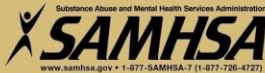


Behavioral Health is Essential To Health

Prevention Works

Treatment is Effective

People Recover



Addressing Suicidal Ideation and Behavior in Individuals with a First Episode of Psychosis (FEP)

Part II: September 7, 2016



SAMHSA Welcome

Monique S. Browning

Public Health Advisor/Project Officer

SAMHSA's Center for Mental Health Services, Division of
State and Community Systems Development



Agenda

- **Brief Review of Part I: *Recognizing Suicidal Ideation and Behavior in Individuals with FEP* (June 28, 2016)**
- **Clinical Perspective once Suicidal Ideation and Behavior is Identified, with Real-World Examples**
- **Selection of Suicide Prevention Resources Available from SAMHSA**



Addressing Suicidal Ideation & Behaviors in Individuals with a First Episode Psychosis (FEP)

Yael Holoshitz, MD

Psychiatrist, OnTrackNY/WHCS

Tara Niendam, PhD

Assistant Professor in Psychiatry

Director of Operations, EDAPT & SacEDAPT Clinics

University of California, Davis



Vignette: M

M is a young woman who has been in treatment with you for one year. She was admitted to your program after being hospitalized for psychotic symptoms, including: disorganization, auditory hallucinations and significant delusions about a neighbor, which led to stalking him



Vignette: M

M has a 9-5pm job, completed college, and lives independently. Over the past year of treatment, M has made significant progress. Her symptoms improved on medications, and she has been socializing and has multiple recovery goals



Vignette: M

However, M has also expressed hopelessness and ambivalence about treatment and medication. In particular, she frequently makes statements like, “normal people don’t need medication.” When things are going well, she is apt to discontinue her medication for a few days, but then reluctantly restarts upon prompting from you.



Vignette: M

M comes to the office one day and admits, tearfully, that she has not been fully forthcoming about what she has been experiencing over the past month. She has continued to believe that her neighbor can read her thoughts, that he is in love with her, and ultimately they will be together romantically



Vignette: M

When asked more about how she has been feeling, she reluctantly confides that the other day, while at home, she had an experience where she felt her neighbor was communicating to her through the television. She felt “terrible, awful, so bad.” She has been withdrawing more. She tells you, “as long as he and I can be together, I will feel good.”



Vignette: M

M has no history of suicide attempts. Immediately prior to her first hospitalization, she engaged in self-injurious behavior (cutting) while psychotic. No cutting since. Also has a history of binge drinking; denies current alcohol use.

When asked if she was suicidal when she felt “so bad,” or whether she is currently suicidal, she says, “no, I’m fine...”



What do you do?

- Help M deal with: feelings of hopelessness, feelings of perceived loss over neighbor, feelings of being “not normal”
- Help M work through ambivalence about medications and treatment
- Focus on recovery, strengths, and plans for the future



What about Suicide Prevention?

- M is not coming in saying she is suicidal
- She has multiple strengths
- She is engaged in treatment
- She has no history of suicide attempts

BUT... She has multiple risk factors, too, and has recently been experiencing periods of intense distress...



Vignette: M

- Two weeks after this session, M attempts suicide by ingestion of her medication (perphenazine). She is brought to the emergency room, medically stabilized, and hospitalized for psychiatric reasons



Vignette: M

- Even when someone says they are not currently suicidal, or denies recent suicidal thoughts, **planning ahead is crucial**
- **Suicide risk assessment and management should be a core component of FEP care**



Objectives

- **In this presentation, we will review:**
 - *“Proactive” Suicide Risk Management*
 - Initial and ongoing risk assessment
 - Proactive interventions - Psychoeducation, Safety planning intervention
 - *“Reactive” Suicide Risk Management*
 - Crisis Management, including Safety Planning and increased monitoring



Background

- **Suicide Risk is a significant issue for FEP care providers**
 - *15% of people who die by suicide are psychotic at the time of death*
 - *4-10% of people with schizophrenia die by suicide*
 - *20-40% attempt suicide*
 - **50+% of attempters make repeat attempts**
 - **Suicide attempts are serious in their own right**
 - **They can result in permanent damage and/or disability**



Avoiding Hospitalization

- **Reducing hospitalization rate is a common goal for many FEP programs**
- **Hospitalization can be traumatizing – for individuals and families**
- **BUT hospitalization can be necessary...**
- **KEY QUESTION: How do we maximize our ability to keep individuals with FEP safe in an outpatient setting?**



Risk Assessment

- In Part I of this presentation, we reviewed the importance of **suicide screening** and **suicide risk assessments**
- Excellent suicide prevention hinges on:
 - *Excellent assessment of risk, in a proactive, structured and ongoing manner*
 - *Appropriate reaction to acute risk when it occurs*



Proactive Risk Management

- **Integrate suicide risk assessment as standard part of care**
 - *Intake evaluation*
 - **Screening → Risk assessment for positive screen**
 - *Reassessments at standard intervals (e.g. every 6 months)*
- **Integrate safety planning as part of standard relapse plan**
 - *Re-visit it regularly as part of treatment*
- **For individuals with elevated risk**
 - *Integrate other treatment options as part of FEP care*



Categories of Risk Factors

1. Suicide-specific characteristics
2. Demographic risk factors
3. Psychiatric diagnosis and symptoms
4. Family and social factors
5. Precipitants
6. Treatment history difficulties
7. Access to means

Source: American Foundation for Suicide Prevention



Link to Webinar

- <http://www.nasmhpd.org/content/part-i-recognizing-suicidal-ideation-and-behavior-individuals-first-episode-psychosis>



Potential Protective Factors

- Positive attitude towards mental health treatment
- Feeling connected to others
- Effective problem solving skills
- Accepting & Supportive social environment
- Reasons for living
- Limited access to lethal means



What happens with a positive screen?

- Conduct a risk assessment
- Identify those at elevated risk—necessary but insufficient to prevent suicide
- Inform a triage decision and appropriate level of care or follow-up action to be taken



Types of Risk Factors: Proximal vs. Distal vs. Warning Signs

For our case, M:

- **Distal (chronic, background) risk factors**
 - Past self-injurious behavior, history of hospitalization for psychosis, unmarried, history of substance abuse (alcohol)
- **Proximal (acute) risk factors**
 - Recent nonadherence to medications, worsening of psychosis
- **Warning signs (most acute risk factors)**
 - Periods of feeling “really bad,” social withdrawal, thinking more about her neighbor



Intervention

- The Risk Assessment guides clinical management and triage
- After suicide risk assessment, comes appropriate intervention...
 - “Proactive” management = **No ACUTE risk** → Consider the Safety Planning Intervention
 - “Reactive” management = **ACUTE RISK** → Consider alternative options to maintain safety (including SPI in some cases)



Specialized Therapy for Suicide Prevention

- Collaborative Assessment and Management of Suicidality (CAMS)
- Dialectical Behavioral Therapy (DBT)
- Cognitive Behavioral Therapy – Suicide Prevention (CBT-SP)
- Often require specialized training: visit sprc.org, SAMHSA



Why Use a Brief Intervention?

Empirically Supported Psychotherapies and
yet **no decrease in suicide rate**
(WISQARS, 2012)

We don't always have the opportunity to
engage outpatients in treatment.



Evidence-Based Risk Reduction Strategies

- **Means Restriction**
- Brief problem solving and coping skills (including distraction)
- Enhancing **social support**, identifying **emergency contacts**
- **Motivational Enhancement** for further treatment



What is the Safety Plan Intervention (SPI)?

- SPI is a clinical intervention that results in development of a one-page document to use when a suicidal crisis is emerging.
- Suicide risk fluctuates over time and SPI is a plan for managing and decreasing suicidal feelings and for staying safe when these feelings emerge
- The individual at risk completes the SPI with the help of a clinician.
- Can be done in one brief session and refined over time.



SPI relevance for FEP

- Majority of suicide attempts in FEP population are impulsive
- In a recent study of young adults with FEP who attempted suicide, only one in 10 sought out help immediately before attempting suicide, despite being connected in treatment
- Given impulsive nature, helping clients learn to cope with overwhelming emotions can be incredibly beneficial

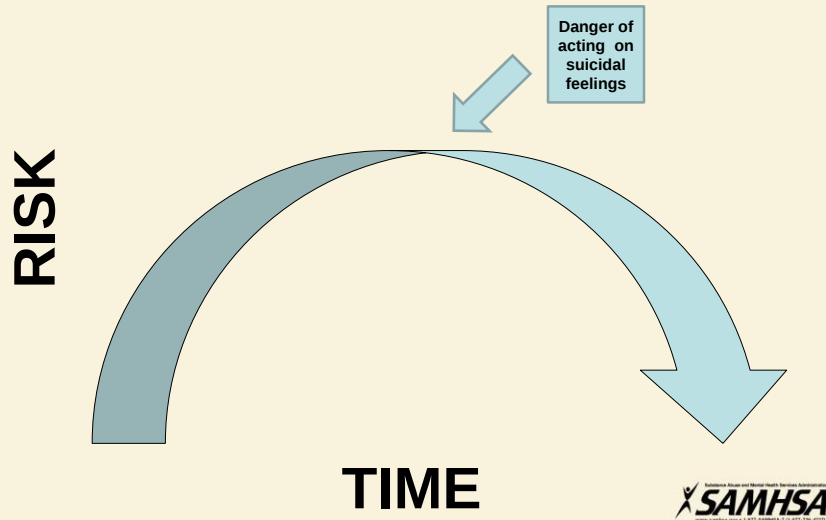


Tangible + Concrete Plan



SAFETY PLAN	
Step 1: Warning signs:	
1.	_____
2.	_____
3.	_____
Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:	
1.	_____
2.	_____
3.	_____
Step 3: People and social settings that provide distraction:	
1.	Name _____ Phone _____
2.	Name _____ Phone _____
3.	Place _____
4.	Place _____
Step 4: People whom I can ask for help:	
1.	Name _____ Phone _____
2.	Name _____ Phone _____
3.	Name _____ Phone _____
Step 5: Professionals or agencies I can contact during a crisis:	
1.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
2.	Clinician Name _____ Phone _____ Clinician Pager or Emergency Contact # _____
3.	Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4.	Local Emergency Service _____ Emergency Services Address _____ Emergency Services Phone _____
Making the environment safe:	
1.	_____
2.	_____
From Stanley, B. & Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. <i>Cognitive and Behavioral Practice</i>, 19, 256-264	

Risk fluctuates over time



Theoretical Foundation of SPI

*Problem solving capacity diminishes during crisis so **over-practice with a specific template** can help coping.

- *Parallel to STOP-DROP-ROLL for fire safety.*

*Clinician and suicidal individual collaborate to determine **cognitive and behavioral strategies** to use during suicidal crises



SPI: An Overview

- Creates a tool for participants to use in distress: **step-wise increase in level of intervention**
 - Starts “within self” and builds to seeking help in the psychiatric emergency room
- Plan is step-wise but individual can advance in steps without “completing” previous step...
- SPI can be done in one brief session and altered over time



Overview of SPI: 6 Steps

1. Recognizing **warning signs**
2. Employing **internal coping strategies** (without contacting another person)
3. **Socializing** with others as a way of distraction
4. **Contacting** family members or friends to help resolve crisis
5. Contacting **mental health professionals/agencies**
6. Reducing potential for use of **lethal means**



SAFETY PLAN	
Step 1: Warning signs:	
1.	_____
2.	_____
3.	_____
Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:	
1.	_____
2.	_____
3.	_____
Step 3: People and social settings that provide distraction on:	
1.	Name _____ Phone _____
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3.	Place _____
4.	Place _____
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Reproduced with permission (© 2013 Stanley & Brown). www.suicideofhope.com Stanley, B.J. Brown, G. K. (2012). Safety planning intervention: A brief intervention to mitigate suicide risk. <i>Cognitive and Behavioral Practice, 19</i>, 295-304.	



The SPI is NOT:

- **NOT** a substitute for treatment
- **NOT** help for an individual in imminent danger of attempting suicide
- **NOT** a “no-suicide contract”
 - *Avoid “no-suicide contracts”– all this does is ask patients to promise to stay alive without telling them HOW or giving them the resources to cope*



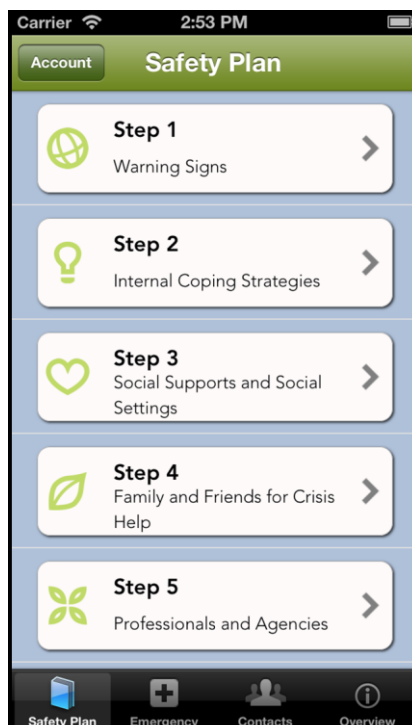
SPI: When to use

- Consider using for “crisis prevention” in addition to suicide prevention; consider for all clients beginning treatment
- For anyone with positive screen on C-SSRS
- Annual or semi-annual revision
- Whenever an event has occurred (hospitalization, suicide attempt, emergency room visit)



Safety Plan

Available in
iTunes



Link to Training

- http://www.suicidesafetyplan.com/Home_Page.html
- <http://www.sprc.org/resources-programs/safety-planning-guide-quick-guide-clinicians>
- Safety Plan Template: www.suicidesafetyplan.com.



Safety Planning Intervention in FEP

- **Psychosis is not a contraindication to using the SPI**
- Focus on warning signs can be very helpful and can be an ongoing process; May have more difficulty in awareness of feeling states
- Assess degree of delusional thinking and determine whether this interferes with safety planning
- Incorporate family if necessary
- May have decreased problem solving capabilities



Vignette: V

- V is a 25 year old man with schizophrenia, baseline delusion that the FBI is tracking him
- Has been a client in the program for 1 year
- Recent loss of his mother leaves client sad, lonely, overwhelmed
- When speaking to him, he mentions he has recently thought about suicide



Vignette: V

- Potential obstacle: Clinician has to decide if the SPI is an appropriate clinical intervention
- What would you ask?
 - *Does he have access to a gun or other lethal weapons?*
 - *Has he made a plan?*
 - *What has provoked this?*
 - *What is his level of reality testing?*



Vignette: V

- Delusions have not worsened and he is not more disorganized than his baseline
- He has thought of ways to hurt himself, including jumping off of the bridge, “to be with my mother”
- BUT acknowledges need for treatment, expresses wish for help



Vignette: V

- V and his therapist completed the SPI
- V generated simple warning signs: “feeling sad,” “thinking about my mother,” “crying”
- V had no trouble coming up with ways to distract himself or turn to others
- Concretely focused on step 6, specifically- how to keep V away from the bridge
- V said, “every time I think about the bridge, I’ll go to the park instead”



Other Interventions & Monitoring

What additional interventions can be incorporated into FEP care when SPI isn't enough?

- **Skills training programs**
- **Family Involvement**
- **Medications**
- **Structured monitoring & follow up**



Skills training programs

- Consider focusing on distress tolerance, interpersonal effectiveness, and problem-solving
- In one study, proximal non-suicidal self-injurious behavior was the strongest predictor of suicide behavior (Fedyszyn et al, 2012)
- Suicide attempts are often impulsive, accompanied by serious intent, and without help-seeking, suggesting they are carried out as a way to find relief from emotional distress



Family Involvement

- Young adults with FEP often live with their families
- Suicide attempts may frequently occur at home
- Information about risk detection, management, and information about who to contact should be provided early on in treatment, as the first few months of treatment are particularly high risk
 - *Emergency contact name and an ROI should be obtained at intake*



Family involvement

- If family notices change in behavior, this can be indication that risk is increasing
- If family reports: withdrawal, agitation, recent hopeless comments, make note and discuss with client
- During high risk times, family can work with team to help keep client safe and implement safety planning, crisis visits and phone calls, etc.



Medications

- Can be one component of suicide prevention
- Treat positive symptoms
- Clozapine and lithium have been shown to reduce suicidality; consider use if appropriate
- Consider giving smaller amounts of medication every visit to reduce lethal means
 - A recent study found that *overdose was the most common method of suicide attempt in a FEP population (Fedyszyn et al, 2014)*
 - Majority of suicides are very *impulsive* in nature. Smaller amounts of medicine = reduction of lethal means



Structured Follow-up & Monitoring

- Standard clinical training does not provide a framework for increasing contact, which is sometimes necessary when people are at elevated risk



Structured Follow-up & Monitoring

- **Structured Follow-Up & Monitoring** can provide:
 - a *bridge* to fill the lag
 - a *safety net*
 - an opportunity to *identify risk* and *ongoing assessment*
 - Increased treatment engagement
 - Decreased isolation



When Can it be Used

- **Clinical Intervention** designed to fill the lag between ED visit or inpatient hospitalization, and engagement with outpatient mental health care
- **OR...Clinical Intervention** used in outpatient treatment when **acute risk for suicide is increased**
- Usually conducted by *telephone*, but can also be done by *text*, *email*, *home visit*
- Or increased *office visits*



3-Step Process

- **Mood check & Risk assessment**
 - May require *crisis intervention* if imminent risk
- **Review and Update Safety Plan**
 - Are they using it? Also always check about *access to lethal means*
- **Facilitate & Enhance Treatment Engagement**
 - *Problem solve* around obstacles to treatment engagement



Outpatient Treatment: Increased Frequency of Visits

- During crisis, consider increased frequency of visits in addition to check-in calls
- Can help you assess change in clinical status and need for higher level of care
- Increases supportive capacity of outpatient treatment
- Adds structure to the day, which can help if people are experiencing worsening depression/suicidal ideation
- Can also consider community visits/home visits, if infrastructure allows



Coordination with the Team

- Proactive management works best if the FEP Care Team is informed and involved.
- Clearly communicate the know risk factors, components of the safety plan and any other interventions
- Ensure rapid communication between team members to monitor changes in risk



“Reactive” Risk Management

- Individual is at ACUTE RISK based on:
 - *Risk Assessment = increased ideation, intent, behaviors*
 - *Increased psychosis symptoms*
 - *Unable to engage in safety skills*
 - *Lack of family/collateral support*
 - *Not able/willing to engage in treatment*
- Hospitalization or crisis treatment is necessary



Part II: Complex Vignettes

- CAH and ongoing delusions
- Adolescent with poor social supports



Vignette: S

- S is a 13 year old female who presented to FEP care after experiencing command auditory hallucinations to kill herself. She had a history of NSSI behaviors (cutting, burning). Reporting daily ideation, moderate intent, desire to “end the pain.”
- Socially isolated – not in school. Father at home on disability. Mother worked full time, school at night.



Vignette: S

- Risk Assessment = HIGH
- Hospitalized early in course of care
 - *CAH to harm herself, not able to develop safety plan*
- After discharge, monitored her ideation and desire for NSSI daily
- Worked on distress tolerance skills, affect labeling. Realized poor sleep was a warning sign.
- Medication adherence improved → CAH decreased
- Social support continued to be a challenge...



Vignette: S

- Symptoms and SI stabilized
- Developed plan to return to school...
 - *Hoped to increase social support*
- 2 weeks prior to school starting → CAH returned, decreased sleep, increased desire for NSSI
- Reported to MD that she felt she could not keep herself safe → Hospitalized



Vignette: S

- **Challenges**
 - *Persistent SI → hard to know when risk was truly acute*
 - *Lack of social support*
- **Lessons learned**
 - *Ongoing assessment (daily) helped us learn when risk truly increased*
 - *Other treatments increased client's ability to clearly communicate needs*



Vignette: G

- G is a 25 year old man with schizophrenia
- Multiple high lethality suicide attempts in the past
- Worsening psychotic symptoms, including paranoia, ideas of reference, and hallucinations, in the setting of psychosocial stressors
- Comes to the clinic saying he wants to “kill myself with a gun.” States he is hearing voices commanding him to do so



Vignette: G

- **What would you ask?**
 - *Does he have access to a gun or other lethal means?*
 - *Has he made a plan?*
 - *What has provoked this?*
 - *What is his level of reality testing?*



Vignette: G

- When questioned, Mr. G states he doesn't have a gun but "I know where I can get one"
- Then begins to speak, rapidly, about his neighbors who refuse to leave him alone, the fact that they are keeping him up at night and he is not sleeping
- Cannot reality test around worsening delusion
- States suicide is "the only way out," and is particularly distressed by CAH



Vignette: G

- **SPI not appropriate here, as G cannot engage in that collaboration.**
 - *Past high lethality suicide attempt*
 - *Potential access to lethal weapon*
 - *No sleep for days*
 - *And, **perhaps most importantly for this case example**, he is disorganized and his worsening delusion is directly linked to suicidal thoughts, and he is having commands to act on this*



Vignette: G

- **G appears to be at high level of risk.**
- **Determine if he can safely leave office**
 - *Can he come back again tomorrow?*
 - *Can he reliably do check-in calls over the week?*
 - *Can the family be called upon to help keep G safe?*



Vignette: G

- Depending on a multitude of factors, both protective and risk, clinician can determine what the next step is
- Always consider consultation and the rest of the team
- If imminently unsafe, consider sending G to the ER for evaluation
- However, remember, there are MANY CLINICAL STEPS prior to this



References

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Expanded Suicide Prevention Resources and Importance of Evaluation

James Wright, LCPC

Public Health Advisor
Suicide Prevention Branch



SAMHSA Programming Based off of the Different Stages of Interventions

- **Identification-** (triage, screening, assessment)
- **Treatment-** actual treatment of suicidal behavior
- **Education and referral-** safety planning, continuity of care
- **Follow-up**



SAMHSA's Six Major Suicide Prevention Components

- **Garrett Lee Smith State and Tribal Suicide Prevention Grant Program**
- **Garrett Lee Smith Campus Suicide Prevention Grant Program**
- **National Suicide Prevention Lifeline**
 - *Crisis Center Follow-up Grant Program*
- **Suicide Prevention Resource Center**
- **National Strategy for Suicide Prevention**
- **Tribal Grants**



Suicide Prevention Resource Center

The Nation's first and only Federally funded suicide prevention resource center



- SAMHSA-funded resource center devoted to advancing the National Strategy
- Information on suicide prevention activities in every state (state plans, coordinators)
- Everyone has a role in preventing suicide: Information sheets for parents, teachers, co-workers, faith leaders, EMS, and more
- Clinical training for MH professionals
- Free on-line trainings
- Weekly newsletter- SPARK (Sign up!!)
- www.sprc.org



Resources on SPRC

- Detailed information on programming, including evidence based and best practices
- Webinars, Toolkits and program guides
- Treatments including Dialectical Behavior Therapy (DBT), Cognitive Therapy for Suicide Prevention (CBT-SP), Collaborative Assessment and Management of Suicidality (CAMS) and Non-demand follow-up contact
- <http://www.sprc.org/events-trainings/zero-suicide-webinar-principles-effective-suicide-care-evidence-based-treatments>



National Suicide Prevention Lifeline 1-800-273-TALK (8255)

- 160+ local crisis centers
- Answered 1.5 million calls in 2015, more than **8 million** to date
- Regional Back up capacity
- Collaborates with Veterans Administration for Press 1 option
- In response to Lifeline evaluation findings, created the Crisis Center Follow-up Grants (36 crisis center grantees funded to-date)
- Chat services added 24/7 Feb 2014
- Spanish sub-network
- Linked by calling 1-800-273-TALK (8255) or 1-800-SUICIDE
- *Follow-up grants, risk assessment standards, and imminent risk guidelines were all a result of the Lifeline evaluation findings. (research-to-practice in action)*



Suicide Risk Assessment and Imminent Risk

- Both produced through the Lifeline's Standards, Training & Practices Subcommittee (STPS) of nationally and internationally recognized experts in suicide prevention
- Four core principles for **Risk Assessment**: Suicidal Desire, Suicidal Capacity, Suicidal Intent and Buffering.
- Three core areas for **Imminent Risk**: the use of Active Engagement, use of Active Rescue and the focus on Collaboration with other community crisis and emergency services
- <http://www.suicidepreventionlifeline.org/media/5388/Suicide-Risk-Assessment-Standards.pdf>
- <http://www.suicidepreventionlifeline.org/media/7432/IR-Executive-Summary.pdf>



The Need for Follow-up

- Demonstrated as an evidenced based practice
- Highlighted through all of SAMHSA's SP efforts and in the National Strategy, Zero Suicide, Crisis Services effort and the Sentinel Event Alert 56
- Ensures responsibility during continuity of care and in between treatments and appointments.
- In SAMHSA evaluations 80% of individuals who received follow-up support said the contact directly saved their life



Suicide Prevention Apps



Suicide Safe
SAMHSA's free
suicide prevention app:
a learning tool
for behavioral health
and primary care providers.

Suicide Prevention learning based on the nationally recognized Suicide Assessment Five-step Evaluation and Triage (SAFE-T) practice guidelines



SAMHSA's Suicide Safe helps providers

- Learn how to use the SAFE-T approach when working with patients.
- Explore interactive sample case studies and see the SAFE-T in action through case scenarios and tips.
- Quickly access and share information, including crisis lines, fact sheets, educational opportunities, and treatment resources.
- Browse conversation starters that provide sample language and tips for talking with patients who may be in need of suicide intervention.
- Locate treatment options, filter by type and distance, and share locations and resources to provide timely referrals for patients.



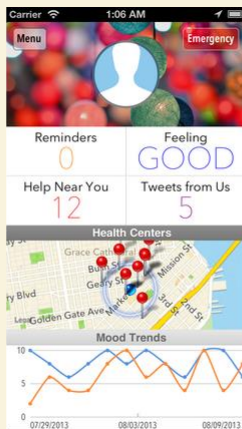
SAMHSA SP App Challenge 2013

- To develop an application for a mobile device that will provide continuity and follow-up linkages for someone at risk for suicide who was discharged from an inpatient unit or emergency department.
- *Many integrated safety plan and mood monitoring into provider databases or systems with the ability to push communications between systems and app users*
- Large variation of additional features
- Brought different perspective to historical approaches

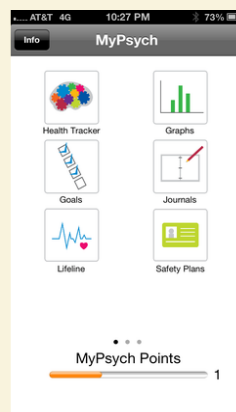


Suicide Prevention App Challenge

Relief Link



MyPsych



ReachZ and Companion



Effective Suicide Prevention

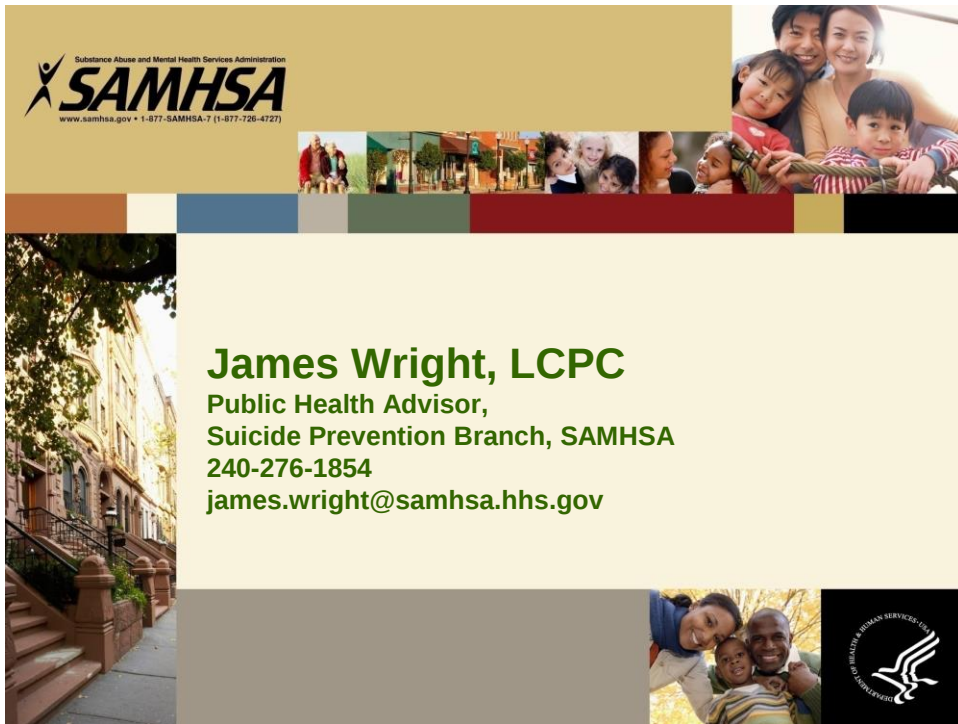
- **Must ensure that you thoroughly track and evaluate implementation and outcomes of all Suicide Prevention Interventions**
 - *How will you know if you are having a positive impact? (**Are you tracking suicidal behavior?**)*
 - *Are you evaluating increase in utilization and referrals? (system)*
 - *Are you evaluating reduction in BH crises from your clients? (individual)*



Next Steps for You?

- **Identify how you are assessing suicide among individuals with FEP**
- **Identify what gaps you have and how emerging technology can help bridge/enhance traditional services**
- **Utilize evidenced based and best practices for all steps of interventions**
- **Plan to show impact, short term and long term, through tracking and evaluation**





The slide features a header with the SAMHSA logo on the left and a collage of images on the right, including a family and a street scene. The main content area is a light yellow rectangle containing the name and contact information of James Wright, LCPC. To the right of the text is a small circular logo for the Department of Health and Human Services. The slide is framed by a gold border at the top and a gold bar at the bottom.

Substance Abuse and Mental Health Services Administration
SAMHSA
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Questions/Discussion

Thank you!

