SPRC Research to Practice Webinar

Emergency Departments: A Key Setting for Suicide Prevention

June 16, 2015

3:00 pm – 4:30 pm EDT

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Moderator

Lisa Capoccia, MPH

Assistant Manager Clinical Initiatives, Suicide Prevention Resource Center

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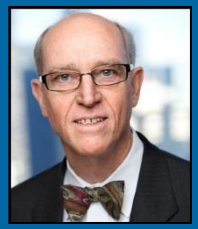
Speakers

Dr. Marian (Emmy) Betz, MD, MPH
Assistant Professor, Department of Emergency Medicine, University of Colorado School of Medicine

Leslie S. Zun, MD, MBA
System Chair of the Department of Emergency Medicine, Sinai Health System; Chairman & Professor, Department of Emergency Medicine; Secondary Appointment, Department of Psychiatry at the Rosalind Franklin University of Medicine and Science/Chicago Medical School



Michael H. Allen, MD
Professor of Psychiatry and Emergency Medicine, University of Colorado School of Medicine; Medical Director, Rocky Mountain Crisis Partners

Edwin Boudreaux, PhD
Director of Research, Department of Emergency Medicine, University of Massachusetts Medical School

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The Role of the Emergency Department in Suicide Prevention

Marian (Emmy) Betz, MD, MPH

Assistant Professor

Department of Emergency Medicine

University of Colorado School of Medicine

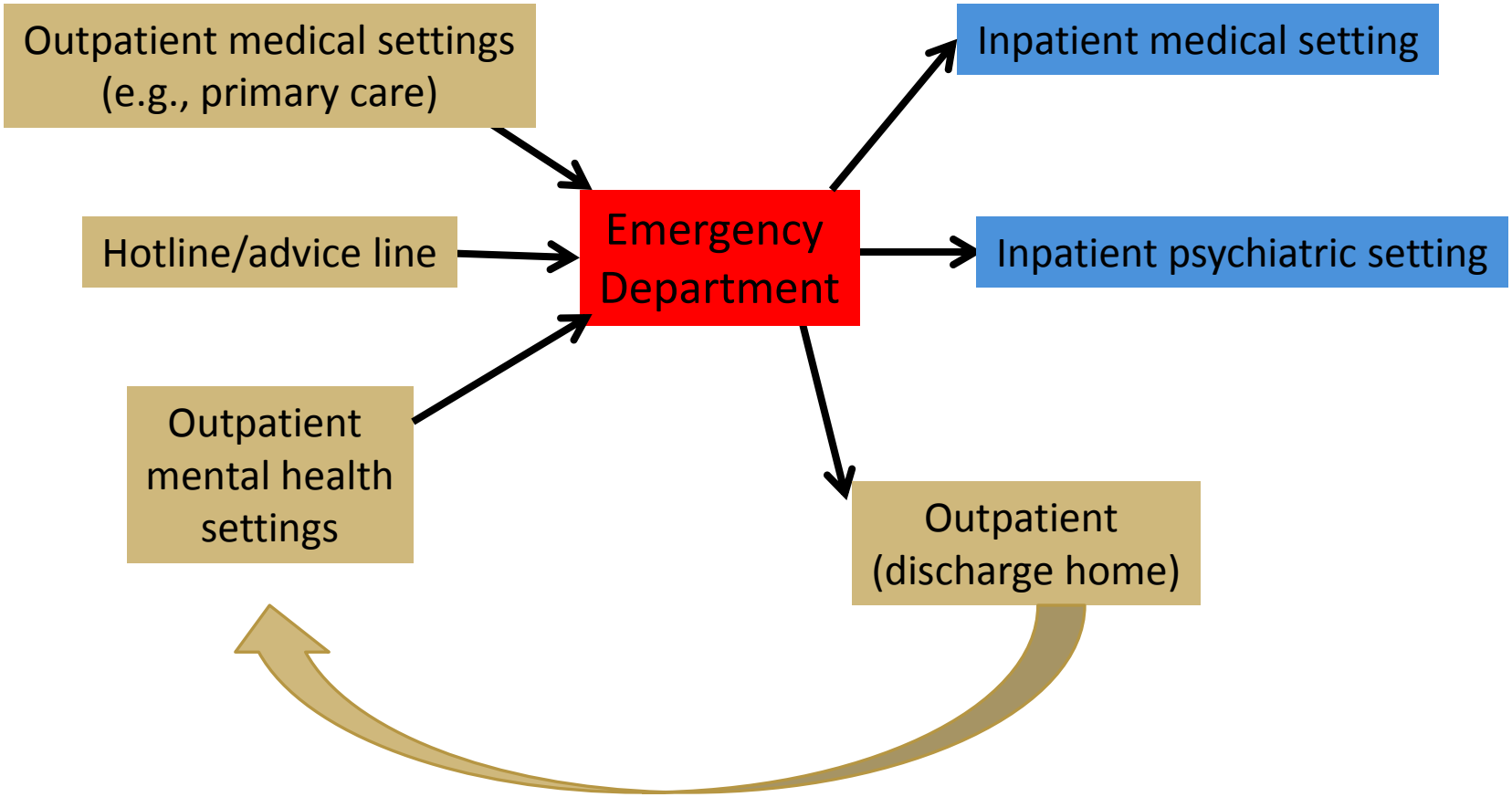
Marian.Betz@ucdenver.edu

Emergency Medicine

- "The medical specialty dedicated to the diagnosis and treatment of unforeseen illness or injury" (American College of Emergency Physicians)
- Emergency physicians "care for all patients regardless of age, gender, time of presentation, or ability to pay"
- Unique focus on preventing short-term morbidity & mortality

Schneider SM et al. Definition of emergency medicine. Acad Emerg Med. 1998. 5(4):348-51

Conceptual framework of ED use



Morganti et al. The Evolving Role of Emergency Departments in the United States. RAND. 2013

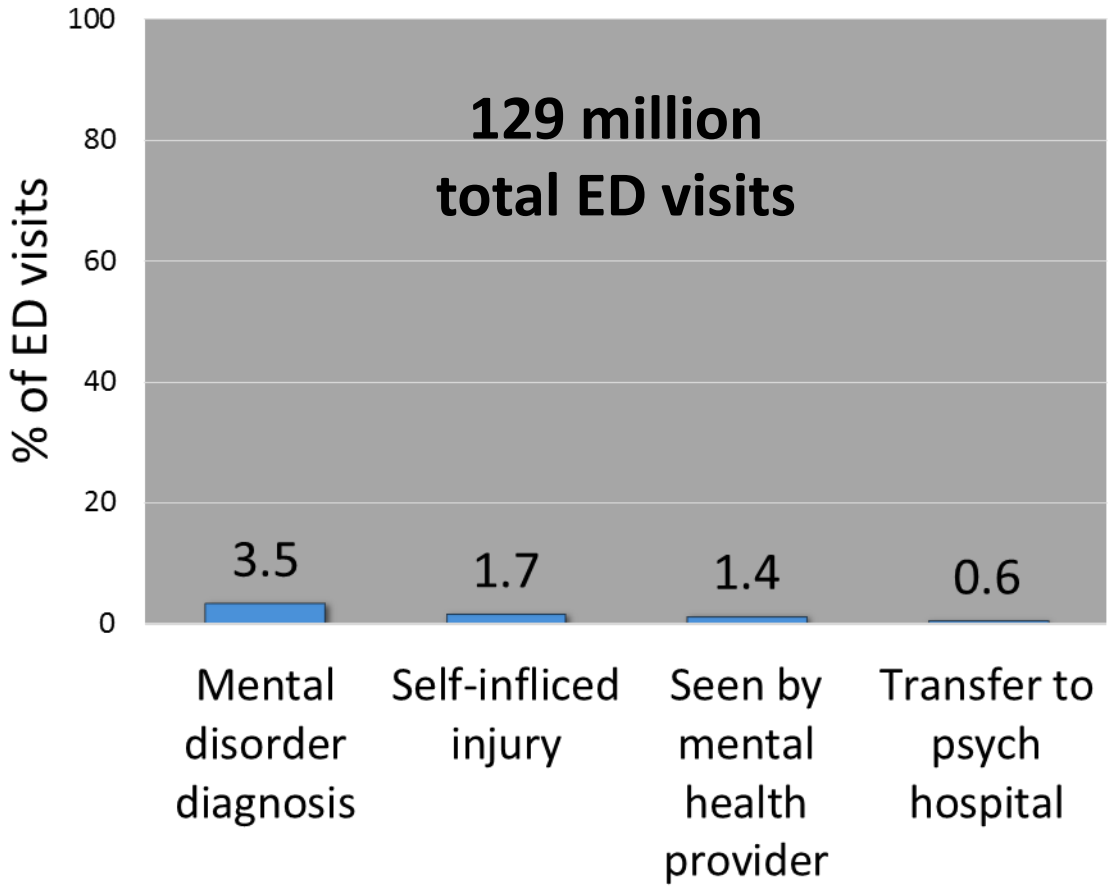
Typical ED process

- Patients cared for by nurse(s) and ED physician
  - Board-certified in Emergency Medicine after EM residency
  - Sees ~15-40 patients per 8-hour shift
  - Cares for multiple patients at once
  - Calls consultants as needed
  - Focus on disposition

ED visits in the US, 2010

Top 10 reasons:

1. Abdominal pain
2. Chest pain
3. Fever
4. Headache
5. Back pain
6. Shortness of breath
7. Cough
8. Pain
9. Vomiting
10. Throat symptoms



http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2010_ed_web_tables.pdf

Visits for mental health

- ED visits for mental health reasons rising
- 39-43% of suicide decedents visit an ED in the year before death
- Multiple ED visits may indicate elevated suicide risk

Ting et al. Gen Hosp Psychiatry 2012 ; Gairin et al. BJPsych 2003
DaCruz et al. Emerg Med J 2011; Kvaran et al BMC Public Health 2015

Identification of suicidal patients

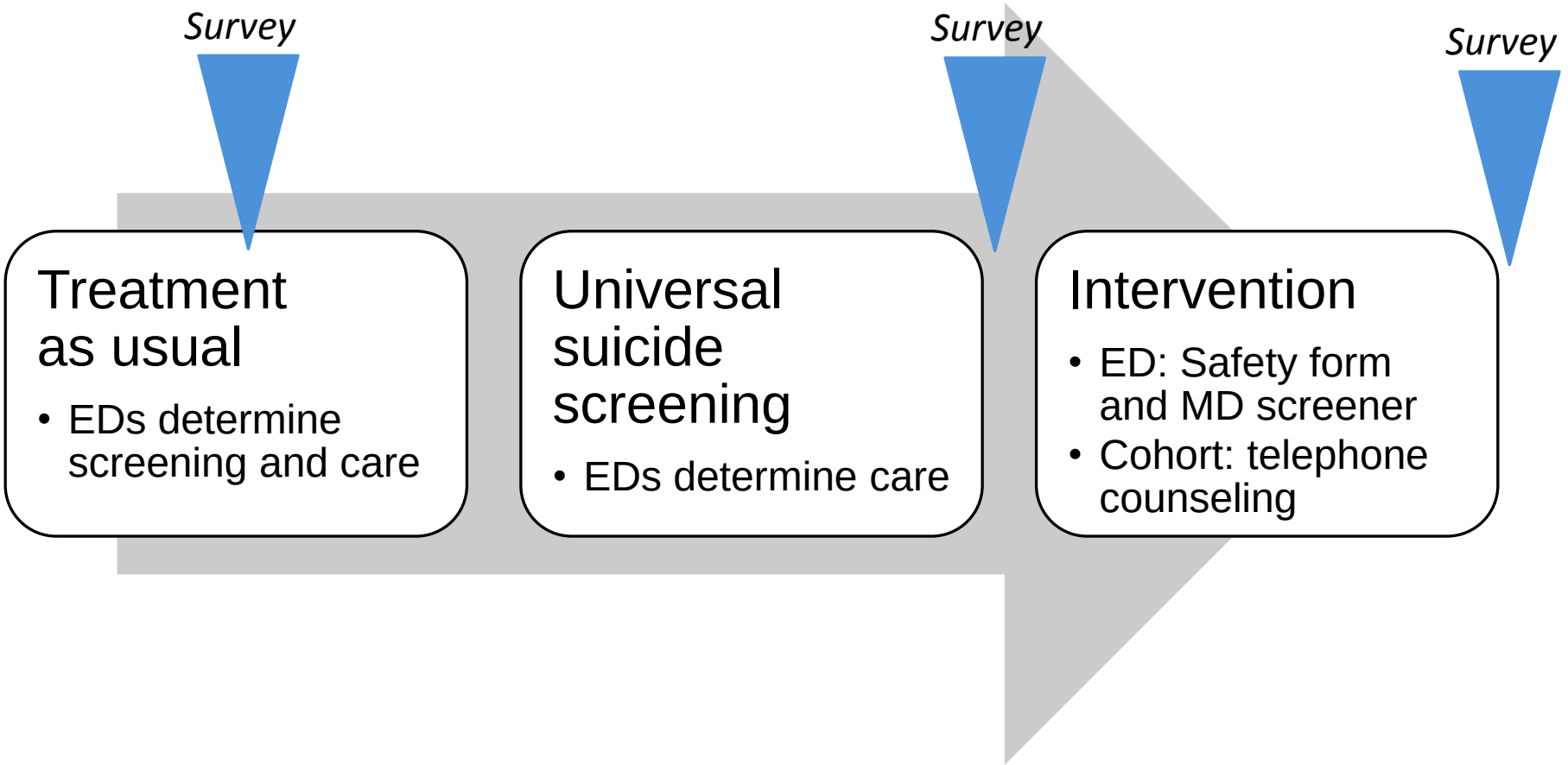
- Many—but not all—patients come with psychiatric reason for visit
  - Estimated 3-11% of all ED patients have “occult” suicidal ideation
- Screening options
  - Indicated
  - Selective
  - Universal

} Either of these likely fulfils Joint Commission requirement (National Patient Safety Goal 15)

Boudreaux et al. Prim Care Comp to J Clin Psychiatry 2006; Kemball et al. Am J Emerg Med 2008
Claassen & Larkin. Brit J Psychiatry 2005; Caterino et al. Acad Emerg Med 2013.

Emergency Dept Safety and Follow-up Evaluation Study

Aims: Test Universal Screening and Telephone Counseling



ED-SAFE: Universal screening

Patient Safety Screener
1. Over the past 2 weeks, have you felt down, depressed, or hopeless?
2. Over the past 2 weeks, have you had thoughts of killing yourself?
3. Have you ever attempted to kill yourself?
4. If Yes to item 3: when did this last happen?

Care of suicidal patients

Once suicidality recognized:

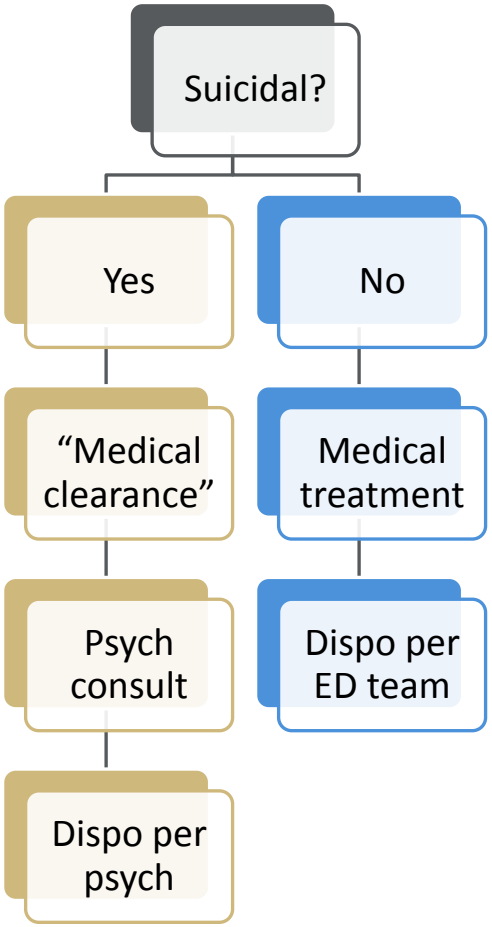
→ Questioning by ED physician

→If ED physician concerned, next step varies:

- On-site psychiatry or trained social workers (available 24/7 vs limited hours)

or

- Off-site psychiatry or mental health team comes to ED



Problem: Inadequate resources

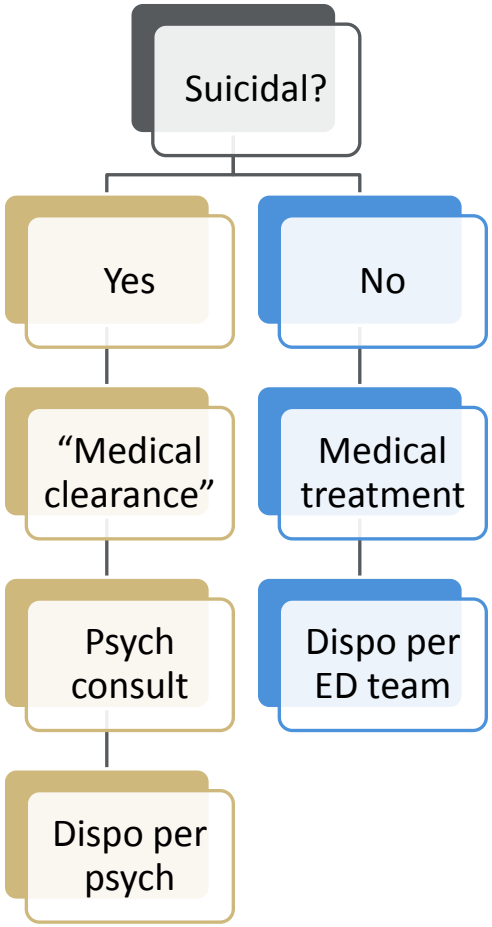
- Limited inpatient beds and outpatient resources

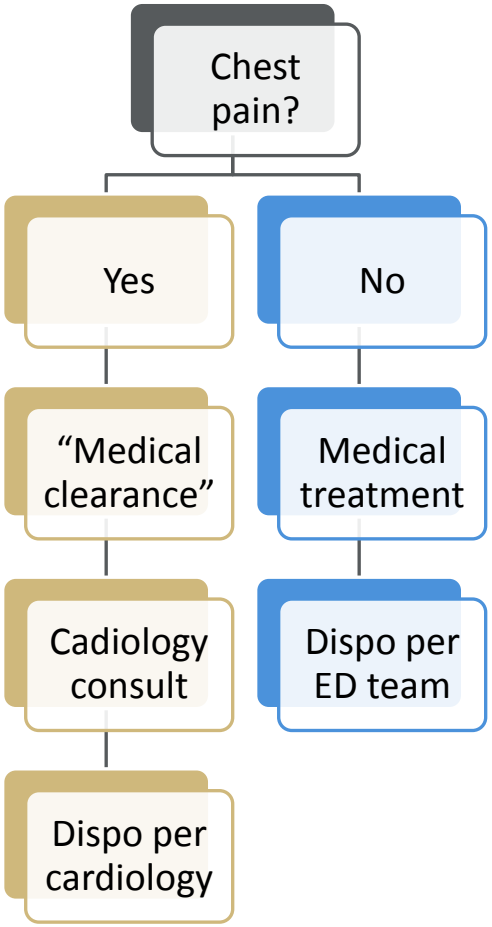
  →long ED waits for suicidal patients under less-than-ideal circumstances

- Limited mental health professional availability
  - Especially in rural areas or at smaller hospitals
- With time pressures and growing ED volumes, these issues add to provider frustration

Sharfstein and Dickerson. Hospital Psychiatry For The Twenty-First Century. Health Aff 2009.
Mechanic. More People Than Ever Before Are Receiving Behavioral Health Care In The United States, But Gaps And Challenges Remain. Health Aff 2014.

But: Does every suicidal patient need a mental health consult in the ED?





Current assessment options

Examples of available tools that might be in use

- Modified SAD PERSONS
- Manchester Self-Harm Rule
- Short version of Columbia-Suicide Severity Rating Scale

None is ideal for use in busy EDs in US

Clinical Practice Guideline: Suicide Risk Assessment (ENA 2012)
https://www.ena.org/practice-research/research/cpg/documents/suicideriskassessmentcpg.pdf

Emergency Dept Safety and Follow-up Evaluation Study

Survey

Survey

Survey

Treatment as usual

- EDs determine screening and care

Universal suicide screening

- EDs determine care

Intervention

- ED: Safety form and MD screener
- Cohort: telephone counseling

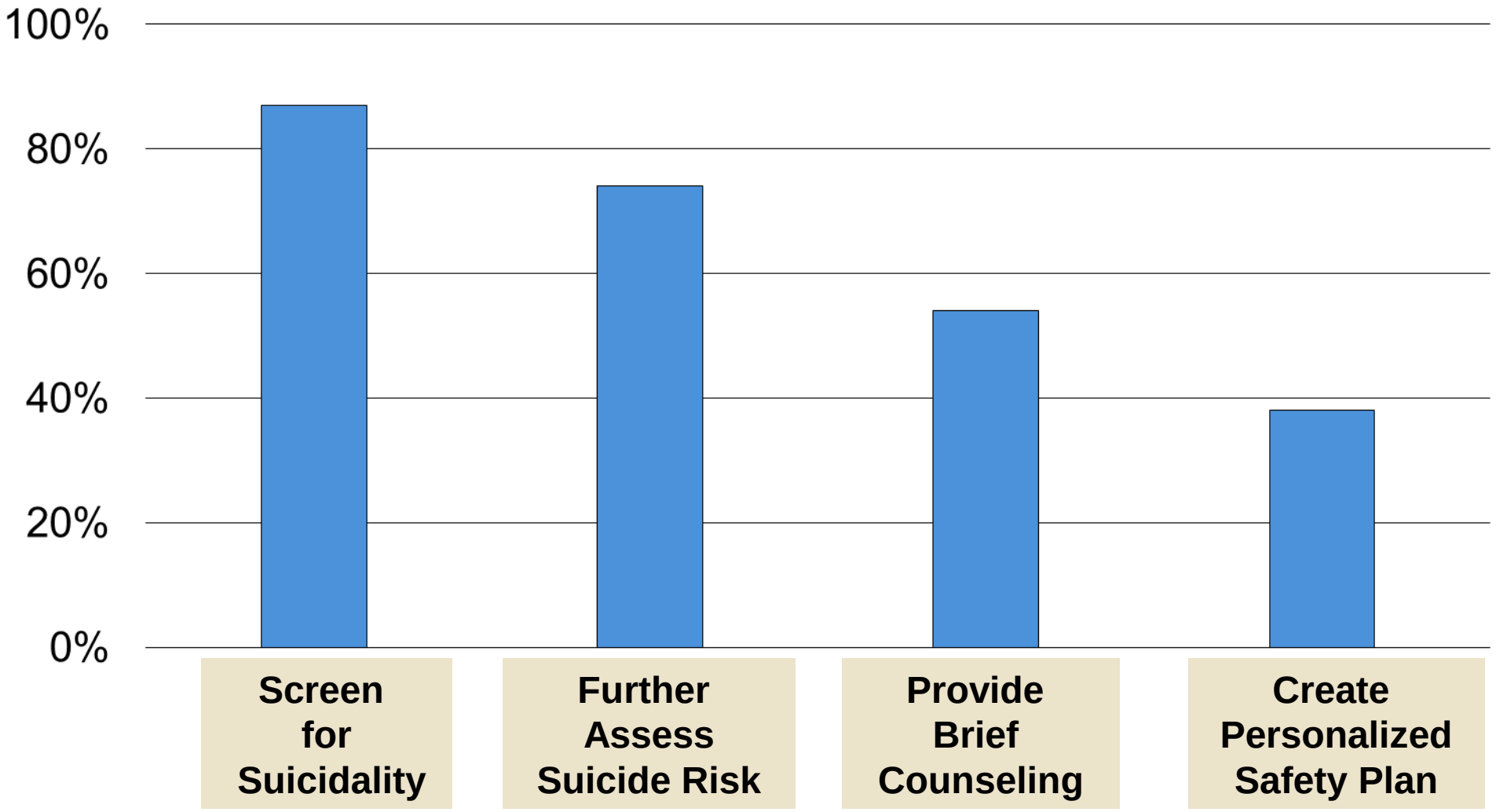
71% response rate

- 64% female
- Median age 40
- 68% nurses

- Working in healthcare median 13 years
- Cared for median 15 suicidal patients per month
- **43% thought "most/all suicides are preventable"**

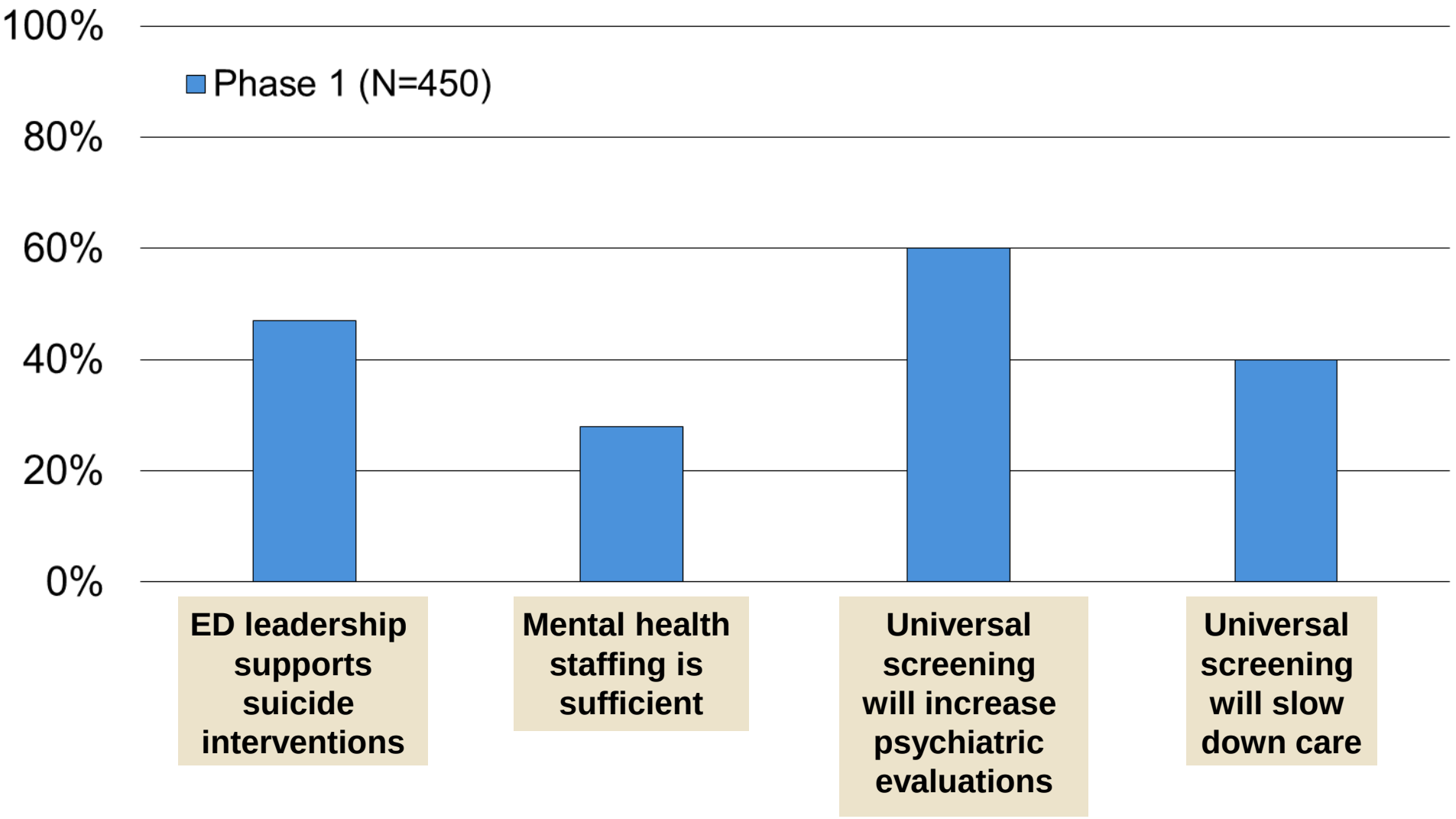
Physician & nurse self-confidence in skills for care of suicidal ED patients

(ED-SAFE phase 3; N=420)



Betz et al. Psych Services 2015.

Physician & nurse opinions of ED environment
(ED-SAFE phase 1 & 3)



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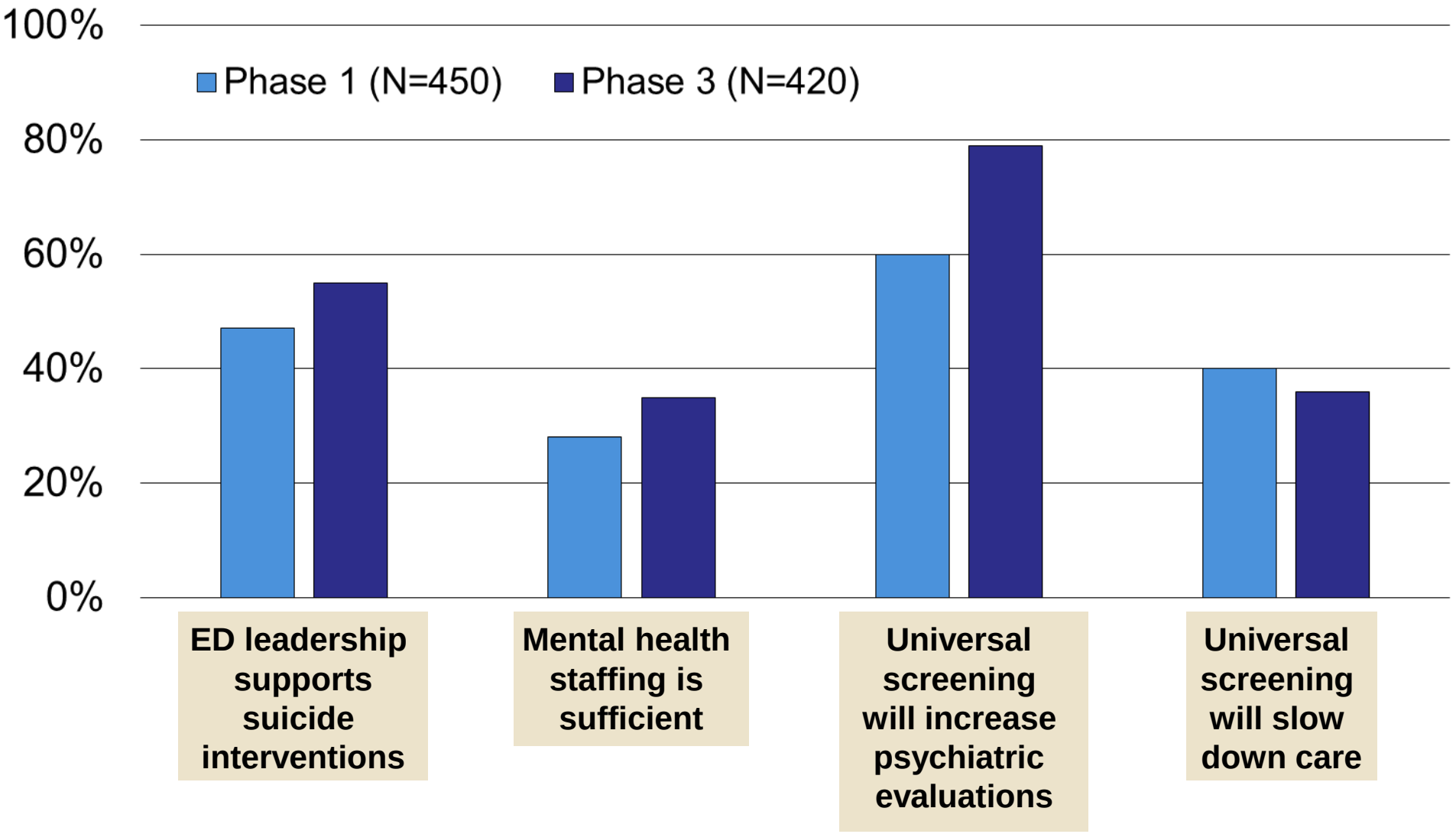

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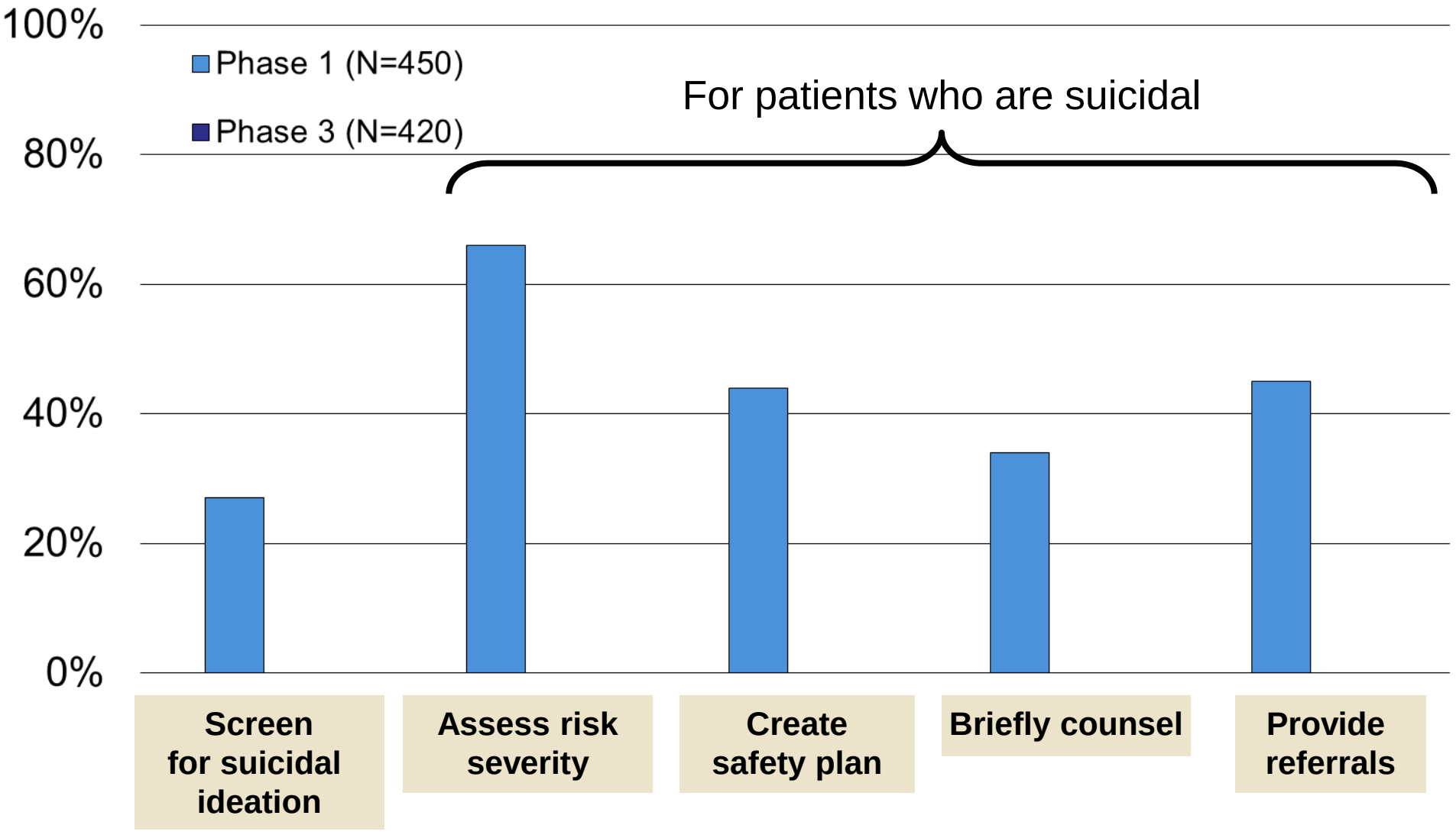
Reported behaviors for most/all ED patients

(ED-SAFE nurses & physicians, phase 1 & 3)



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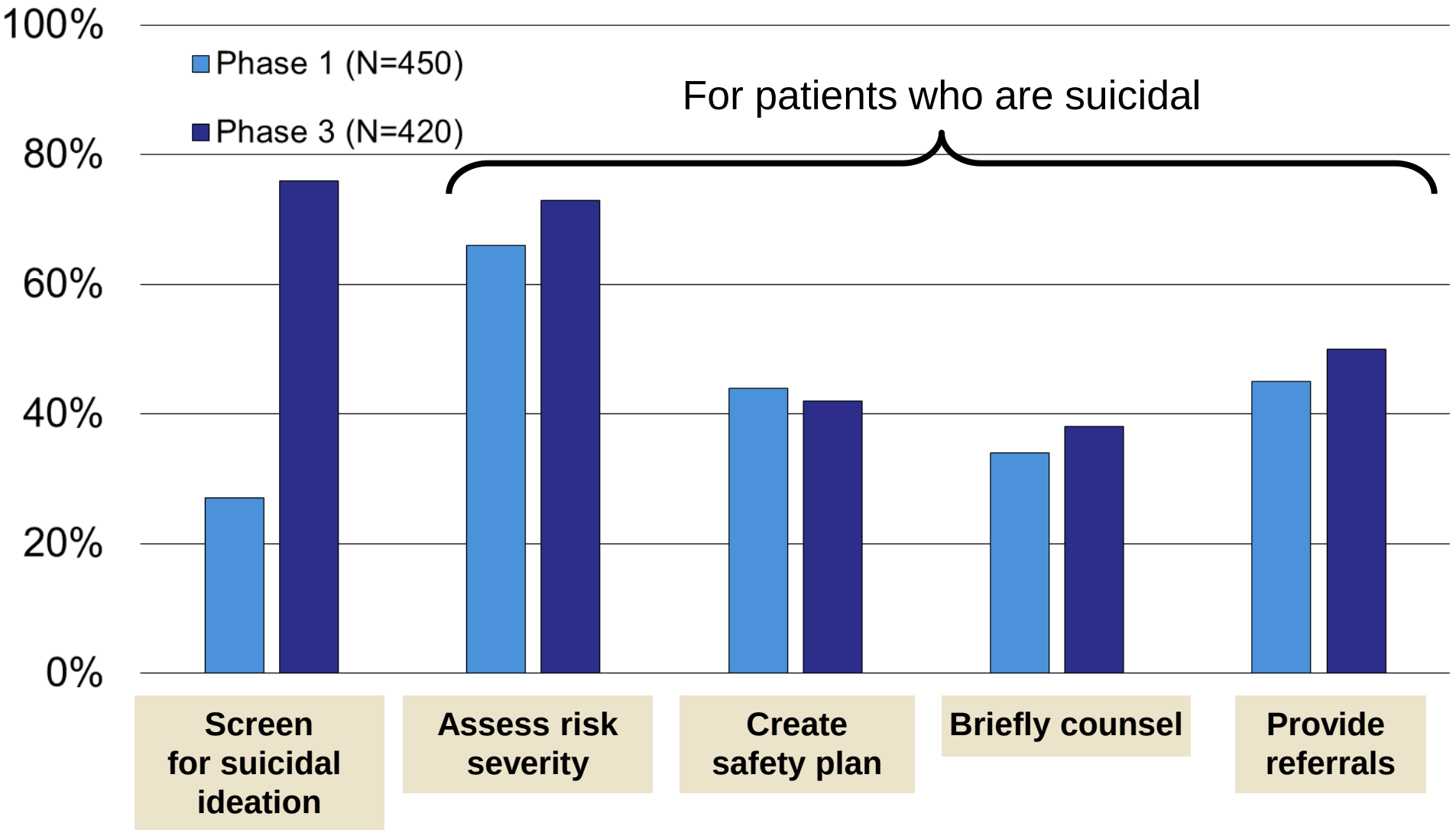
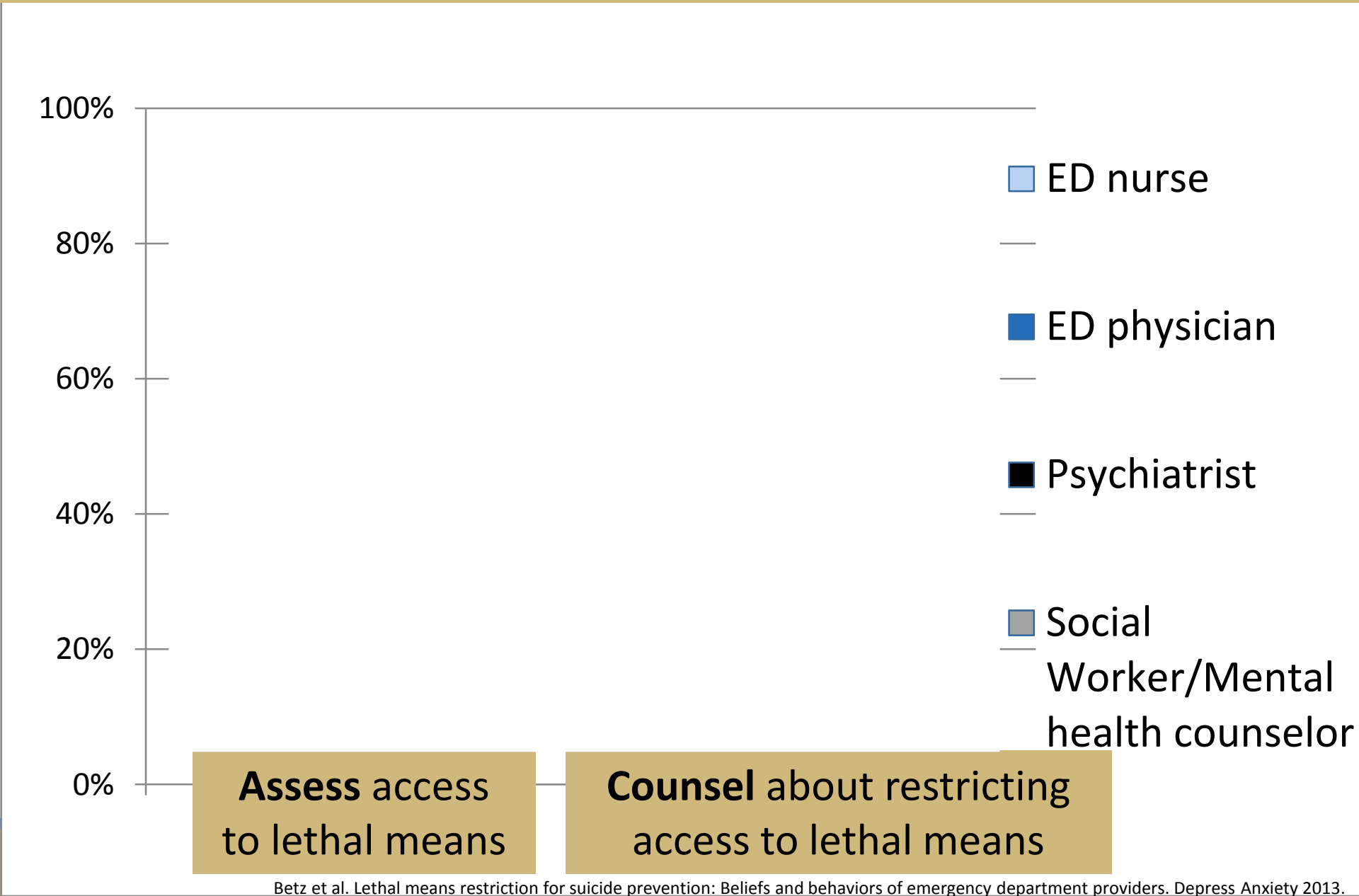


Betz et al. Psych Services 2015.

"Who is responsible for talking to patients about access to lethal means?"



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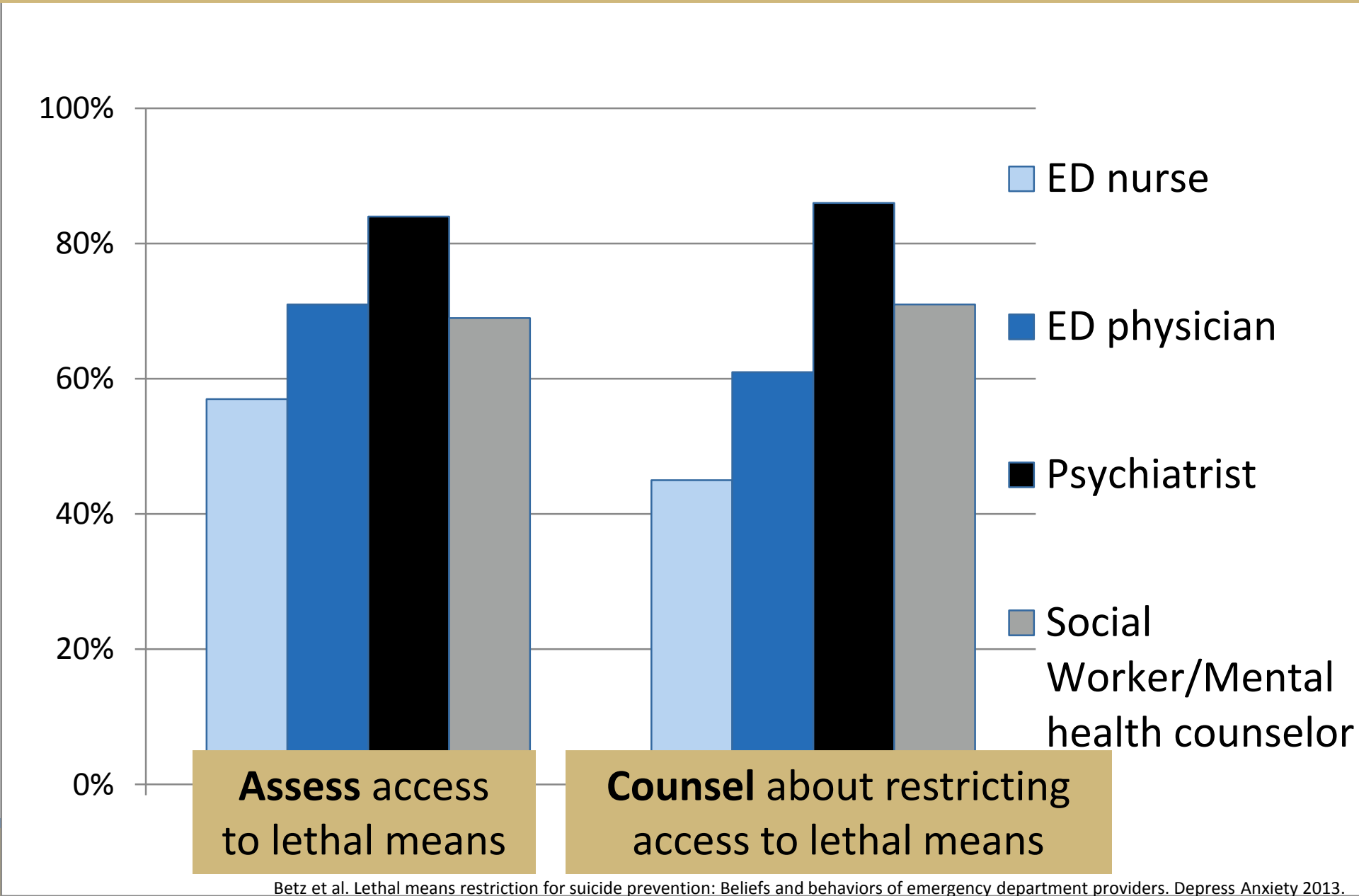
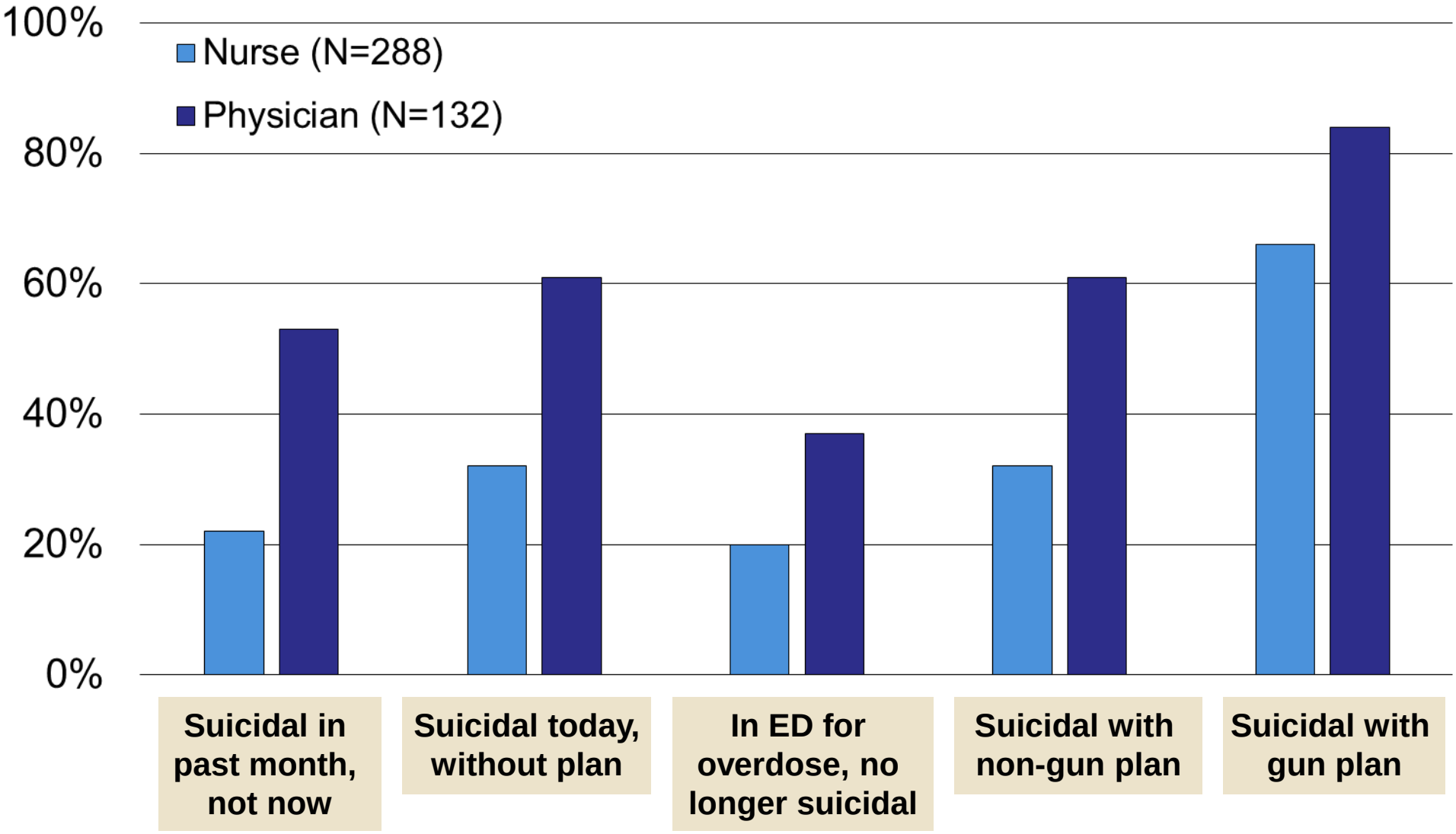


Betz et al. Lethal means restriction for suicide prevention: Beliefs and behaviors of emergency department providers. Depress Anxiety 2013.

"I often/almost always ask if there are firearms at home" (ED-SAFE phase 3)



Betz et al. Psych Services 2015.

Next Steps: Many Challenges

- Who will do suicide screening and assessment?
- Variation in ED capability
- Inadequate training for MDs and RNs
- Need evidence-based ED tools for
  - Rapid risk assessment
  - Stratification and thresholds for hospitalization
  - Options for brief ED treatment
- Need better access to inpatient or outpatient mental health resources

Implementing Suicide Prevention Strategies in Emergency Departments: Barriers and Solutions to Overcome Them

Leslie S. Zun, MD
Professor and Chairman
Mount Sinai Hospital

Objectives

- To understand emergency medicine
- To learn how to approach emergency care providers
- To determine how to modify physician behavior in the emergency department

History of emergency medicine

- Emergency Departments
  - Staffed by physicians of various backgrounds
  - No specialty training
- American College of Emergency Physicians
  - Established 1968
- American Academy of Emergency Medicine
  - Established in the 90s
- American Board of Emergency Medicine
  - Formed 1979
  - Independent specialty 1988

Role of emergency medicine

- Providers of emergency care
  - Non urgent
  - Urgent
  - Emergent
- Coordinator of follow up care
- Emergency department as a safety net
- Emergency department in a managed care environment

Engaging the emergency department sector

- How to engage emergency departments and organizations at the state and local level?
- Come ready to offer solutions
- Build relationships

Barrier: It can be difficult to engage the emergency department sector

- How to engage EDs at the state and local level?
  - American College of Emergency Physicians
    - State chapters
  - American Academy of Emergency Medicine
    - State and regional chapters
  - Emergency Nurses Association
    - State and local chapters
  - Contract Management Company
  - Hospital system

How to approach emergency providers

- Learn about the emergency department
  - Primary patients served
  - Teaching or non-teaching
  - Problem areas
  - Contracted, employed or other
- Find out who is nurse manager, medical director, chair
- Time, date & location of MD, PA, RN meetings
  - Possibility to present material at a staff, regional or system meeting

Building relationships with emergency departments

- Build relationships
  - Find the champion
  - Connect with the department medical director or chair
  - Connect with the nurse manager
  - Role of social work
  - Role of psychiatry

How to change emergency physician behavior

- "Cowboy/Cowgirl" – the first one on the block to try something
- One starts to use it and it spreads
- Comes from psychiatry department
- Literature based
- Advantages and persuasion to try it
- Guidelines demonstrates improved care

Come ready to offer solutions

- Emergency departments are busy places
- Anything that can make the job easier will be appreciated
- Can it expedite patient care?
- Can it reduce the number of patients boarded in the emergency department?

Barrier: Developing the evidence base for these interventions

- Consensus guidelines based on available research and RAND methodology
  - Some studies are difficult to perform in the emergency department
    - Especially
      - Mental health patients
      - Randomized controlled trials
  - Consensus guidelines are the best available
  - Consensus guidelines may be used prior to randomized controlled trials

Developing the evidence base for these interventions

- Build evaluation into your prevention approaches and collect feedback from emergency department sector
  - Obtain feedback on the use and utility of the guidelines
  - Obtain information about how the tool is used and improvements

Addressing emergency department lack of time and training

- Tools in the guide are designed for feasibility in the emergency department
  - Tool was designed by group composed of emergency physicians and psychiatrists
- Guide can be used as basis for training materials
  - Emergency departments have a need for training in dealing with psychiatric patients

Behavioral Emergencies Meeting

6th Annual National Update on Behavioral Emergencies Conference

December 2-4, 2015; Las Vegas, Nevada

www.behavioralemergencies.com

A New Resource to Promote Suicide Prevention for Adults in ED's

SPRC R2P Webinar
June 16, 2015

Michael H. Allen, M. D.

Professor of Psychiatry and Emergency Medicine
University of Colorado School of Medicine

Medical Director
Rocky Mountain Crisis Partners

Helen and Arthur E. Johnson Depression Center
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

ROCKY MOUNTAIN CRISIS PARTNERS
.....leaders in 24/7 support

Usual ED Care

University of Colorado Hospital

66 yo male presents after stepping on a nail

H/O of depression, prostate cancer, Type 2 DM

Denied using alcohol, drugs or tobacco

Affable, in no physical or emotional distress

Normal X-ray, DPT and oral antibiotics

Ordinarily, treated and released

Betz ME, et al. J Am Geri Soc 2013; 61(6):1044

Universal Screening

Joint Commission NPSG 15, ED – SAFE

Screen for depression and suicidal ideation

Emergency nurse was surprised to find

- Detailed suicide plan, look accidental
- Sister would receive death benefits
- 1 year anniversary of partner's death
- Pending eviction, loss of his garden

ED Visits and Suicide Deaths

8 Health Systems, 8 States, N = 5984 suicides 2000-2010

Within 4 weeks of death, N = 4988 enrolled

	Deaths	
	N	%
Any visit	2488	49.9
ED Mental Health	373	7.5
ED Chem Dependency	72	1.4
ED Other	640	12.8
IP Mental Health	232	4.7
OP Mental Health	729	14.6

22%

Ahmedani BK, et al, J Gen Intern Med 2014; 29(6):870

Current Practice

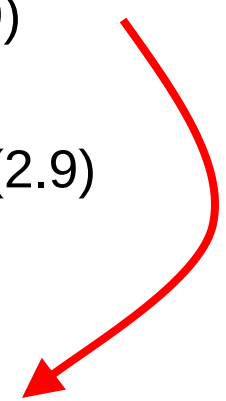
ED SAFE Retrospective, n=800

- Only 4.9% of patients were screened
  - Sites varied from 3 – 23%
- 2.9% had any mention of suicide
- Most with SI had an indication
  - 92% had some risk factor at triage
  - 59% had past or current SI or behavior
  - 33-36% documented substance problem
- Most with an indication were *not* screened, "very selective"

Double the detection rate

→ ***3.4 M add'l episodes per year***

Study	Definition of Ideation	Freq (%)
Allen (2013)	CSSRS Passive SI	79/1068 (7.5)
	CSSRS Active SI	24/1068 (2.25)
	Any SI and history of attempt	12/1068 (3.3)
ED SAFE Retro	Any mention of suicidal behavior	23 / 800 (2.9)
ED SAFE TAU	Any mention of suicidal behavior	2771 / 94,385 (2.9)
ED SAFE Phase 3	Any intentional self-harm ideation or behavior, 75% suicidal	4901 / 236,789 (5.9 -7.3%)



Allen MH, et al. Suicide Life Threat Behav 2013; 42 (3):313.

Increase the Denominator to 4M

National Survey on Drug Use and Health, 2008-2012

	SI		Attempt	
	N	%	N	%
Total US	9031 K	3.9	1290 K	.6
ED	3941 K	6.2	728 K	.3
Specialty Subst Abuse	2613 K	19.4	122 K	5.3
Mental Health Clinic	847 K	26.2	206 K	6.4

Double the number referred to MH?

Increase waiting time

Half get admitted?

Increase boarding

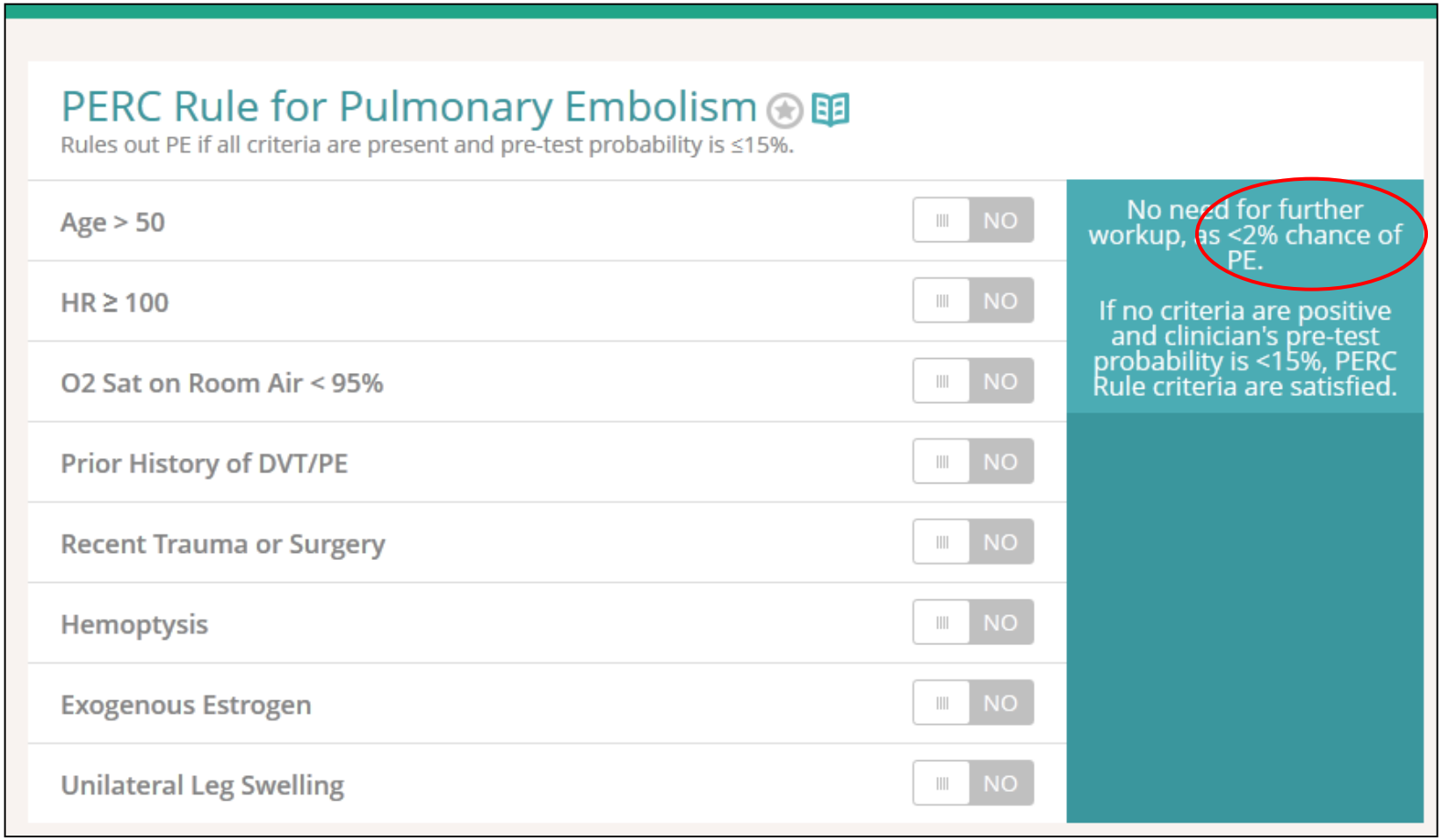
Colpe and Pringle, Am J Prevent Med 2014

Implications

Currently ignoring half the problem

- Can dramatically increase detection
- Space, training, culture = ***triage***
- Rights, preferences of recipients
- *Identify those at low risk, less urgent*
  - Improve care
    - Providing brief interventions in the ED *and*
    - Enhancing transitions of care
- **Secondary screening, negative prediction**

Emergency Medicine



http://beta.mdcalc.com/perc-rule-for-pulmonary-embolism/

Negative Prediction

Modified SAD PERSONS

- 5 negative items
  1. Prior attempt or psych care
  2. Alcohol or drug abuse
  3. Intent
  4. Age 19 – 45
  5. Rational (neg rational thinking loss)
- 99.3% ***no attempt*** at 6 months

Bolton JM, et al. J Clin Psychiatry. 2012 Jun;73(6):

SPRC Emergency Department Project

Develop a **consensus-based** guide for use in emergency departments

- ✓ For patients with ***known suicide risk*** who may be appropriate to treat and release
- ✓ Include **decision support** for disposition
- ✓ Include **interventions and discharge planning**
- ✓ Build on past/current efforts
- ✓ Involve **emergency medicine community**

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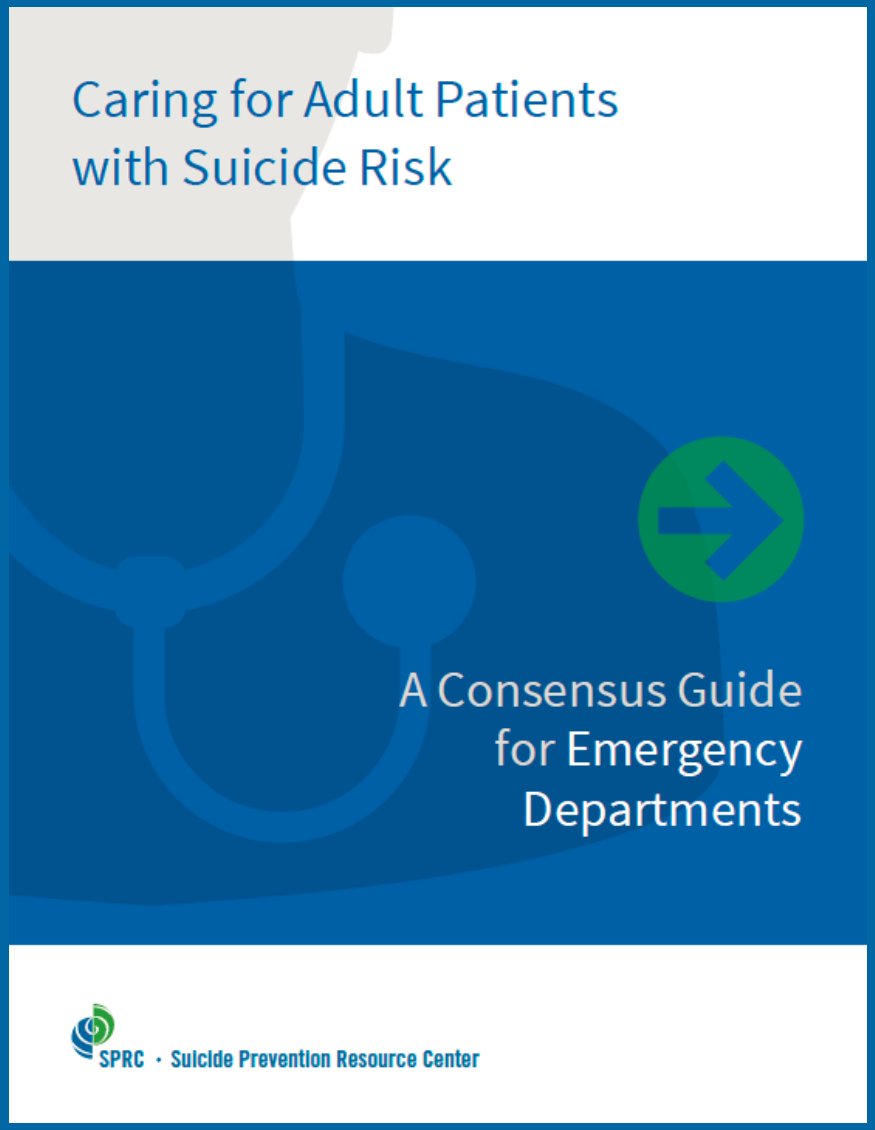

- Full guide
- Quick guide
- Technical report

www.sprc.org/ed-guide

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Building Consensus

- **RAND Corporation and Social Science Research and Evaluation (SSRE)**
- **Two remote studies; Used Expert Lens model**
- **70-82% participation**
- **RAND Appropriateness Method for analysis**

By primary/secondary affiliation

Affiliation	Number (%)
Physicians (non-MH)	10 (29%)
Psychologists	9 (26%)
Clinical researcher	7 (21%)
Suicide prevention professional	7 (21%)
Psychiatrists	6 (18%)
Social workers	4 (12%)
Emergency nurses (non-MH)	3 (9%)
Psychiatric nurse	3 (9%)
Federal agency representative	2 (6%)
Policy expert	1 (3%)
Suicide attempt survivor	1 (3%)
Suicide loss survivor	1(3%)

Percentages exceed 100% due to multiple affiliations by panelists.

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Consensus Panel Studies

Team of 6-8 experts from different perspectives, details available

Study 1: July – August 2013	**Study 2: February – March 2014**
Area of Focus:	Area(s) of Focus:
• Rate item usefulness in making disposition decisions for patients with suicidal ideation (i.e., discharge or further assess)	• Evaluate a draft decision support guide • Rate interventions and discharge planning strategies in EDs
Purpose:	Purpose(s):
• To inform the development of a decision support guide	• To affirm decision support guide approach • To highlight recommended interventions and discharge planning practices in a provider guide

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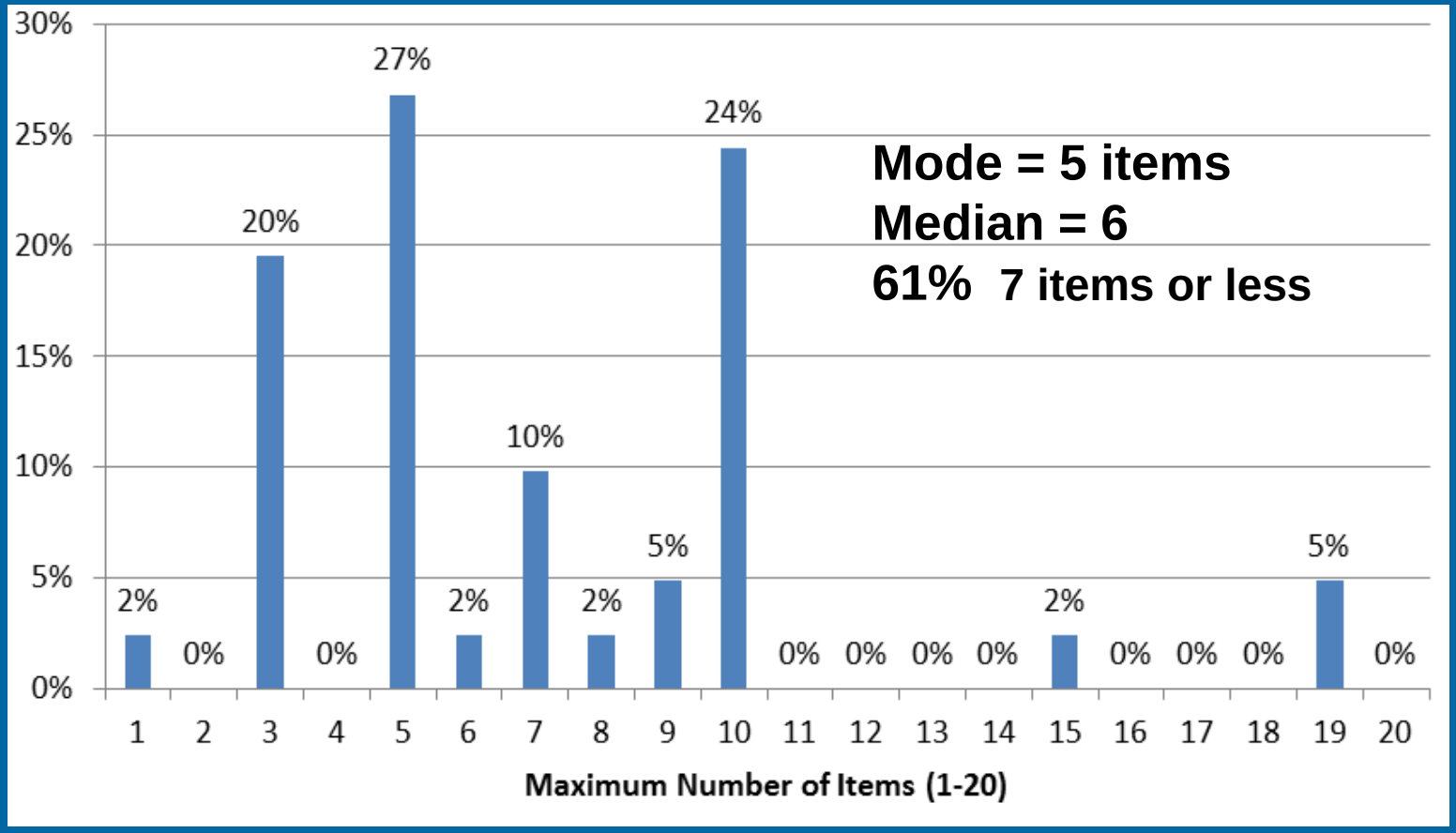
Optimal Assessment Tool for ED Setting : 5-7 Items



N = 41; mean = 7.15; median = 6; mode = 5)

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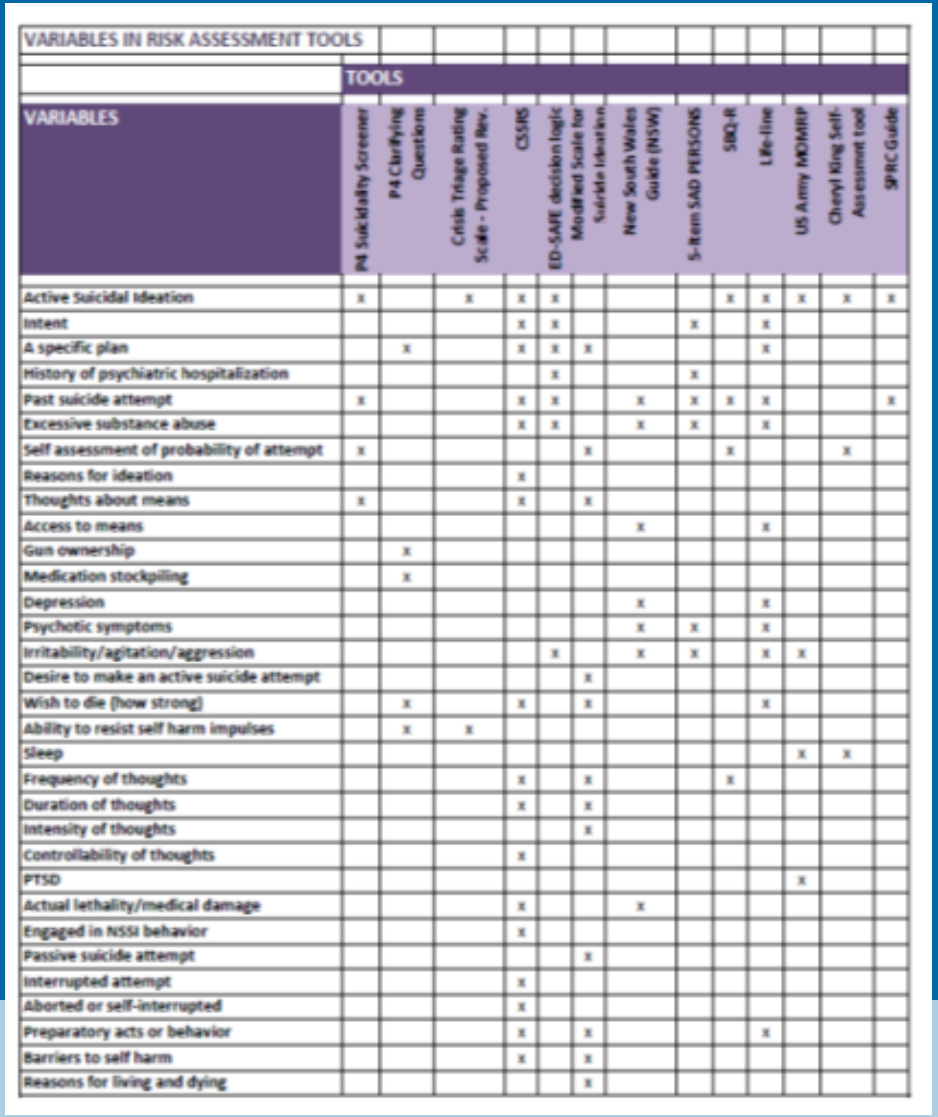
Item selection for Study 1

- ✓ 13 suicide risk tools
- ✓ 47 items
- ✓ Reduced to 13 items
- ✓ Wording based on validated tools



VARIABLES IN RISK ASSESSMENT TOOLS												
	TOOLS											
VARIABLES	P4 Suicidality Screener	P4 Clarifying Questions	Crisis Triage Rating Scale - Proposed Rev.	CSSRS	ED-SAFE decision logic	Modified Scale for Suicide Ideation	New South Wales Guide (NSW)	S-Rem SAD PERSONS	SBQ-R	Life-line	US Army MOMRP	Cheryl King Self-Assessment tool	SPRC Guide
Active Suicidal Ideation	x		x	x	x				x	x	x	x	x
Intent				x	x			x		x			
A specific plan		x		x	x	x				x			
History of psychiatric hospitalization					x			x					
Past suicide attempt	x			x	x		x	x	x	x			x
Excessive substance abuse				x	x		x	x		x			
Self assessment of probability of attempt	x					x			x			x	
Reasons for ideation				x									
Thoughts about means	x			x		x							
Access to means							x			x			
Gun ownership		x											
Medication stockpiling		x											
Depression							x			x			
Psychotic symptoms							x	x		x			
Irritability/agitation/aggression					x		x	x		x	x		
Desire to make an active suicide attempt						x							
Wish to die (how strong)		x		x		x				x			
Ability to resist self harm impulses		x	x										
Sleep											x	x	
Frequency of thoughts				x		x			x				
Duration of thoughts				x		x							
Intensity of thoughts						x							
Controllability of thoughts				x									
PTSD											x		
Actual lethality/medical damage				x			x						
Engaged in NSSI behavior				x									
Passive suicide attempt						x							
Interrupted attempt				x									
Aborted or self-interrupted				x									
Preparatory acts or behavior				x		x				x			
Barriers to self harm				x		x							
Reasons for living and dying						x							

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TRANSITION QUESTION: CONFIRM SUICIDAL IDEATION Have you had recent thoughts of killing yourself? Is there other evidence of suicidal thoughts, such as reports from family or friends? (NOTE: Not part of scoring.)		Y	
1	**THOUGHTS OF CARRYING OUT A PLAN** Recently, have you been thinking about how you might kill yourself? **If yes, consider the immediate safety needs of the patient.**	Y	N
2	**SUICIDE INTENT** Do you have any intention of killing yourself?	Y	N
3	**PAST SUICIDE ATTEMPT** Have you ever tried to kill yourself?	Y	N
4	**SIGNIFICANT MENTAL HEALTH CONDITION** Have you had treatment for mental health problems? Do you have a mental health issue that affects your ability to do things in life?	Y	N
5	**SUBSTANCE USE DISORDER** Have you had four or more (female) or five or more (male) drinks on one occasion in the past month or have you used drugs or medication for non-medical reasons in the past month? Has drinking or drug use been a problem for you?	Y	N
6	**IRRITABILITY/AGITATION/AGGRESSION** Recently, have you been feeling very anxious or agitated? Have you been having conflicts or getting into fights? Is there direct evidence of irritability, agitation, or aggression?	Y	N

Scoring:

0 = "No" on *all* 1-6.

Provide intervention prior to discharge.

≧ 1 = "Yes" on *any* 1-6.

Consult a mental health professional & suicide risk assessment.

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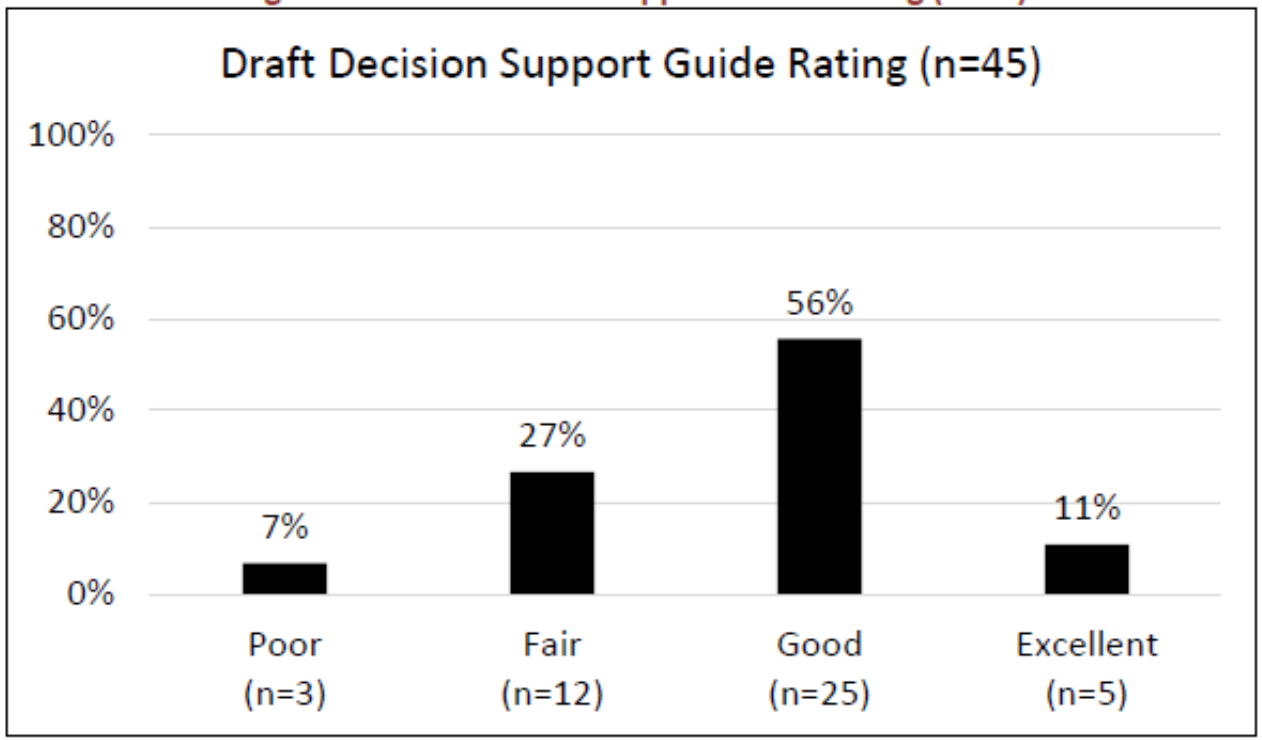
Decision Support Guide Rating

How would you rate this for the purpose of helping ED providers determine which suicidal patients may be appropriate to discharge without further assessment?

67% "good" or "excellent"

Figure 1: Draft Decision Support Guide Rating (n=45)



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Summary Findings: Areas of Consensus

Table 1: Areas of Expert Consensus

	Clinically Useful	Facilitates Continuity of Care	Feasible	Patient-Centered
Brief patient education	X		X	X
Patient-administered safety planning				X
Clinician-administered safety planning	X	X		
Lethal means counseling	X			
Crisis center helpline information	X	X	X	
Brief motivational interviewing	X			X
Telepsychiatry				
Rapid follow-up/referral	X	X		X
Subsequent contact or caring contacts	X	X	X	X

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ED-Based Suicide Prevention Interventions

Brief Intervention	Recommended by: Consensus Panel (1) Best Practices Registry (2)
✓ ***Crisis center/hotline*** *information should be provided as part of each intervention*	
Brief patient education	(1)
Safety planning	(1,2)
Lethal means counseling	(2)
Rapid referral	(1)
Caring contacts	(1)

- ✓ Bundle interventions
- ✓ Patient-centered
- ✓ Use of crisis centers
- ✓ Tailor to patient needs & ED resources

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- ✓ Brief description
- ✓ "How"
- ✓ Resources
- ✓ Some sections: special note or sample scripts

3.3 Lethal Means Counseling

In the Lethal Means Counseling intervention, the provider assesses whether a patient at risk for suicide has access to firearms or other lethal means (e.g., prescription medications), and works with the patient and his or her friends, family, or outpatient provider to discuss ways to limit this access until the patient is no longer feeling suicidal.

Action Steps

- Tell the patient and his or her friends or family that suicide risk can sometimes escalate rapidly, so it is important to consider the patient's access to lethal means during these periods of increased risk.
- Ask the patient and his or her supports about the patient's access to lethal means, particularly firearms. If the patient has access to firearms, ask about the location (e.g., closet, car, attic).
- Provide appropriate counseling to patients who report having access to lethal means. For a list of points to cover in a brief counseling session, view the Lethal Means Counseling Recommendations for Clinicians sheet available from Means Matter.
- Identify strategies for limiting access to lethal means, such as storing firearms at a friend's house until the suicidal crisis has passed, and allowing a family member to keep medications under lock and key and dispense them as necessary in order to prevent self-poisoning.

Lethal Means Counseling Resources

- Recommendations for Clinicians—Lethal means counseling, Means Matter, Harvard School of Public Health
- Recommendations for Families—Information on lethal means, Means Matter, Harvard School of Public Health
- Counseling on Access to Lethal Means (CALM)—Online training course, Suicide Prevention Resource Center
- Firearm Safety and Injury Prevention—Policy, American College of Emergency Physicians (ACEP)

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Discharge Planning Checklist

- ❑ Involve the patient as a partner
- ❑ Make follow-up appointments
- ❑ Review and discuss the Patient Care Plan (discharge plan)
- ❑ Discuss barriers
- ❑ Provide crisis center phone number
- ❑ Discuss limiting access to lethal means
- ❑ Provide written instructions and education materials
- ❑ Confirm that the patient understands the Patient Care Plan
- ❑ Share patient health information with referral providers
- ❑ Communicate your concern

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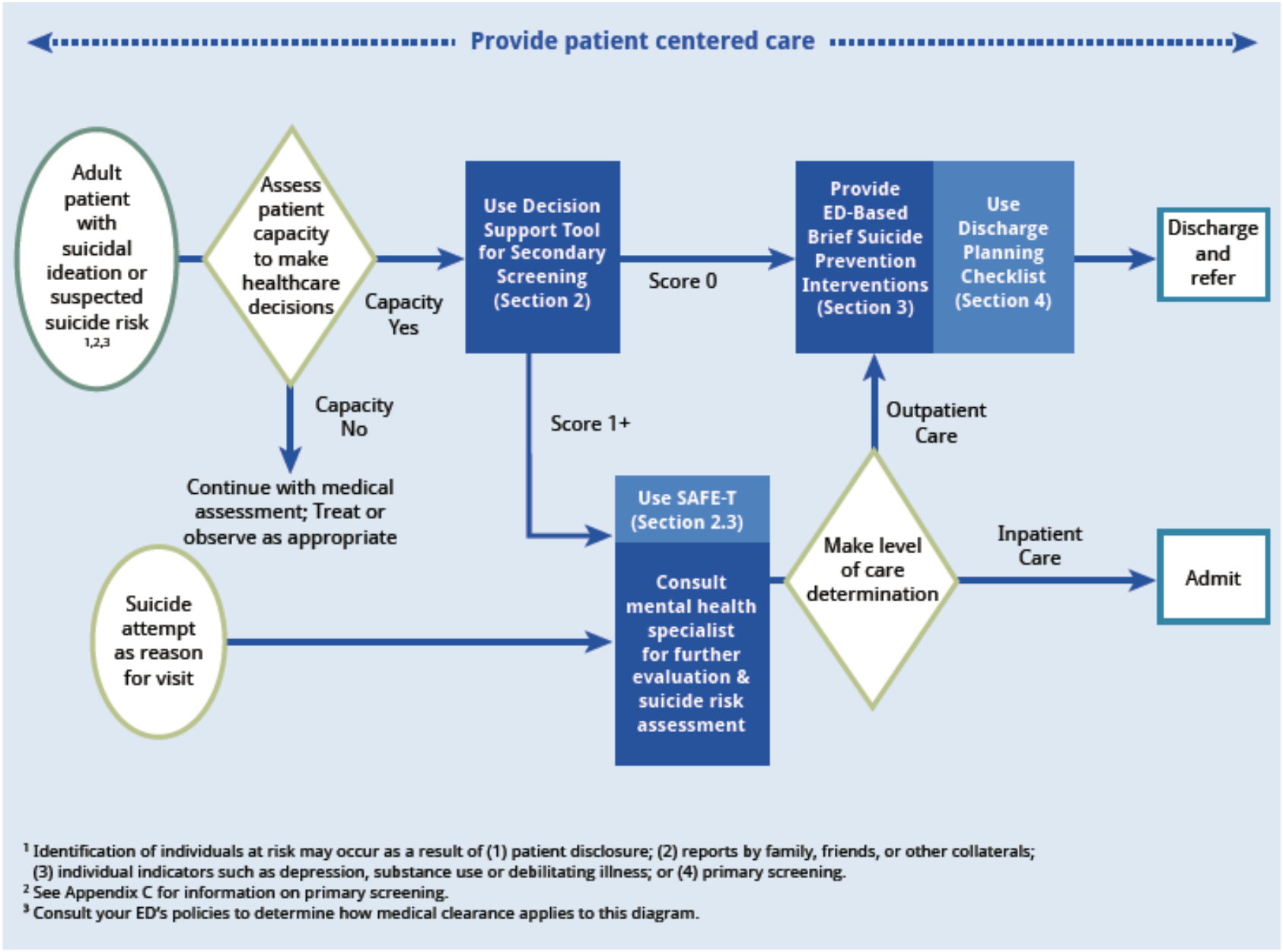
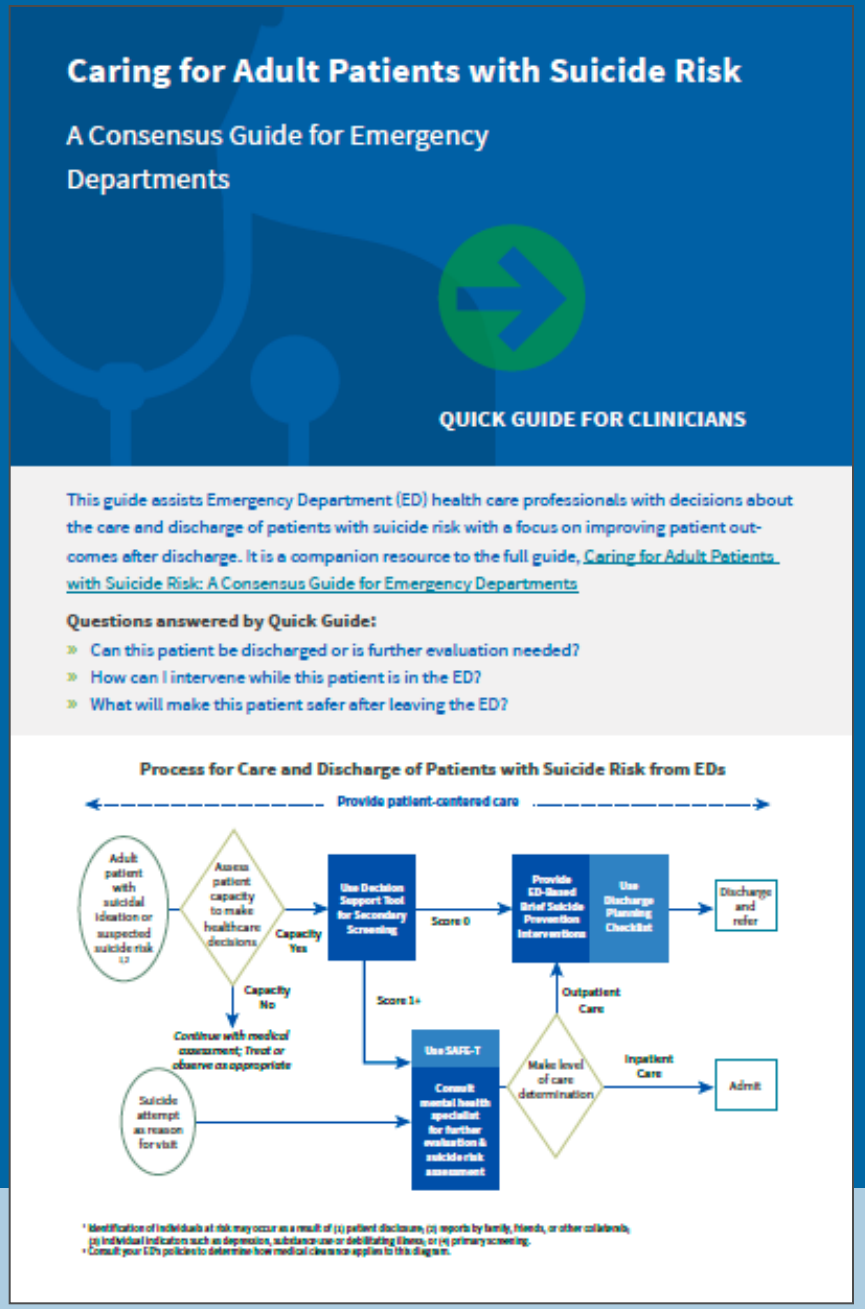
Putting it all together



[1] Identification of individuals at risk may occur as a result of (1) patient disclosure; (2) reports by family, friends, or other collaterals; (3) individual indicators such as depression, substance use or debilitating illness; or (4) primary screening.
[2] See Appendix C for information on primary screening.
[3] Consult your ED's policies to determine how medical clearance applies to this diagram.

Quick Guide

- Two 8.5x11 sides folded
- Companion to the full guide
- Topics covered:
  - Diagram
  - Decision support tool
  - ED-based interventions
  - Discharge planning checklist



Caring for Adult Patients with Suicide Risk

A Consensus Guide for Emergency Departments

QUICK GUIDE FOR CLINICIANS

This guide assists Emergency Department (ED) health care professionals with decisions about the care and discharge of patients with suicide risk with a focus on improving patient outcomes after discharge. It is a companion resource to the full guide, Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments

Questions answered by Quick Guide:

- Can this patient be discharged or is further evaluation needed?
- How can I intervene while this patient is in the ED?
- What will make this patient safer after leaving the ED?

Process for Care and Discharge of Patients with Suicide Risk from EDs

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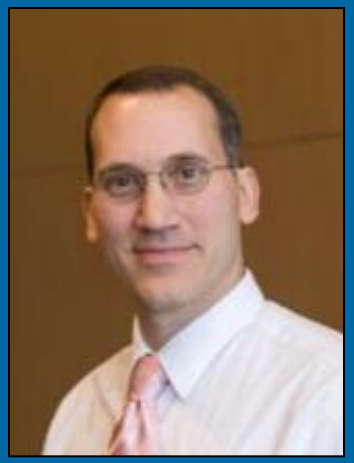
Discussant



Edwin Boudreaux, PhD
Director of Research, Department of Emergency Medicine, University of Massachusetts Medical School

- Implementation
- Emergency Medicine Priorities
- Recommendations for Suicide Prevention Professionals

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Q&A

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Announcements

- *Caring for Adult Patients with Suicide Risk: A Consensus Guide for Emergency Departments www.sprc.org/ed-guide*
- Evaluation

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Contact Us

Lisa Capoccia, MPH
SPRC Clinical Initiatives
Assistant Manager
lcapoccia@edc.org
617-618-2907

Dominique Lieu, MA
SPRC Training Institute
Training Specialist
dlieu@edc.org
617-618-2984

www.sprc.org

Thank you!

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