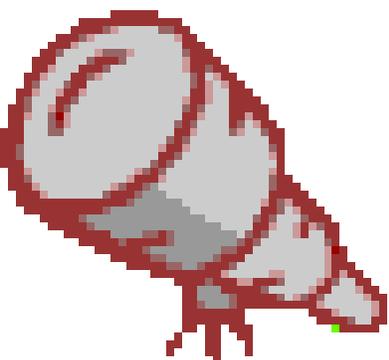
1. Effective clinical care for mental, physical and substance use disorders
2. Easy access to a variety of clinical interventions and support for help-seeking
3. Restricted access to highly lethal means of suicide
4. Strong connections to family and community support
5. Support through ongoing medical and mental health care relationships
6. Skills in problem solving, conflict resolution and nonviolent handling of disputes (aka resiliency)
7. Cultural and religious beliefs that discourage suicide and support self-preservation



SUICIDE WARNING SIGNS

Warning signs are things you can observe, hear or sense about someone that might indicate current or recent suicidal thoughts or plans. Some of the more common warning signs are:

- Depressed or sad most of the time
- Talking/writing about death or suicide
- Withdrawing from family and friends
- Feeling hopeless or helpless
- Strong feelings of anger
- Acting impulsively
- Feeling trapped -- no way out
- Dramatic mood changes
- Abusing drugs or alcohol
- Significant changes in personality
- Losing interest in daily activities
- Altered sleeping or eating habits
- Performing poorly at work or in school
- Giving away prized possessions
- Feeling excessive guilt or shame



PREVENTION IS KEY

Universal Prevention -- Everyone

- Evidence-based educational and stigma reduction media campaigns
- Provide trainings on risk alertness and early intervention
- Provide assistance and education on hotlines and local crisis referrals
- Limit access to lethal means (e.g. dangerous medications and firearms) for at-risk persons

Indicated Prevention – Individuals

- Train PCPs and MH professionals to detect and manage depression and suicide risk
- Institute evidence-based assessment, treatment and follow-up protocols for suicide risk (e.g., Zero Suicide)



Selective Prevention – Specific At-Risk Groups

- Focus services on reducing hopelessness and disconnectedness
- Target specific at-risk groups for upstream prevention efforts that enhance protective factors and resiliency
- Increase provider awareness and education of heightened suicide risk of those in high-risk groups
- available within systems (e.g., primary care, mental health, schools, LTC facilities, workplaces)

AT-RISK GROUPS*

- Groups with a higher risk for suicide or suicide attempts than the general population include:
 - Men in midlife and older men
 - American Indians and Alaska Natives
 - People bereaved by suicide
 - People in justice and child welfare settings
 - People who intentionally hurt themselves (non-suicidal self-injury)
 - People who have previously attempted suicide; People with chronic or terminal medical conditions
 - People with mental and/or substance use disorders
 - People who are lesbian, gay, bisexual, or transgender
 - Members of the military and veterans.

** Of particular importance in selected prevention strategies*

SUICIDE MYTHS & FACTS

1. Myth: Suicide can't be prevented. If someone is set on taking their own life, there is nothing that can be done to stop them.

Fact: Suicide is preventable. The vast majority of people contemplating suicide don't really want to die. They are seeking an end to intense mental and/or physical pain. Most have a mental illness. Interventions can save lives.

2. Myth: People who take their own life are selfish, cowards, weak or are just looking for "attention."

Fact: More than 90% of people who take their own life have at least one and often more than one treatable mental illness such as depression, anxiety, bipolar disorder, schizophrenia and/or alcohol and substance abuse. With better recognition and treatment many suicides can be prevented.

3. Myth: Asking someone if they are thinking about suicide will put the idea in their head and cause them to act on it.

Fact: When you fear someone you know is in crisis or depressed, asking them if they are thinking about suicide can actually help. By giving a person an opportunity to open up and share their troubles you can help alleviate their pain and find solutions.

4. Myth: Teenagers and college students are the most at risk for suicide.

Fact: The suicide rate for this age group is below the national average. Suicide risk increases with age. Currently, the age group with the highest suicide rate in the U.S. is middle-aged men and women between the ages of 45 and 64. The suicide rate is still highest among white men over the age of 65.

5. Myth: Barriers on bridges, safe firearm storage and other actions to reduce access to lethal methods of suicide don't work. People will just find another way.

Fact: Limiting access to lethal methods of suicide is one of the best strategies for suicide prevention. Many suicides can be impulsive and triggered by an immediate crisis. Separating someone in crisis from a lethal method (e.g., a firearm) can give them something they desperately need: time. Time to change their mind, time to resolve the crisis, time for someone to intervene.

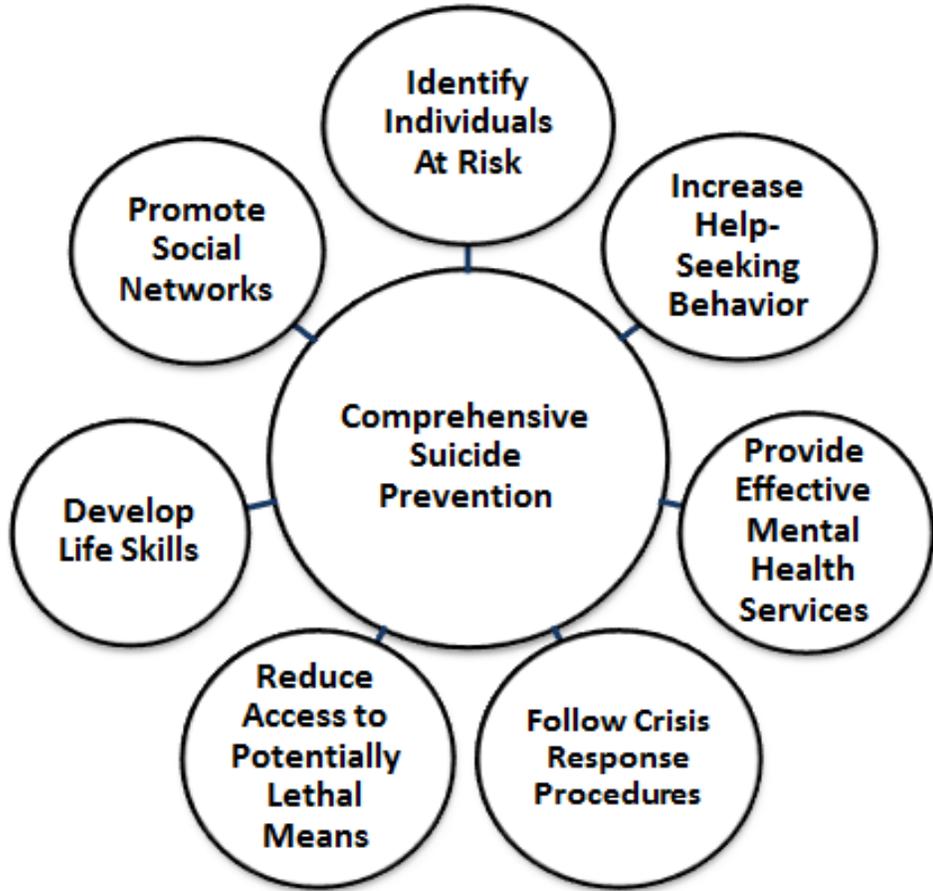
6. Myth: Someone making suicidal threats won't really do it, they are just looking for attention.

Fact: Those who talk about suicide or express thoughts about wanting to die, are at risk for suicide and need your attention. Most people who die by suicide give some indication or warning. Take all threats of suicide seriously. Even if you think they are just "crying for help"—a cry for help, is a cry for help—so help.

7 Myth: Talk therapy and/or medications don't work.

Fact: Treatment can work. One of the best ways to prevent suicide is by getting treatment for mental illnesses such as depression, bipolar illness and/or substance abuse and learning ways to solve problems. Finding the best treatment can take some time, and the right treatment can greatly reduce risk of suicide. In fact, it can bring you back your life.

COMPREHENSIVE SUICIDE PREVENTION



These strategies can be addressed through both (1) Public Health and (2) Clinical approaches

SUICIDE PREVENTION CENTER OF NY

- ***A Focus on Public Health Approaches to Suicide Prevention:***
 - Assistance in coordinating a postvention response for communities impacted by a suicide loss
 - Supports training network with licensed trainers across the state in SafeTALK, QPR, ASIST, Connect and Creating Safety in Schools
<http://www.preventsuicideny.org/#!trainingprograms/c21kz>
 - Technical assistance and support to develop and/or maintain community based coalitions-
<http://www.preventsuicideny.org/#!coalitions/c24an>
 - Supports OMH Suicide Prevention Office in education of clinical applications, such as *Zero Suicide*
 - Sponsors annual banquet to raise awareness and recognize significant achievements across the State of New York

SUICIDE PREVENTION CENTER OF NY

Suicide Prevention as a Public Health Approach:

The suicide prevention framework follows a cyclical public health model that focuses on non-clinical prevention efforts and population-health strategies.

- Formally identifying community needs
- Determining potential influences
- Selecting evidence-based strategies and promising practices that maximize capacity and target identified needs
- Implementing those strategies and practices with fidelity
- Conducting follow-up evaluation and feedback that informs ongoing efforts and future strategic planning

*Embedded in this process is **Building Capacity**, as this has been shown to be vital prior to and during implementation.*



NEW YORK STATE OFFICE OF MENTAL HEALTH

- State agency reporting to Governor of NYS (19+ million people, 57 counties and NYC)
 - OMH directly run services
 - **24 Psychiatric Centers (PCs):** *i.e. Hospitals*
 - Adult, Child and Family, and Forensic Centers
 - 3500 inpatients
 - 16,000 employees
 - 31 mental health clinics in state prisons (8000 patients)
 - Two Research Institutes
 - Psychiatric Institute – Columbia
 - Nathan Kline Institute – New York University
 - 2500 statewide community based programs
 - OMH licenses, regulates and funds
- Given high rate of suicide among OMH consumers and observation that ~90% of individuals who take their own lives have at least one mental illness at time of suicide, OMH priority is making NY a model 'Zero Suicide' state

CLINICAL APPROACHES -- A FOCUS ON *ZERO SUICIDE*

- Embedded in the *National Strategy for Suicide Prevention*
- A priority of the *National Action Alliance for Suicide Prevention*
- A project of the *Suicide Prevention Resource Center*

THE NAME: 'ZERO SUICIDE'

- Aspirational in setting a goal of 'zero' suicides
- But if not designing for zero, than what should the number be?
- There is something qualitatively different that happens when designing for zero, something critically important in facilitating innovation
 - *Volvo* Vision 2020—no car fatalities in all models by 2020
 - More rigorous testing and standards than *Insurance Institute for Highway Safety* and *Euro NCAP*
 - Already have models with no fatalities last year
- Paradox: Most behavioral health organizations do not have formal policies aimed at reducing suicides among those in their care
- Zero Suicide aims to change this

ZERO SUICIDE IS...

- A commitment to suicide prevention in health and behavioral health care systems and is a specific set of strategies and tools.
- A focus on error reduction and safety in health and clinical care
- A framework for systematic, clinical suicide prevention in behavioral health and health care systems
- A set of best practices and tools

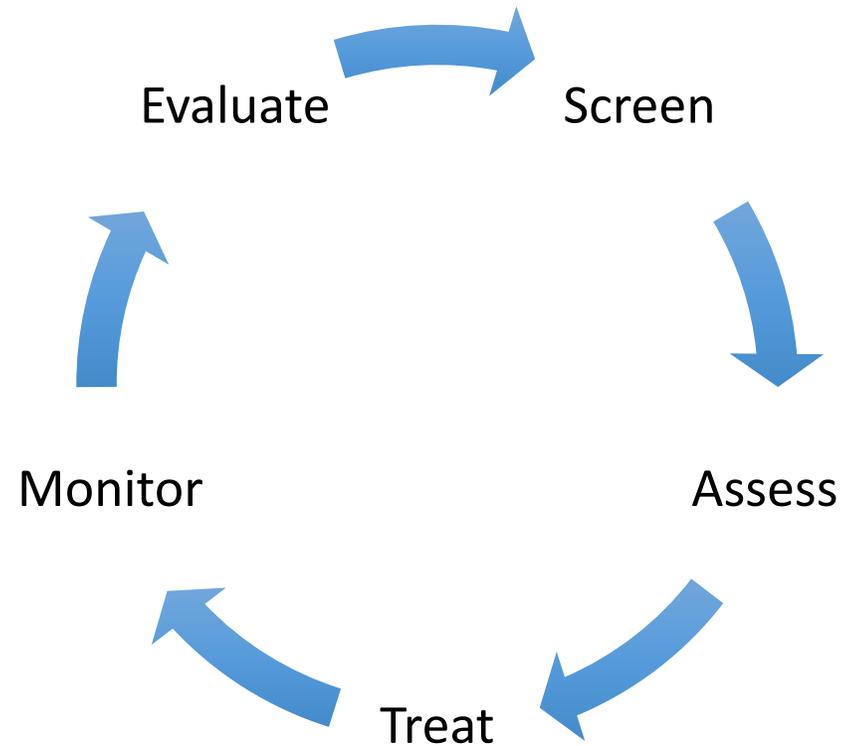
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FOCUS ON ERROR REDUCTION: SHIFT IN PERSPECTIVE

FROM	TO
Accepting suicide as inevitable	Every suicide in a system is preventable
Assigning blame	Nuanced understanding: ambivalence, resilience, recovery
Risk assessment and containment	Collaborative safety, treatment, recovery
Stand alone training and tools	Overall systems and culture changes
Specialty referral to niche staff	Part of everyone's job
Individual clinician judgment & actions	Standardized screening, assessment, risk stratification, and interventions
Hospitalization during episodes of crisis	Productive interactions throughout ongoing continuity of care
"If we can save one life..."	"How many deaths are acceptable?"

IMPROVING EXPERIENCE OF CARE



ESSENTIAL DIMENSIONS OF SUICIDE PREVENTION FROM A CLINICAL PERSPECTIVE

- ❖ Create a Culture
- ❖ Competent Workforce
- ❖ Identify/Assess Risk Level
- ❖ Pathway to Care
- ❖ Use Evidence Based Care
- ❖ Continued Contact After Care

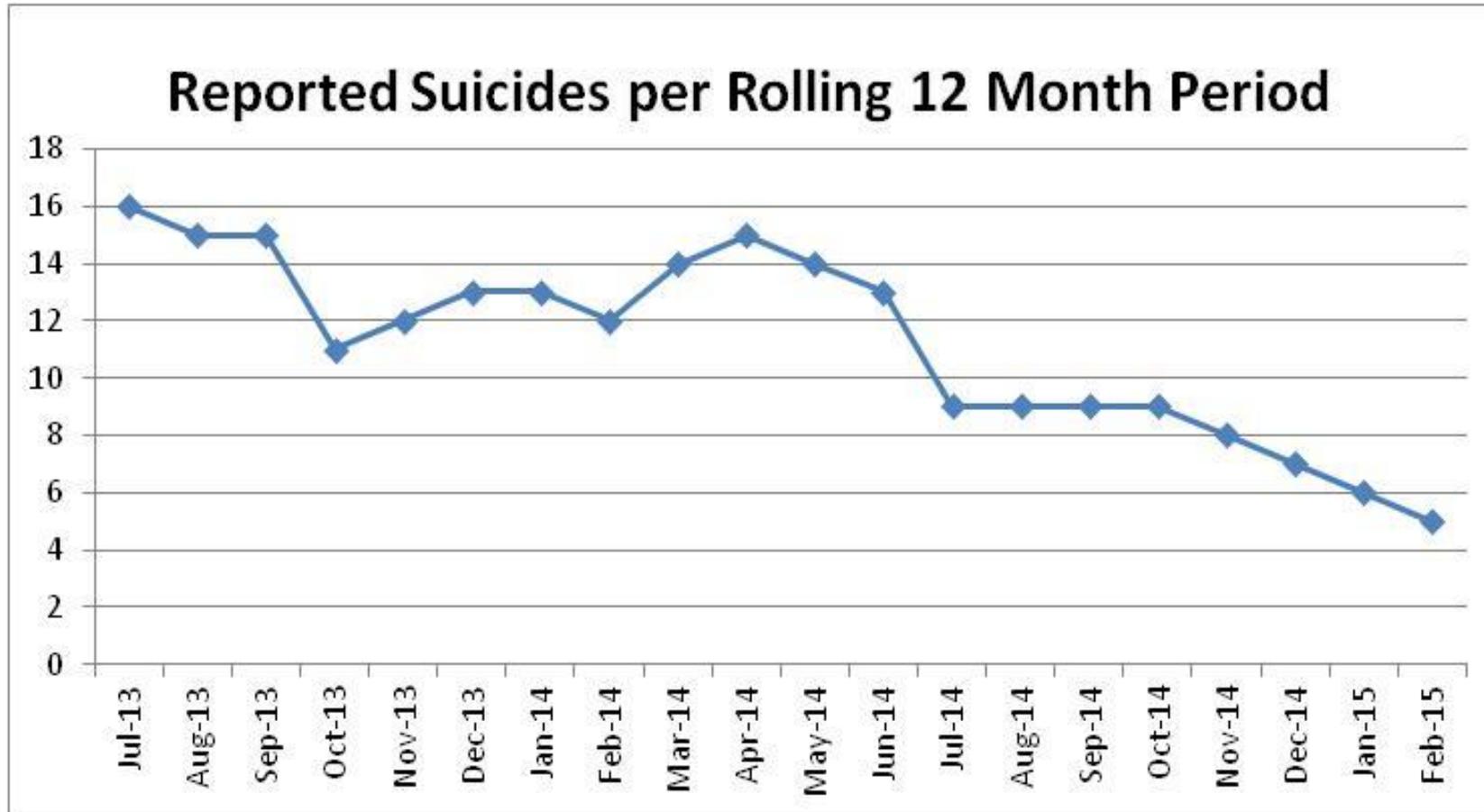


CLINICAL PATHWAY FOR SUICIDE PREVENTION

- ❖ Communication – Internal & External
- ❖ Champions
- ❖ Training
- ❖ Electronic Health Record
- ❖ Screening/Assessment Tool
- ❖ Education & Crisis Planning



ZERO SUICIDE: EARLY EVIDENCE IT WORKS



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OMH MANDATE: MAKING NY A ZS MODEL STATE

- ZS promotion and promulgation within NYS
 - Finding and cultivating ZS Champions in NY
 - Learning Collaboratives
 - Mini grants 2015 to provide advanced clinical trainings
 - Trainings to bridge the competency gap: Partnership with Center for Practice Innovations (CPI)
 - Modules: C-SSRS, Safety Planning, Structured-Follow
 - Webinars: Safety Planning, Risk Assessment, Functional Analysis of Suicidal Behavior

OMH MANDATE: MAKING NY A ZS MODEL STATE

- Leveraging Regulator Role to Support ZS
 - Integrating ZS into Licensing Standards of Care (SOC)
 - Minimum standards to exemplary (finding Zero Suicide champions and putting other providers in touch with them)
- Piloting a licensing suicide prevention protocol
- Common technical language for describing and reporting on suicidal behavior (e.g. C-SSRS screen)
- Looking for policy changes that support a system of suicide care on site visits
- Promoting ZS with providers at every opportunity

OMH MANDATE: MAKING NY A ZS MODEL STATE

OMH Goals for Supporting ZS Implementation

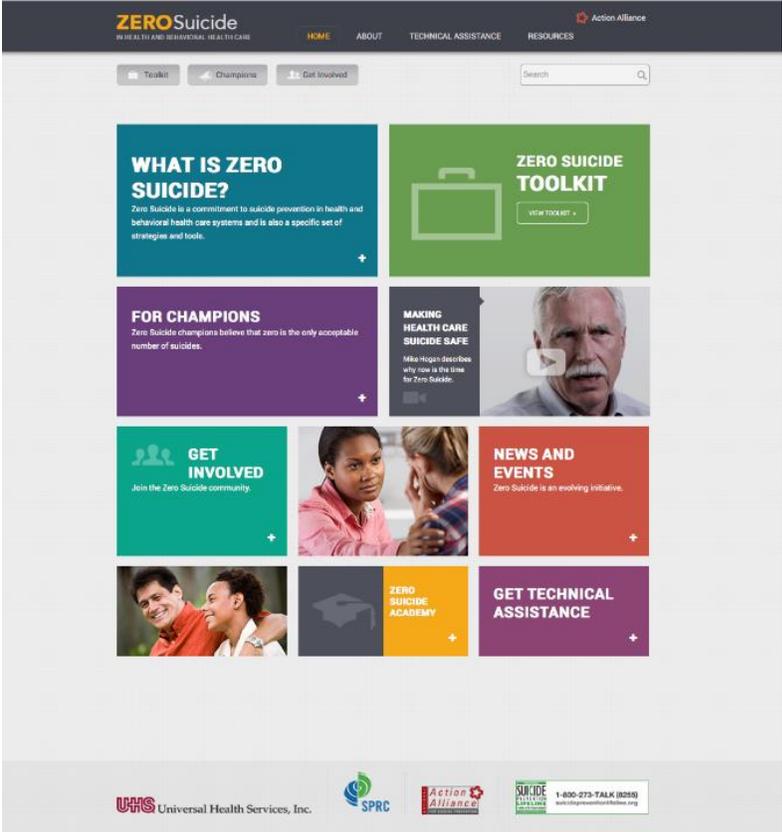
Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.”

- Screening rate
- Assessment rate
- Safety Planning rate
- Lethal Means Counseling rate
- Acute Care Transition rate

PSYCKES Continuous Quality Improvement Project—Rate enhancement for clinics that participate and report data *TBA*

ZERO SUICIDE RESOURCES AND TOOLS

www.ZeroSuicide.com



ADVANCING PREVENTION PROJECT



Putnam County

A Local Collaborative Process

Presented By: Erin Ray Pascaretti, RD MPH - Epidemiologist
Putnam County Department of Health

COMMUNITY HEALTH ASSESSMENT

- Mandated every five years
- Must partner with hospitals
 - Community Service Plan
- Ultimately select health priorities
 - Prevention Agenda
- 2013 Mandated Community Health Improvement Plan

COMMUNITY HEALTH IMPROVEMENT PLAN

- Mobilizing for Action through Planning and Partnerships
 - Community Themes and Strengths Assessment
 - Community Health Status Assessment
 - Forces of Change Assessment
 - Local Public Health System Assessment
- Partnership with Putnam Hospital Center
- Public Health Summit
 - Chronic Disease
 - Mental Health

COALITIONS

- Live Healthy Putnam Coalition
 - Chronic Disease Coalition
 - Obesity, Worksite Wellness, Tobacco Cessation
 - Led by PCDOH
 - Over 20 active partner agencies
- Mental Health Providers Group
 - Mental Health Group
 - Led by PCDOMH & SS
 - Over 20 active partner agencies

CHIP – PROMOTE MEB WELL-BEING IN COMMUNITIES

PROMOTE MENTAL HEALTH

Focus Area 1: Promote Mental, Emotional and Behavioral (MEB) well-being in communities		
Goal 1: Promote Mental, Emotional & Behavioral well-being.		
Objective 1: Reduce the number of adults with poor mental health for 14 or more days (age-adjusted, compared to 2008-2009 data).		
Objective 2: Reduce the number of students with depressive symptoms (grade-specific, compared to 2012 data).		
STRATEGIES	ACTIVITIES	STATUS
Determine the prevalence of depression in Putnam County adults and children.	<ul style="list-style-type: none"> - Gather available data to measure the level of depression. - Develop a specific survey tool to measure the level of depression in Putnam County adults. - Determine in Veterans Affairs health data is available to measure depression prevalence in Putnam County veterans. 	Red
Assess MEB well-being programs.	<ul style="list-style-type: none"> - Develop survey for agencies. - Create an inventory of MEB well-being resources. 	Yellow
Provide youth and adult access to MEB well-being resources.	<ul style="list-style-type: none"> - Develop a system for educating residents, schools and community partners about MEB well-being resources. - Promote programs that support protective factors. 	Yellow
Change individual and social norms around MEB well-being.	<ul style="list-style-type: none"> - Investigate best practices to decrease stigma against mental health illnesses. - Implement a best practice media campaign targeted at decreasing the stigma associated with mental health illness. 	Red
Create a Mental Health coalition to improve MEB programming.	<ul style="list-style-type: none"> - Develop a coalition of government, non-profits, business and educational institutions around MEB well-being. - Assess and improve MEB program effectiveness and sustainability. 	Green

CHIP – PREVENT SUICIDES AMONG YOUTH AND ADULTS

PROMOTE MENTAL HEALTH

Focus Area 2: Prevent Suicides Among Youth and Adults

Goal 1: Prevent suicides among youth and adults.

Objective 1: Reduce adult suicide death rates in Putnam County (age-adjusted; compared to 2008-2009 data).

Objective 2: Reduce adolescent/young adult suicide death rates in Putnam County (ages 15-19; compared to 2008-2009 data).

Objective 3: Reduce adolescent/young adult self-inflicted injury hospitalization rates in Putnam County (ages 15-19; compared to 2008-2009 data).

STRATEGIES	ACTIVITIES	STATUS
Determine the prevalence of suicide attempts and suicide completions.	<ul style="list-style-type: none"> - Gather available data that measures suicide attempts and completions. - Determine in Veterans Affairs data is available to measure suicide prevalence in PC veterans. 	
Increase community awareness of suicidal warning signs and available resources.	<ul style="list-style-type: none"> - Investigate best practices for community education on suicide awareness, prevention and coping. - Promote <i>safeTALK</i>, <i>ASIST</i>, and <i>Project Connect</i> trainings to partners and the community. - Promote <i>Means Matter</i> to community partners. - Increase use of community- and school-based peer mentoring programs. - Increase community awareness to available resources. - an inventory of MEB well-being resources. 	

SUICIDE PREVENTION TASK FORCE

PUTNAM COUNTY SUICIDE PREVENTION TASK FORCE



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SUICIDE PREVENTION TASK FORCE

- Task Force developed in 2014
- Multi-disciplinary participation
 - Mental Health
 - Schools
 - Health
 - Coroner
 - Law Enforcement
 - Government

SUICIDE PREVENTION TASK FORCE

- Workgroups
 - Means Matter
 - Youth Outreach/Schools
 - Public Awareness Campaign
 - Post-Vention
 - Training (Public & Professionals)

COMMUNITY EDUCATION

safeTALK

- ½ day training
- Prepares participant to:
 - recognize a person who might be having thoughts of suicide
 - engage a person at risk in direct and open talk about suicide
 - connect person at risk with resources for full-scale intervention

ASIST

- Applied Suicide Intervention Skills
- 2 day training
- Prepares participant to carry out life-saving interventions

DATA GATHERING

- Difficult to gather local data
- Suicide
 - Working with Coroner to gather local & timely suicide data
 - Plan to work with Sheriff to gather data re: method
- safeTALK
 - Working with Hospital and Mental Health Association to develop survey
 - Goal is to identify how many safeTALK-trained helpers identify a person at risk, communicate with and connect them with resources

FUTURE PLANNING

- Annual Public Health Summit
 - October 2015
 - Break out sessions
 - Re-evaluate selected Goals and Priorities
- Continue to partner with:
 - PHC Community Health Needs Committee
 - Mental Health Providers Group
 - PC Suicide Prevention Task Force
 - PC Veterans Task Force

Use of Suicide Screening in a Hospital EMR

Presented By: Putnam Hospital Center A Health-Quest Affiliate
Sarena Chisick, RN BSN MEd - Community Health Education
Dennis Ullman, Ed.M - Coordinator of Behavioral Response Team

COMMUNITY SERVICE PLAN

- Mandated every three years
- Community Health Needs Committee
 - Hospital led
 - Health Department and Mental Health Department
- Quarterly meeting
 - Local Public Health System
 - CSP and CHIP priorities

COMMUNITY SERVICE PLAN INITIATIVES

- Prevent Suicide Among Youth and Adults
- Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

PREVENT SUICIDE AMONG YOUTH AND ADULTS

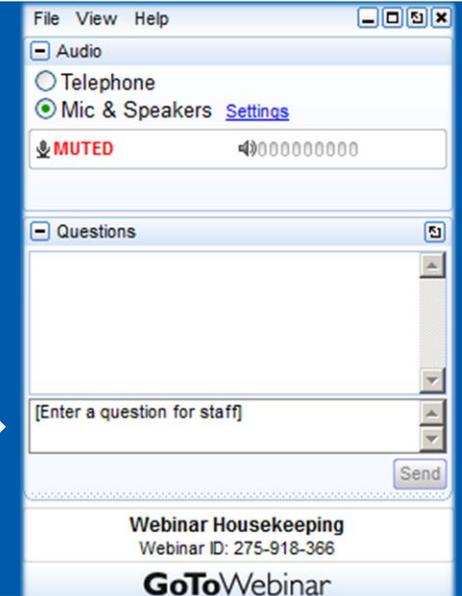
- Increase rate of suicide screening
 - Inpatient and ED population
 - Use of EMR
 - Columbia Suicide Severity Rating Scale
- Develop system for positive screenings
 - Protocol developed
 - Staff education
 - Suicide hotline information
 - Discharge materials

PREVENT SUICIDE AMONG YOUTH AND ADULTS

- Community Education
 - safeTALK
 - ASIST
 - Project Connect

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Questions? Type them here →



Upcoming Learning Opportunities

SIGN UP FOR TA!

On the Advancing Prevention Project website you can:

- Find resources and current training opportunities
- Schedule a one-on-one TA appointment
- Join a Learning Collaborative
- Sign up to join a Working Group

UPCOMING WEBINARS

Addressing ACEs: Building a Trauma-Sensitive and Resilient Community

When: Tuesday, July 28th, 1 pm-2:30 EDT

Who is the Audience: Staff from Local Health Departments (LHD), Hospitals, Local Governmental Units (LGU), and Community-Based Organizations.

Learn about data collection and interventions in various community settings including pediatric primary care and schools

Presenters: Elizabeth Meeker PsyD of CCSI inc., Mary McHugh LCSW-R of the NYS Office of Mental Health, and local practitioners.

Preventing Non-Medical Use of Prescription Opioids and Heroin

When: September 2015

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Thank you!

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