ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

Improving Care for Homeless Patients at Risk for Suicide

January 30, 2018

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Funding & Disclaimer

The Suicide Prevention Resource Center at EDC is supported by a grant from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), under Grant No. 5U79SM062297.

Moderator

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Director of Health and Behavioral Health Initiatives
Suicide Prevention Resource Center

Suicide Prevention Resource Center

The nation's only federally supported resource center devoted to advancing the *National Strategy for Suicide Prevention*.

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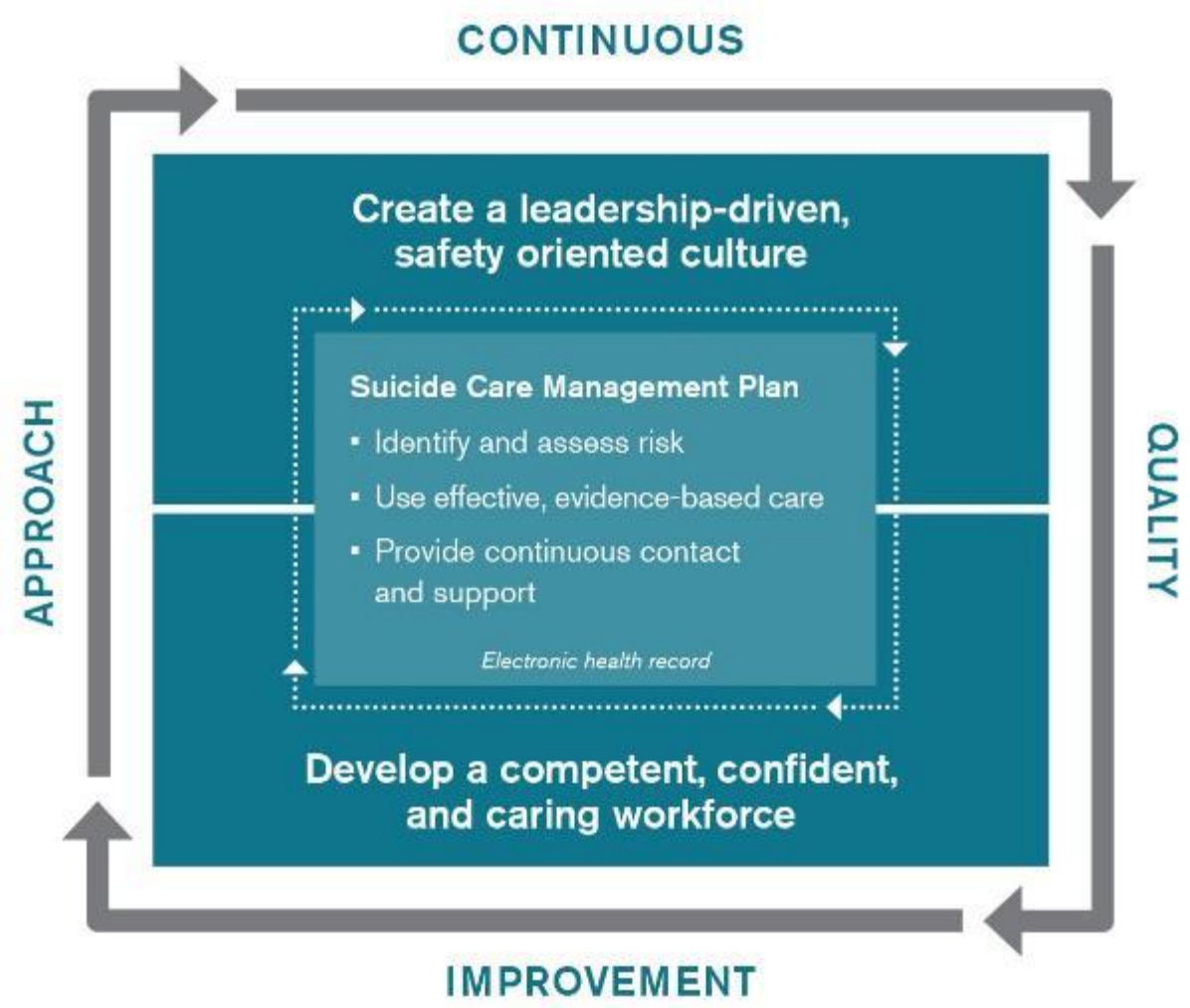
Zero Suicide is...

- Embedded in the *National Strategy for Suicide Prevention* and *Joint Commission Sentinel Event Alert #56*
- A framework for systematic, clinical suicide prevention in behavioral health and health care systems
- A set of best practices and tools including www.zerosuicide.com

Elements of Zero Suicide

A Continuous Process



Zero Suicide Website

Access at:
www.zerosuicide.com

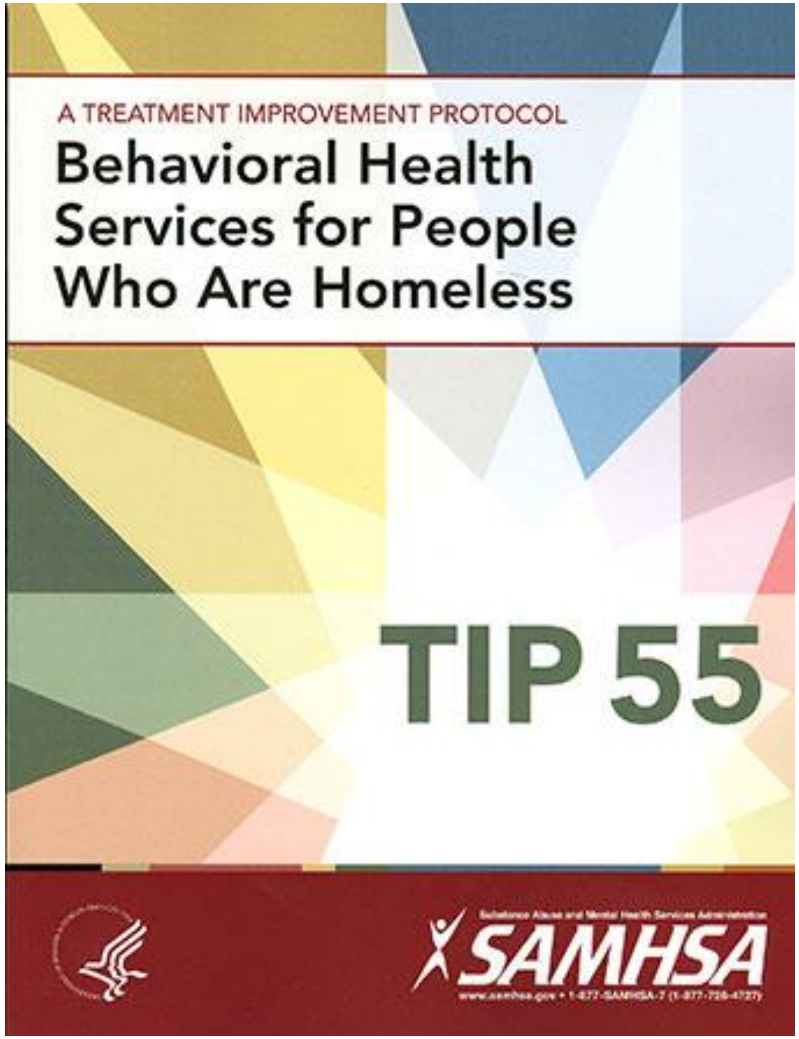
Caring for Homeless Patients at Risk for Suicide

- Rates of suicide deaths among homeless individuals are approximately nine times higher than the general population (Poon et al, 2017).
- For every 10,000 people in the United States, 17 of them were experiencing homelessness (U.S. Department of Housing and Urban Development, 2017a).
  - 49% met criteria for a severe mental illness and/or a chronic substance use disorder.

Caring for Homeless Patients at Risk for Suicide

- Healthcare Cost and Utilization Project (HCUP) data from 8 states:
  - About 17% of homeless patients who visited and left the emergency department received care related to suicide or intentional self-inflicted injury (Sun, Karaca, & Wong (AHRQ), 2014).

SAMHSA TIP 55



Learning Objectives

By the end of this webinar, participants will be able to:

1. Identify commonly experienced challenges in providing suicide care to homeless patients.
2. Describe unique suicide screening, risk assessment, and safety planning considerations for homeless patients.
3. Demonstrate how health and behavioral health organizations can establish partnerships with community organizations to improve suicide care practices for homeless patients.

Speakers

Virna Little

Center for Innovation in Mental Health at City University of New York

Jeff Sung

University of Washington Department of Psychiatry & Behavioral Sciences

Astrea Greig

Boston Healthcare for the Homeless

Matt Tice

Pathways to Housing Pennsylvania

Facilitator

Virna Little PsyD, LCSW-R, SAP

Associate Director of Strategic Planning

Center for Innovation in Mental Health at City University of New York

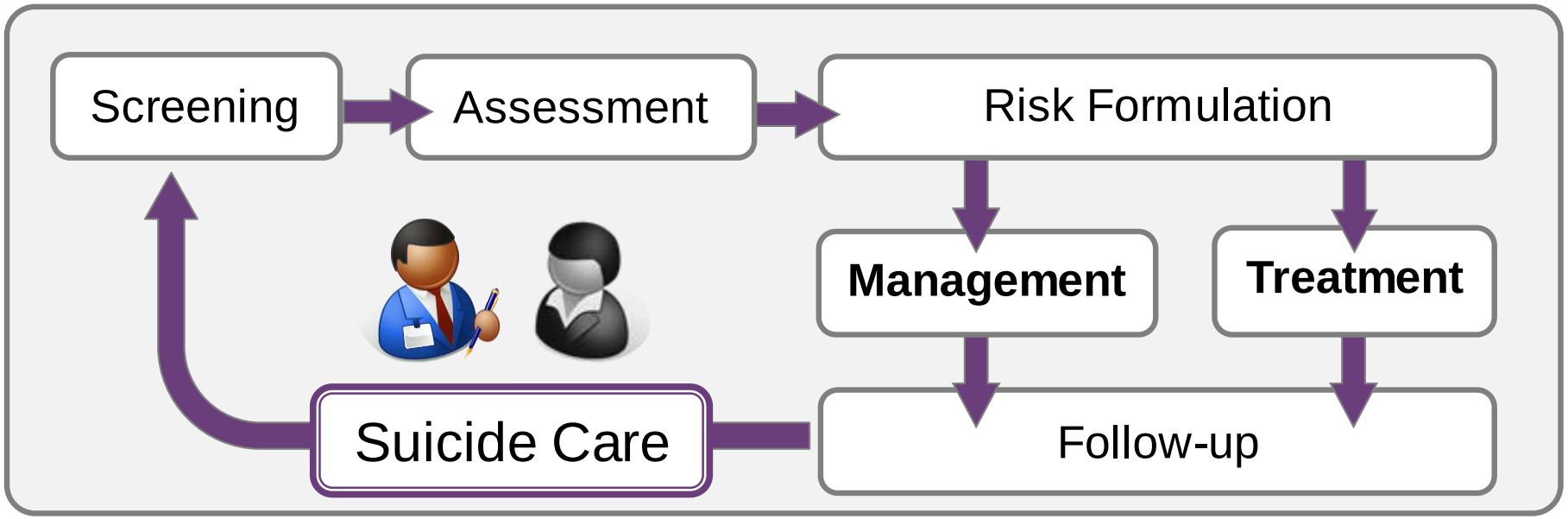
Presenter

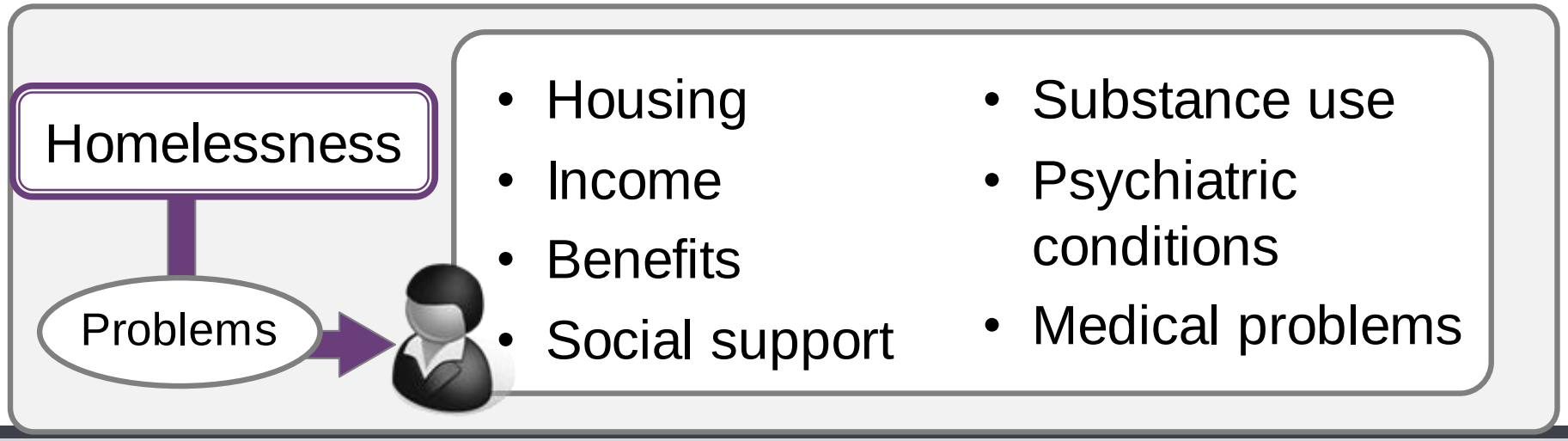
Jeff Sung, MD

Acting Instructor

University of Washington Dept. of Psychiatry and Behavioral Sciences

Suicide Care with Homeless Patients





Respondent and Operant Suicidality

- Thwarted belongingness
- Perceived burdensomeness
- Hopelessness
- Emotion dysregulation

Respondent: Suicidality controlled by preceding events; more typical of acute suicide risk.

Antecedent: Preceding event → **Behavior:** SI or behavior → **Consequence:** Internal or external

Operant: Suicidality controlled by consequences; chronic suicidality that might require **treatment** to facilitate self-management of suicide risk.

- Emotion regulation
- Problem solving
- Communication

Operant Suicidality in Homeless Patients

Homelessness

Problems

- Housing
- Income
- Benefits
- Social support
- Substance use
- Psychiatric conditions
- Medical problems

Alone with unbearable **emotional pain** and inability to solve **problems**

I'll kill myself if I have to go back to the street.

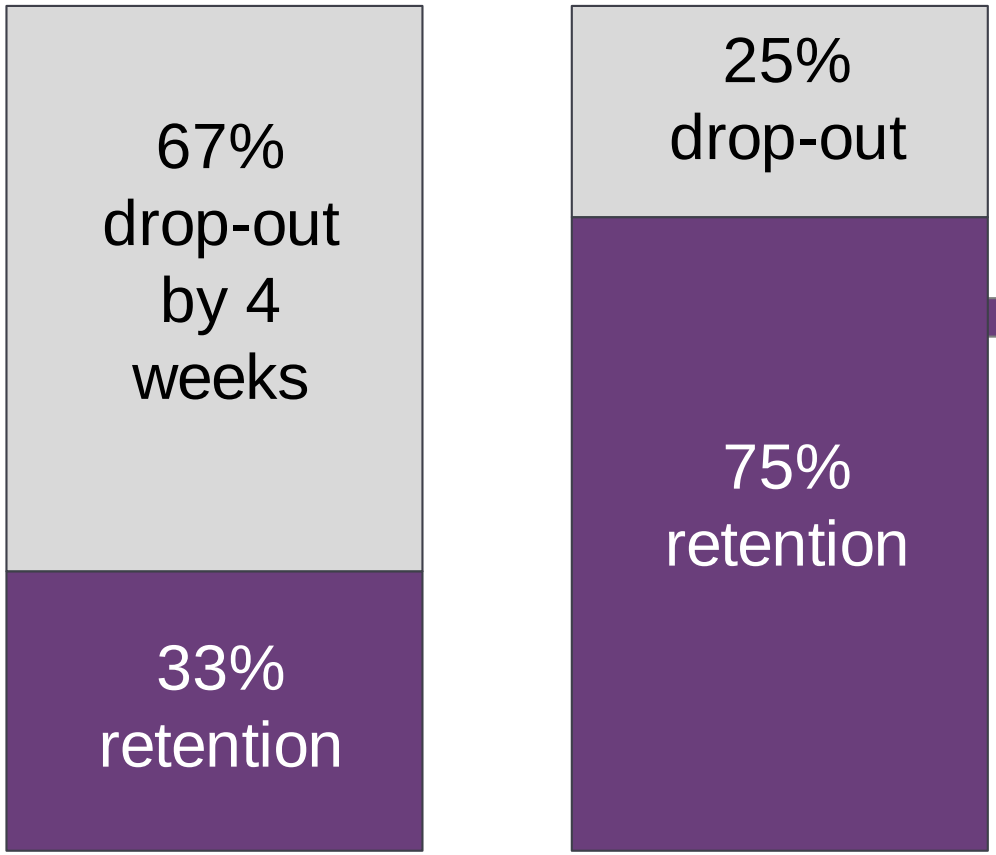
Emotion regulation
I'll always have an 'out.'

Problem-solving
I need a safe place to stay.

Communication
Finally, someone is listening.

Linehan, 1993

Case Management to Facilitate Treatment (CT-SP)



Pilot: No case management

Study: Case management

- Coordination with contacts and facilities
- Community voicemail
- Scheduled and unscheduled contact
- Birthday and holiday cards
- Reminder calls
- Subway tokens
- Outreach visits
- Flexible session times

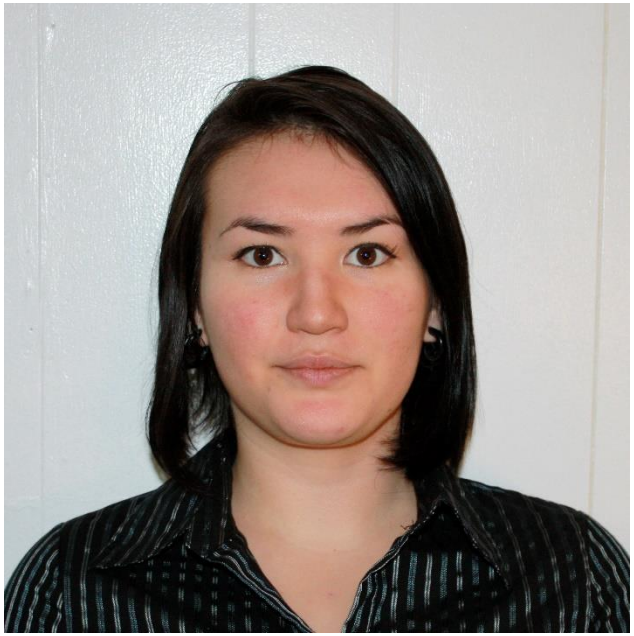
Berk, et al., 2004; Brown, et al., 2005; Gibbons, et al., 2010

Zero Suicide Reflections

Audience:

Using the chat box, please share one key takeaway from Dr. Sung's presentation.

Presenter



Astrea Greig, PsyD

Manager of Outreach Behavioral Health

Boston Healthcare for the Homeless

Getting Clients Engaged in Care

- Low barriers / easy access to care
- Satellite Clinics in shelters
- Outreach
  - Supported housing
  - Street team

- Bridge group
  - Bimonthly psychoeducation group
  - Meetings with psychiatry before scheduled appts
- Walk in / “open access” appointments

Homelessness & Suicide Risk Assessment

- Non-behavioral health staff involved in depression screening
- Behavioral health fairs
- Depression screening days
  - PHQ-9 screening
  - Incentives
- Suicide ideation versus secondary gain?
  - Increase engagement in services
  - Case management

Safety Monitoring

- Depression screening is an organizational goal
- Electronic medical record
  - PHQ-9 scores in clinician schedule
    - Clinicians see scores before each visit
    - Clients re-screened every 3 months

- PHQ-9 score performance monitored
  - Behavioral health team
  - Boston Healthcare for the Homeless Program overall

Safety Planning & Engaging Collaterals

- Collaboration with community partners
- Boston Emergency Services Team (BEST)
  - Safety alerts
- Homeless organizations / shelters
  - Outreach workers
- Department of Mental Health
  - Outreach case workers
  - Crisis hotline

Keeping Clients Engaged in Care

- Back to low barriers to care
- Depression regularly screened at non-behavioral health appointments
- Outreach services
- Incentives to engage in care (meal tickets, socks)
- Organizational push to monitor depression screens

Zero Suicide Reflections

Audience:

Using the chat box, please share one key takeaway from Dr. Greig's presentation.

Presenter

Matt Tice, LCSW

Clinical Services Director

Pathways to Housing Pennsylvania

Pathways to Housing PA

- Housing First Assertive Community Treatment (ACT) Teams provide permanent supportive independent apartments with no preconditions.
- Exclusively serve chronically homeless individuals with severe mental illness or severe addiction disorders.
- Home and community-based intensive case management and care coordination; harm reduction focused substance use counseling; behavioral health support; peer support; community integration.
- Integrated health care with nursing, medication management and psychiatry.
- Major focus for care transitions – Street to Home; Home to Street; Hospitalizations; Incarcerations; Substance Use Treatment (In and Out).

Suicide Screening and Prevention

- Screening with psychiatrists, nursing staff, and case managers.
  - If risk factors occur the team members notifies leadership and coordinates with the psychiatrist for an assessment.
- Regular risk assessment across multiple areas including personal risk.
- Safety planning completed with all participants regardless of current risk factors.
  - Living document: Safety plan is revisited regularly and adapted as needed.
- Follow-up both during and after all hospitalizations.

Community Partners

- Crisis Response Centers
- Street Outreach Workers
- Local Syringe Exchange
- Hospitals, Clinics, or Other Health Care Providers
- Drug and Alcohol Treatment Providers
- Landlords and Property Managers

- Establish Service Expectations
- Communications Protocols
- Response Capacity
- Key Team Staff
- Emergency Support

Case Study – Respondent Suicidal Behavior: Miguel

- Opioid Use Disorder, Obsessive Compulsive Disorder, Unspecified Depression Disorder
- Triggering Event: Death of grandfather
- Initial stated intent: Overdose on heroin
- Community Support: Street Outreach Worker, Case Manager → Crisis Response Center, Detox → Inpatient mental health stabilization
- Follow up plan post discharge: Adaptive harm reduction based support – Naloxone, Individualized Overdose Prevention Plan

Case Study – Operant Suicidal Behavior: Dolores

- Severe anxiety, frequent panic attacks, heavy alcohol use.
- Frequent presentation at emergency department with intent of obtaining Xanax or other support.
- Chronic suicidal ideation, "I feel like I'm going to die every day."
- Thorough support plan with her favored Emergency Department including 24/7 phone support from case management staff familiar with her case.

Zero Suicide Reflections

Audience:

Using the chat box, please share one key takeaway from Matt’s presentation.

Audience:

Type in the Q&A box:

What questions do you have for our presenters?

THANK YOU FOR JOINING US!

CONTACT US

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Zero Suicide: Improving Care for Homeless Patients at Risk for Suicide 1.30.18

Speakers: Julie Goldstein Grumet, Chelsea Pepi, Virna Little, Jeff Sung, Astrea Greig, Matt Tice

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>> JULIE GOLDSTEIN GRUMET: Thanks, Chelsea. And I really want to thank all of the staff who put this webinar together. They take a lot of work. And we have an incredible team that ensures that you hear from great speakers, but also hopefully that it's seamless for you.

So, today's webinar is called Improving Care for Homeless Patients at Risk for Suicide. This is part of our Zero Suicide suite of webinars. They are all archived and on our zerosuicide.com website. Hopefully they dive a little bit more into some of the details about doing the really incredibly hard work of integrating comprehensive suicide care in your health care system, and hopefully taps into a topic area that you've been really thinking about and gives us an opportunity to walk through and help you to improve.

Before we get started, this is just a reminder that the SPRC, the Suicide Prevention Resource Center, is funded by SAMHSA, Substance Abuse Mental Health Services Agency. And that the opinions and content shared here are our own and don't reflect those of SAMHSA or the Department of Health and Human Services.

That's me. I'm Julie Goldstein Grumet. I'm the Director of Health and Behavioral Health Care Initiatives at the federally funded Suicide Prevention Resource Center, and I also direct the Zero Suicide Institute. And thank you so much for joining us today.

The SPRC hopefully many of you are already familiar with. It's federally funded by SAMHSA and it's been funded since 2002, housed here at EDC. We provide the training and technical assistance for suicide prevention grantees and state suicide prevention coordinators. We provide support for health and behavioral health care organizations looking to improve suicide

care in their systems, the secretariat support for the National Action Alliance for Suicide Prevention. And on SPRC's website, SPRC.org, you will find a clearing house of resources regardless of the setting in which you work to really look at best practices in suicide care, articles, we have training. So, if you haven't taken a look at SPRC.org, I hope you will. If you're on Twitter, you can follow the Zero Suicide hashtag as well as our Zero Suicide Institute and SPRC Twitter accounts. We love to have lively conversations there as well.

So, to get started and give you a little bit of background about Zero Suicide, the revised 2012 National Strategy for Suicide Prevention includes Goals 8 and 9, and those are specific goals related to health care. Health care as a focus of suicide prevention was left out of the first National Strategy which really seems remarkable when you think about it. How could we not think about health care being an important place to reduce suicide in this country. Since then, what we've really thought about is that what's necessary to save lives is a better trained, better prepared clinical workforce and health care systems that believe suicide is a necessary and core responsibility of their work.

Zero Suicide as a framework focuses on error reduction and on patient safety through a robust comprehensive systemwide bundled approach to suicide care and health and behavioral health systems. We know that one intervention, one training alone won't work to improve suicide regardless of the setting. Zero Suicide thinks about a bundle of interventions that work when bundled in health care systems. Through continually applying new knowledge about suicide and conducting rigorous evaluation and quality improvement efforts, several systems, many systems who have already adopted this approach have seen reductions in suicide and suicide behaviors for their patients.

We've developed the tools and resources to help you to do this work. That's available at zerosuicide.com. There's a lot of information really about how to get started and how to do this work. However, there are gaps and challenges. I'm not suggesting at all that this work is easy. Today's webinar focuses on the challenges that many health care systems have encountered, and that is engaging and keeping homeless individuals in care.

These are the elements of Zero Suicide. As I mentioned, it's essential that these elements be seen as a bundle of evidence-based practices that when used consistently and with fidelity can reduce suicide.

Another way to think about this is how it's depicted here in this diagram, with the outer box really highlighting the pieces that need to be in place to have a Zero Suicide framework. That would include a leadership commitment to safety, accountability, transparency, somebody who is highly committed to suicide care as a core responsibility, and a workforce. Not just the clinical care team, though, of course. That's important as well. But the entire workforce for the system that is competent, confident, caring, and believes that suicide prevention is part of their job.

The inside box are the components of care that we'll call a Suicide Care Management Plan. Suicide care needs to be systematized and routinely delivered much like standard care management plans that are routinely delivered for those diagnosed with diabetes or heart disease. You get check-ups for those illnesses at every appointment, standardized blood tests. Well, suicide care and the elements of care are things like screening for suicide and safety plans should be embedded in the electronic medical records where errors don't occur and compliance with these protocols can be reviewed.

Data must be gathered and frequently reviewed to determine where changes can be made to policies or management or training, also to see how you're doing. Continuous quality improvement should be a priority. You must know what your data looks like now as you begin your initiative so that you know where to focus your efforts and know how you're doing in these efforts. Zero Suicide is embedded in a just culture. This is the concept that no blame is delivered when suicides do occur. It is the entire system's responsibility, so it's impossible to blame one individual. These back-ups, these fail-safes, checking in when patients don't make it to appointments, having elements embedded in the electronic health record when present really do back up therapists so that it is a systemwide responsibility. And when adverse events do happen, then we have to learn from those events, update the training, or modify protocols to do our best to avoid the next suicide.

Zero Suicide is an ambitious goal. Because I'm often asked, I'm putting it out front. Some people may not like the name Zero Suicide. I've certainly heard that many times before. But, really, what other number would be acceptable? We call many other initiatives zero, Zero Prostate, Zero Accidents. So, what other number is acceptable? Zero Suicide is not a public marketing campaign, but it should be an aspirational goal for

the health care system to get to zero, believing that suicide can be preventable and certainly reduced. This is the Zero Suicide website. It includes resources for getting started and how to implement a program in your health care agency. Zerosuicide.com.

Today we're talking about best practices for improving care for homeless patients at risk for suicide. We know that homeless individuals have higher rates of suicide and mental illness. We can see that for every 10,000 people in the United States, 17 of them were experiencing homelessness, and 49% met criteria for a severe mental illness. We do know that this is a patient population who many of you will encounter. We know that homeless patients are coming to emergency departments and other health care settings. About 17% of homeless patients coming to the emergency department have care related to suicide or self-injury. So, the workforce must be prepared and confident to work with this vulnerable population. We will hear from our speakers today about how health care staff can engage with and help homeless patients utilize the services they have to offer.

One resource you may not be familiar with is the SAMHSA Treatment Improvement Protocol. It's called the TIP 55. This is a manual that offers skills and resources to service providers working with people who are experiencing homelessness or are at risk of homelessness. It outlines the types of homelessness and stages of recovering, including substance abuse screening and supportive treatment. You can find that on SPRC's website if you search TIP 55 on SPRC.org.

So, by the end of this webinar, we certainly hope that you'll be able to identify commonly experienced challenges in providing suicide care to homeless patients. We hope that you will learn more about unique suicide screening or risk assessment, safety planning considerations for homeless patients, and we also hope that you'll be able to demonstrate how health and behavioral health organizations can establish partnerships with community organizations in really innovative ways, maybe ways that you haven't yet tried to improve suicide care practices.

We have an incredible lineup of speakers. We're so privileged that they were able to do this today. We have Virna Little, Jeff Sung, Astrea Greig, and Matt Tice. I'm really looking forward to their presentations today.

So, without further ado, I'm going to turn to my colleague, Dr. Virna Little. Virna is one of our Zero Suicide faculty. She

is an early adopter of the Zero Suicide approach and has really – many of you may have already met her because she's really innovative in her suicide care as well as many other things. Her talents are enormous. She's the Associate Director of Strategic Planning at the Center for Innovation and Mental Health at the City University of New York. Previously, Virna served as the Senior Vice President of Psychosocial Services and Community Affairs at the Institute for Family Health in New York. She is a nationally recognized speaker and advocate for integrating primary care in behavioral health services, collaborative care, the development of viable behavioral health services in community health settings, and behavioral health workforce development.

Virna is going to facilitate our discussion today and share her experience as someone who has been implementing the Zero Suicide framework in a health care system. But, also, to begin to think more about working directly with homeless individuals, some of these tips and skills might be helpful to you. Virna, thank you so much for joining us today. I'm going to turn it over to you.

>> VIRNA LITTLE: Great. Thank you, Julie. And thank you so much for that wonderful introduction. I encourage everyone to visit the website, the Zero Suicide website. It has a huge amount of information and trainings and can really serve as a resource and a guide for the work that you're doing. So, thank you, Julie, for such a great overview. And, again, I really encourage people to follow up and to visit the website.

And I would like to start us off today with our first presenter, Dr. Sung, who is the Acting Instructor at the University of Washington Department of Psychiatry and Behavioral Health Services. So, Dr. Sung, I would like to turn it over to you.

>> JEFF SUNG: Right. Thank you so much, Dr. Little. So, I was hoping to provide just a general overview of what we mean when we're talking about suicide care with homeless patients.

So, this slide that you can see, on the top, this is an overview of what I mean when I'm saying suicide care. So, the different interventions are screening, assessment, risk formulation, management, treatment, and follow-up. And I want to make sure I make this distinction between management-based interventions and treatment-based interventions. So, I'm going to define our management-based interventions as short-term or

intermediate-term interventions that are designed to mitigate risk. They don't necessarily resolve suicide risk. So, this would be our interventions like fostering connectedness, treating depression, and other mental health conditions like substance use, reducing access to lethal means, and making a safety plan. So, connectedness, depression treatment, means restriction, safety planning can keep people alive but don't necessarily resolve people's suicide risk.

Then in contrast I'll talk about treatment interventions. These are intermediate or longer-term interventions where people will learn how to recognize the emotional/psychological factors that cause them to become suicidal and then they'll learn how to self-manage those over time. Suicide care, these interventions that we're using in our clinical systems.

Suicide care with homeless patients. Below, people who are homeless have these high level psychosocial problems. You can see my list here: housing, income, benefits, social support, substance use, psychiatric conditions, and medical problems. We're talking about trying to implement clinical interventions designed to address suicide risk in a population that has high levels of psychosocial problems.

This next slide – I want to give some case conceptualization about the different kinds of suicidality we might encounter when working with people who are homeless or actually anyone. This sort of comes out of having trained thousands now of mental health clinicians. Some of you know that in Washington State we have mandated training for health care professionals. Whenever a clinician hears that I work with homeless people, almost always the first question is what do you do when someone is hospitalized and they say, if you discharge me, I'll kill myself. Or if you're in the emergency department and someone says, unless you admit me, I'll kill myself. I wouldn't say that this is necessarily the most abundant problem. What I will say is that it gets a lot of emotional attention and it has a lot of emotional dalliance around it.

This is some case conceptualization just to think about that sort of suicidality. If you just look at the sequence in the center, the antecedent behavior consequence, this is straight up learning theory, behavior therapy. The perfect reference for this is Marsha Linehan's 1993 textbook on DBT. So, the antecedents, things that come before, prompting events or triggers, and then in the middle the behavior that we're interested in is suicidal ideation or suicidal behavior, and

then the consequence can be internal or external. An internal consequence, like maybe someone's emotion changes, or an external consequence, maybe the environment mobilizes to change something. So, on top, suicidality, I'll call it respondent if it's being controlled by the preceding events, so the antecedents. And, so, in that box on the top left, we have these aversive cognitive and emotional experiences, so like we'll say Joiner's theory of thwarted belongingness, perceived burdensomeness, hopelessness, or Marsha Linehan's theory of emotion dysregulation. So, aversive experiences which then prompt people to have suicidal ideation or behavior.

Another sort of suicidality that we might encounter at the bottom, suicidality can also be operant. This is suicide ideation or behavior that's being controlled by consequences. Once suicide becomes sort of an enduring style of responding and coping with stress, we'll call it chronic suicidality. Chronic suicidality tends to require a treatment intervention, so in contrast to management interventions. And, so, the kinds of consequences at the bottom right, we'll see that sometimes I will say that suicidality is functioning as emotion regulation, problem solving, or communication. I live in Seattle. Kate Comtois was my supervisor for DBT. So, the words manipulation and secondary gain have basically been completely trained out of me. I tend to use this kind of long-hand terminology, that is suicide ideation, a behavior that is functioning to reduce emotions. People experience a decrease in guilt, shame, anger, fear. Problem-solving, the environment mobilizes around them to improve their circumstances. And communication, that people are listening and taking someone seriously. Again, once suicidality becomes operant or chronic, it tends to require a treatment-based intervention. Management tends to be insufficient.

Now this slide, operant suicidality in homeless patients gives kind of a case conceptualization of how might operant suicidality look when you're working with people who are homeless and at risk of suicide. Again, at the top, we have people who are homeless, who have high level psychosocial needs, instability in all of these areas, and then that person might feel alone with unbearable emotional pain and an inability to solve these problems in any expedited manner. And then out of that experience, we might hear things like I'll kill myself if I have to go back to the street.

And, so, if we unpack that suicidal ideation or that statement around suicide, on the right we might see that it is functioning according to emotion regulation, problem-solving,

and communication. So, the emotion regulation, I'll always have an out, so then fear goes down. Problem-solving, if you say that you're thinking about suicide, sometimes the environment mobilizes to improve your housing status. And then communication, if you say that you are thinking of suicide, sometimes people will take you more seriously. The case conceptualization hopefully implies solutions. Are there alternative ways to regulate emotions, solve problems, or communicate distress? Those would be treatment interventions to help people learn that that's how suicidality is functioning in their lives and then what can they do to implement alternative styles of coping.

This is last slide that I have. Sometimes the problem then or the challenge of working with homeless patients who are at risk of suicide is that we're engaged in management-based interventions in in-patients or emergency-based settings. What is needed to resolve suicide risk are treatment-based interventions in out-patient or ambulatory care settings. And, so, this slide is just sort of an example of what's it going to take so that someone who is at risk of suicide can be successful in a treatment intervention in an outpatient ambulatory care setting. This is some information that is taken from the study that Greg Brown and colleagues did, their cognitive therapy for suicide prevention that was published in JAMA in 2005. Cognitive therapy for suicide prevention is effective for reducing the risk of repeat suicide attempts in this population who had been at high risk of suicide.

What we see on the left, in their pilot study without any case management services, their retention rates after four weeks was about 33%. About two-thirds of people were not able to be retained in their treatment intervention without case management. Then in their actual study, they implemented a case management services for all of the study population and you see that it dramatically improved their retention. This was not a subtle case management intervention either. On the right, you can see all of the different components of it: coordinating with other friends, family, contacts, and other facilities, everyone in the study had access to a voicemail that they set up, there were scheduled and unscheduled contacts with the subject, they sent them birthday and holiday cards, reminder calls, subway tokens, outreach visits, flexible session times so that people could be seen even if that's not exactly when their appointment was scheduled. I emailed Greg Brown about this and he said that actually there weren't that many homeless people in their study. Even then, they required these high-level case management

interventions to retain people in treatment. How much more are we going to need case management interventions if people actually are homeless?

I will just summarize then and say we're talking about trying to implement suicide care, so the screening, assessments, risk formulation, management, treatment, follow-up in a group of people who have high-level psychosocial problems, and number two, we have case conceptualization around distinguishing respondent versus operant suicidality. And then trying to make a distinction between management-based interventions and treatment-based interventions. And then finally, trying to think about what is it going to take to implement treatment-based interventions to resolve suicide risk so that we are not sort of just managing suicide risk over time, keeping people alive, but frankly miserable in their circumstances.

With that, I will turn it back to Dr. Little.

>> VIRNA LITTLE: Thank you so much. That was a wonderful overview. And thank you for sharing the work that you are doing. I was wondering, going back to your first slide you talked about screening, and I know working with a lot of organizations around the country, screening is often someplace in the workflow where they really struggle. And I know we've been doing a lot of talking about sharing or doing what they're calling task shifting which is really involving everyone in the center to do screening or to do safety planning. I'm just wondering if you might take a minute and just talk a little bit about screening and any lessons learned and information that might be helpful to folks on the phone.

>> JEFF SUNG: Right. I think it sort of depends on what the paradigm is for suicide care. I think the paradigm around screening, assessments, and then management and treatment, and this idea of the high-risk approach to suicide prevention, regrettably, the finding is that the majority of people who die by suicide have sort of screened negative for suicidal ideation. I would say that screening can be useful for identifying the highest risk population. If we know that people who are homeless are at higher risk of suicide and that half of them have mental health or substance use conditions, we know that this entire population is at risk. I guess I focus a little bit less on screening because we already know that everyone is at elevated risk of suicide. And if we know that that's the case, an alternative paradigm might be to implement some of these suicide

risk management strategies in a more universal fashion than to rely on screening for high risk populations.

>> VIRNA LITTLE: Okay. And I know that many of the sites probably use the PHQ since they're connected to health care organizations. So, certainly, using that and sort of working and maybe adopting some of the points from your workflow. So, thank you. And I love the information you gave with some suggestions about where to maybe put letters or birthday cards. And I know that a lot of organizations have taken the caring letters. When you think about the homeless population, it's often a struggle to figure out how to get caring letters out to people or to reach. I spoke to an organization recently that put the caring letters in some of the hygiene kit bags that they were giving out to people and had a workflow around that. I think that was an interesting thing that they had adopted.

>> JEFF SUNG: That's a great idea.

>> VIRNA LITTLE: Again, thank you so much for your presentation. That was some really good information. I encourage people to put questions in the box and we can answer them at the end.

So, I want to move on to our next presenter, Dr. Grieg, who is the manager of Outreach Behavioral Health in Boston Healthcare for the Homeless. I will turn it over to you.

>> ASTREA GREIG: Thanks very much, Dr. Little. I'm going to speak now about particular suicide prevention efforts here at Healthcare for the Homeless or Boston Healthcare for the Homeless Program.

And jus to give a little brief background on Boston Healthcare for the Homeless Program, we basically function as a large community health center, so we have not just primary care but also behavioral health, we have oral health, dental, case management. As I'll talk, you'll learn that we actually have a large outreach kind of service that we provide. We've actually been kind of working now for 30 or so years. Kind of the most important takeaway is that we serve only, actually, in the Boston area persons, clients who are experiencing homelessness or who are unstably housed.

So, to get started, at the foremost, we want to have low barriers to care, have really easy access for clients to access care. And the reason for that is that the literature really

shows that persons experiencing homelessness do not access health care as often as persons who are not homeless. That's really well known and has been seen in many different areas. We really want to provide that, especially ourselves given that all we see are persons experiencing homelessness. So, as I mentioned, we have a lot of outreach services because of that. We want to really bring the treatments or bring the services to our clients because it's hard for them to access it.

We have satellite clinics, actually, in shelters all across the city, and we also have a lot of outreach teams. A lot of our staff will do home visits to lots of supported housing across the city. I actually do some of that myself. We also have like a street team where a group of staff, so primary care providers, psychiatry, case management, will actually walk around the streets of Boston providing care to persons experiencing homelessness where they are at on the street. We also have a large medical respite unit where a person, maybe they've been discharged from nearby hospitals and emergency departments, will kind of get a step-down level of care in our main facility. We actually kind of spread out our services all throughout the city.

And, so, as an example of really providing a low barrier to accessing care, we have started recently actually a bridge group. Specifically, what that is is that it's a bimonthly group, a lot of psychoeducation is provided by a therapist that we have. And because it's so hard to access therapy and also psychiatry or behavioral health prescribers, people will then be taken out of that group kind of just for a brief meeting and will actually meet with a psychiatry prescriber or psychiatrist before they even meet someone. This is like without an appointment. They'll just be kind of taken out from that group, meet with a prescriber, and then they'll rejoin the group and they'll get to perhaps start a medication or get a refill of a medication that they're already on that they've gotten somewhere else. This is one way that we've been able to really have a low barrier to our folks receiving care.

Aside from that and aside from the outreach, we have walk-in appointments all throughout our clinics. We have clinics inside each shelter, as I've said, and also inside different hospitals across the city. In those respective clinics, all of these clinics have walk-in or open access behavioral health appointments. We really hope to have people really easily access our care.

Moving forward and now speaking more about suicide prevention, we really have made that a focal point of our work as an organization. Because, as Dr. Sung had mentioned, homeless clients are at higher risk of experiencing suicidal ideation, we want everyone, everybody involved in depression screening which then would kind of tackle the suicide screening. And, so, as Dr. Little mentioned, we do use the PHQ-9, or the 2 and the 9. That is done by not just behavioral health staff but also by, again, primary care and dental. We'll also have really neat behavioral health fairs or just regular health fairs and depression screening days. We try to use a lot of incentives. This is something that if someone doesn't have basic needs, they have lots of need for toiletries and clothing, we want to give that to people. These act actually as prizes for visiting every table at the behavioral health fair. So, not only do they get incentives, but they also learn about depression and suicide and how to get help in our system or other systems nearby. We try to make it kind of as easy and friendly as possible.

Dr. Sung had actually mentioned a really wonderful concern that we have when treating or providing services to persons experiencing homelessness, is someone suicidal and wants to end their life or is there – for lack of a better word – a secondary gain? And you actually agree that the secondary gain is kind of a harsh way to say it because persons experiencing homelessness really truly are struggling and have so much stress and their basic needs are not met. And to take a more client-centered approach, more patient-centered approach, however you want to say it, it's not really that they're trying to kind of manipulate us or try to get something out of us. They're really trying to make their ends meet. They're really trying to get help in whatever way that they can. Given their limited resources, they don't really have many ways to get help. A lot of folks will present to our clinic saying that they feel suicidal, rightfully so because they're inundated with all their stressors, but is it because of their stressors or do they really truly want to end their lives. In a nutshell, it's really hard to give a blanket answer to that, but we always want to increase engagement and services, particularly case management, but also behavioral health for all of our folks because of this difficult kind of dyad that can happen.

So, moving forward. As an organization, and Dr. Little is talking about monitoring as an organization, we've really pushed to make depression screening an organizational goal and we make it part of the electronic medical record. And, so, behavioral health clinicians will see our patients' or clients' PHQ-9

scores before each visit and are screened every three months. The behavioral health team, their performance in updating the PHQ-9 scores of their clients is monitored. This is another way as an organization that we make sure that every client of ours is being screened, is being addressed. Earlier Dr. Goldstein Grumet was mentioning how we really want to make this part of the organization just as you would with diabetes, that they're screening at certain levels, and then there's rescreening, and there's a big push from the organization. We want to definitely do the same for depression and suicide, especially for our homeless clients. In addition, there are safety plans that, if applicable, will be in our electronic medical record. And if suicide is present in the PHQ-9, then clinicians, especially our behavioral health clinicians, are prompted to further assess with kind of pre-set questions that they can use or not to help them further get their clients to safety.

And, so, another way that we really make sure that our folks are screened and our patients or our clients are well is that we really collaborate with outside collaterals and organizations in the community. We're actually pretty fortunate to have a lot of organizations that really work really well with us. One in particular in the city of Boston is really quite cool. We have something called the Boston Emergency Services Team. This is a team of clinicians that will go wherever the client is, assess them, and then if they need a higher level of care, will take them to an emergency department or in-patient unit or crisis stabilization unit or whatever is applicable to the client's needs. That's something that we'll use often.

If someone calls me and they're across town and they're expressing suicidal thoughts, I'll use the BEST team to help me keep that person safe. This is another way that outreach, bringing care to the person, is really effective in this population. Also, as I mentioned, we collaborate with so many shelters across the city. We'll have in these shelters outreach workers that work for the shelters, not necessarily for us, but often will work closely with us and we'll talk to them and we'll say, hey, so-and-so that I met with recently, he seemed like he was doing pretty not so great and I'm afraid that he might be having some suicidal thoughts. Would you mind keeping an extra eye on him when you see him pass through the shelter? Or would you mind sending out one of your outreach workers to go find him? He often hangs out in this neighborhood and just give him a wellness check. That's another resource that we'll often use.

And, also, for the Department of Mental Health in Massachusetts, and every state has a similar department, we have outreach case workers, and actually outreach case workers at the Department of Mental Health that focus specifically on the homeless population in Massachusetts. We'll work with them. As well, they have a crisis hotline that we often use. We're really fortunate to be able to use all these community services to help us give better care and to help us bring the care to our clients.

So, moving forward, just as a way to keep clients engaged in care is really just to summarize all I've said. It's to really go back to how we need to have low barriers to care, to screen depression regularly, and even to do so at non-behavioral health appointments, to have a lot of outreach services, and to collaborate with community partners, to provide incentives to engage in care, and to really have organizational buy-in and organizational push to be monitoring depression and to make depression at the forefront as a goal of the organization.

As an ending point, I would like to actually share a case example of how the service system can be utilized. So, a client that I want to talk about, he is a 50-year-old white male. He has been homeless now for actually over 20 years. However, he stays at a shelter. However, he is frequently in conflict with the staff there, and so he often gets kicked out. Unfortunately, he sleeps on the street. Even though he can stay at different other shelters, he likes this one shelter but gets kicked out often. He has no significant employment history aside from multiple short-term labor-like jobs or kind of restaurant industry. He has a diagnosis of schizoaffective disorder. He's actually been sober from alcohol now for almost three years. It'll be three years next month, actually.

And, of course, he really wants housing. But this is difficult for him because he has a sex offender status. He has a level three sex offence status due to his history of exhibitionism and multiple counts of that. And, so, you can imagine he is wanting housing, he can't get housing. A lot of supportive housing – and you'll learn more about supportive housing from Matt next – but a lot of the supportive housing organizations in the city of Boston and the state of Massachusetts don't actually accept people with a sex offender status. And, so, of course, you can imagine that he feels very hopeless and kind of at a loss of what to do. Of course, it could be understandable that someone in his situation starts to experience suicidal ideation.

He'll come up to a behavioral health clinician, myself, and he'll really express this. Here again is the question, does he really want to end his life or is he more hopeless regarding his housing status and his difficulty rather getting housing and his inability no matter where he's turned in the past many years to get housing? The intervention here is referral to case management to find other ways to get housing, that we haven't really exhausted all housing options, and that there is likely more that he hasn't kind of applied to yet, but, also, as a behavioral health clinician, using our behavioral health skills to engage in problem-solving and explore how we can get housing despite your sex offence status. All the meanwhile using this flexible system where we bring care to the clients.

He was banned actually from the hospital clinic that I saw him in due to his aggression, and so I actually now see him across town in another clinic as a way to give flexible client-centered care to meet him where he is at and get his needs better met. I also collaborate with the BEST team and I've had a lot of BEST alerts out for him where they've helped me to monitor him when he's on the street. And I collaborate with the shelter that he stays at some of the time when he's not kicked out and I talk there with the staff and know them very well. They also keep an eye on him for me and help him to go back to accessing the case manager when he expresses these complaints. This is a whole kind of system in the city. It's like that saying, it takes a village. It really has taken a village to help this gentleman. Nowadays, he's actually just recently splitting an apartment with a friend. He's paying rent to this friend, and he's applying for jobs. It's really nice how we've been able to get him through this rough moment in his life.

That's the end of that presentation. I will now turn it back to Dr. Little. Thank you.

>> VIRNA LITTLE: Thank you so much. That was a wonderful job. Thank you very much for that case presentation. I think you did a wonderful job of really talking about how complicated some of the patients are that we care for and how you really need to go back and be very patient-centered. That was a very creative approach. Thank you so much for sharing. I want to go back to something – to two things, actually, that you said. You talked a couple times about it taking a village. I think we hear that over and over again. Certainly, one of the core components of Zero Suicide is training and really training everyone on the team to be able to care for people at risk. I'm wondering if you

could just take a second to sort of elaborate on the kind of training you might have done for staff.

>> ASTREA GREIG: Oh, that's a great question. We didn't really have ever formal training. I think what happens when working with this type of client population, we'll learn as we go. We do have regular team or staff meetings where we do talk about all these resources and whether or not we're using them. We'll often invite them. We've invited the BEST team and we've invited all these organizations that we collaborate with in the community to our team meetings and talk with them and learn from them and learn about their services and learn how we can better use them. They in turn will learn how they can better use us. So, yeah, I guess there's been kind of informal training in that way, but it's also a nice way to kind of meet and see the people that we're working with and form a relationship given that we do use this village mentality, we do use this community mentality so much. Yeah, I would really emphasize getting to know these partners that you work with.

>> VIRNA LITTLE: Okay. You also mentioned open access. I think that's something that organizations often struggle with. I know many times particularly centers that care for homeless populations are often part time or not there all the time and it's always a struggle to make sure there's some sort of open access for patients when they are there and the ability to care for them when the team might be at another center. I know that's something really important to think about, especially if we want patients to come in, to feel welcome, to not use the emergency room, and to try to provide some continuity. So, certainly, to think about that as you go forward. I think there are some creative ways to be able to do that and to think about involving everyone on your team to make sure that that happens and to be a part of the entire process.

I noticed that you also referenced the PHQ. I wanted to put out there that what some sites are doing is the PHQ-3, which is that they're asking the first two questions and then asking the question about suicide directly. I just wanted to put that out there as an option for organizations to know that there are some folks doing that and it might be a practice that might work in your organization. So, thank you for a wonderful presentation.

I would like to ask folks in the audience to remember to use the chat box and maybe think about a takeaway from the presentations, either of the two presentations, so that we can

share them and we can also try to identify some best practices. We'll give folks a minute to do that.

>> JULIE GOLDSTEIN GRUMET: Thanks, Virna. I've seen sort of conversations people have been typing in even while some of the presenters were speaking. Clearly, there are a lot of great questions coming up. We'll definitely have more time for Q&A at the end. But we certainly want you to think a little bit about both Dr. Sung and Dr. Greig's presentations so far. What are your key takeaways?

I find myself thinking training of the staff to think differently about homeless patients so that they understand. You know, Dr. Sung talked a lot about the motivation behind the thoughts of suicide. What might be motivating patients. I can imagine in some health care systems sometimes people, the staff begin to forget that when the work gets really challenging. And I loved Dr. Grieg's presentation about meeting the patient where they are. I think Zero Suicide is all about being patient-centered. You have to educate patients, tell them what to expect, tell them what's coming. And their families as well. I loved both of these.

I see some people typing in now. I see somebody from Anchorage said they put health clinics in homeless shelters. I think that's innovative and great. And that's absolutely patient-centered. You can't expect people are going to come to you. You have to meet your patients where they are to give them the best care possible.

The discussion of secondary gain and respondent versus operant behavior sounds like it was also a key takeaway and learning about what motivates people's thoughts of suicide. Thinking about training others to do the PHQ in a more structured way, of doing this in a routine way. And Kim's – I think that's great. Again, that's really what the Zero Suicide framework is about is where are the gaps in the system if you haven't trained individuals. People that you might be able to think about collaborating with doing this work. It doesn't all have to fall on the back of one individual. Somebody else said she likes the option of the PHQ-3 instead of the 9 because it gets right to the point and then you're going to have to do an assessment anyway. And there are a lot of health care systems doing that. Virna, I don't know if you want to speak to that. But I know where you've been, you've talked a lot about the PHQ-2, or 3, or 9. Do you want to take a quick second and speak to that?

>> VIRNA LITTLE: Sure. And I think what a lot of organizations are finding – and to go back to some of what our first speaker was talking about – is that organizations are finding it very helpful, particularly for the homeless population, to ask directly about suicide. And that many times many of the patients might screen negative for the first two questions, but when asked directly about suicide. And then work with organizations to put a process in place, the Columbia Scale or some other assessment tool, and really be able to have conversations with people while they are there. I think that's the really important piece is to really have the systems in place to care for people who you identify are at risk. It's so important when we talk a lot about engaging patients. I think that's one thing that we found over time.

I saw some questions in there about engaging people. And, really, to be able to have conversations with people to do safety planning, to provide a safe place where they're able to come and get support was really key in engaging patients. I think in this population and these settings, you have to have very different conversations about lethal means because you might not be there every day or they might be in another part of the city on another day and maybe not able to come back for medications. Sometimes we had patients who were restricted to certain pharmacies, and many times they were pharmacies that wouldn't be as willing to work around lethal means. Really having a relationship with that pharmacy or some of the other service providers to be able to work with you to engage patients around those pieces, and also to train them and talk to them about the PHQ so that they understood what it was, that if they saw patients, they might be able to give the PHQ-9 as well and provide that information back. We often did that with community-based organizations where they would actually be a part of the treatment team. That was really helpful for patients and for our staff.

>> JULIE GOLDSTEIN GRUMET: And, Virna, I think I've heard you say this, that clearly when you screen somebody, but before they leave that day, if they screen positive for suicide, they should have a safety plan that includes counseling on access to lethal means and discussion of reducing their access to lethal means because, as you said, you're not sure if or when you'll see them again. Before the patient leaves that day, a clear plan for their safety for reducing that access has to be discussed.

>> VIRNA LITTLE: Absolutely. One of the things that I know we did in my prior organization and I know other organizations have done is, particularly for this population, you know, many times we send patients out with safety plans on letterhead paper or after visit summaries that are printed out and that's often not as helpful or convenient for patients who are homeless. We were able to do small fold-up cards which were safety plans that people could carry a little bit easier and tuck somewhere that might be a little bit both easier to find and not to lose. And, so, maybe trying to think about some creative ways for the safety plan where they might be able to access it a little bit easier is helpful.

>> JULIE GOLDSTEIN GRUMET: And a few things, you know, I know Amy made the comment that the PHQ-3 could be helpful in medical systems, and that she's going to check with their dental providers whether they do the PHQ or not. And I'm not sure if you meant PHQ-3 versus 9, but what I love is it sounds like this presentation is stimulating your thinking more about who you might collaborate with, that it really is a systemwide approach to caring for patients at risk for suicide, and that hopefully some of your kind of more non-traditional partners might become more front and center in your collaboration to keep people safe.

So, I see a few other questions. We're going to postpone those to the Q&A that we'll have at the end of the discussion. I'm going to turn – Virna's going to introduce Matt next. And after Matt speaks, we'll certainly have a chance to engage in a lot more question and answer. Than you all. I love the vibrant conversation and thoughtful ideas.

>> VIRNA LITTLE: Thank you so much. And thank you, everyone, for all your questions. And thank you, Julie, for thoughtful discussion.

I would like to move us on now to Matt Tice who is the Clinical Services Director in the Pathways to Housing in Pennsylvania. So, Matt, I'm going to turn it over to you. Thank you.

>> MATT TICE: Great. Thank you so much. So, we at Pathways to Housing work off of a Housing First model. That means that we will engage individuals who are chronically homeless, who have been on the street for at least a year or longer, but sometimes much, much longer than that, with severe mental illness or severe addiction disorders, and offer them an apartment with no other preconditions. Really the only thing that they need to do

to work with us and to get an apartment is to agree to work with us, to work with our case management teams, to work with the rest of the supports. We do come at it from Assertive Community Treatment's perspective. That means that we have a multidisciplinary team that includes case managers, social workers, nurses, substance abuse specialists, all of these – peers, a variety of other individuals that are all able to support and have a shared caseload, communicating with one another on a very regular basis.

Just a quick note, too, on one of the things that Dr. Grieg had mentioned earlier. We actually can work with folks who have sex offender status. It does require a little bit of things that we need to make arrangements for. But we'll do whatever it takes to get a person into housing. Once we do get them in, we are then able to provide them with home or community-based intensive case management and care coordination. We do a lot of work with harm reduction, substance use counseling. Harm reduction really in a variety of other ways, too. We can then do behavioral health support, utilize our peer support specialists, and do other ways to integrate these individuals back into the community as they are transitioning out of homelessness.

We feature a satellite site of a federally qualified health center. As a result, we are able to then integrate health care into everything that we do. Our providers are actually going out to the home. They'll go out to the street and see folks. That is across the board, nurses, doctors, psychiatrists, and just anything that we do depending on the needs of that individual. We're looking a lot at the different care transitions. We know that there is definitely risk for folks when they are moving from the street, or potentially if there are problems in a home and they might be facing eviction, so then there are times when somebody may transition from home back to the street. And then, of course, we're going to be trying to re-engage them and help them get back into the department. But we also are looking out for times when someone might be going into a hospital or facing incarceration. We do deal a lot with folks who are dually diagnosed and dealing with substance use. Treatment coming both in and out and making sure that we have as much support as possible for each of those individuals.

When it comes to screening and assessment for us, some of the primary work happens with our psychiatrists and nursing staff, but our case managers are incredibly important. The psychiatrists and nursing staff are seeing all of our participants on a very, very regular basis where we're getting

them out and about. But case managers are seeing – it could be anywhere from daily on up to at least once every couple weeks. We don't have a massive caseload, but we do have enough that we are still following up based on the needs of those individuals we're engaging, especially if they're transitioning from the street, too. And we're looking out for all of those different potential risk factors and then making referrals to our clinical team leadership or the psychiatrist or nursing or whoever else again to say whether or not we need to utilize a different intervention for them.

What we also do require for every one of our participants - and it is voluntary. They can decline it. At least from a staff perspective, everyone needs to be offered safety plans. We do that as an adaptation of Stanley and Brown that brings in multiple other factors all related to their environment, supports, lethal means, and other ways that they can get additional support, too. And it's a living document. It's something that needs to be reviewed and revisited regularly all the time. We give that to them. It is not a form for us. It's a form to empower their own process. And when things change, we also want to make sure that the safety plan is adjusted for their own purposes. We're also trying to make sure that we're following up both during and after all transitions into the different kinds of care. I'm actually going to get into that somewhat in the next slide.

We've developed some really excellent partnerships with a lot of our other providers. It's really nice to see that we have some commonalities with our friends like Dr. Grieg in Boston even though this upcoming weekend we're going to see if we will still maintain this good relationship in light of the big game. We have some very, very similar relationships in that we want to make sure that we are being at the forefront of the process with crisis response centers. We have a really robust and great relationship with our street outreach workers. They know our teams well. They know that we are out there looking for everyone. Our participants are often hitting the different emergency departments, clinics, and health care providers. We have formed quite a few relationships with them so that they know to please contact us and get in touch if they are seeing any sort of concerning behaviors, any other things that are happening with our participants, and we are then able to mobilize our staff to then support them. The same is the case for drug and alcohol treatment providers.

And then also our landlords and property managers at the community level are really important in this. We don't own our own property. We work with independent landlords. And, so, if they are seeing something that may be representing a change or a concern, they also will communicate with our housing department or they also have access to our case management staff 24/7. We maintain an on-call rotation that anybody would actually go out and see somebody if they were really, really concerned. With each of these partners where we are discussing things like what are the service expectations, what are the communication protocols, how will we respond also, what are we able to do, and one of our staff will be able to do that, too. Because we have this multidisciplinary team, is it always going to be clinical leadership or is it going to be someone else? And then what does that look like when we need to shift to more of an emergency level when it's not necessarily just maintenance?

I did want to change over and shift gears somewhat to looking at a couple case studies. What I did with our case studies is I wanted to spend a little bit of time both with looking at a case that looks at respondent suicidality, as Dr. Sung had mentioned earlier, and then the next slide I'm going to look at an individual that we worked with that was more on the operant suicidality.

The first one is an individual – both of them are kind of a little bit indicative of – we work with a lot of situations like this, but this one was a 26-year-old white male. His name was Miguel. He was a part of one of our clinical teams that we actually serve a large group of folks who have opioid use disorder. In fact, we have a team that is specifically designed to work with folks that are primarily heroin users and help get them immediately into housing. So, he had a variety of other things, too, including unspecified depression disorder. While he had been housed since 2016, he had been back and forth in between the street and his apartment. A lot of that had to do with his substance use. We had an outreach worker that was really looking out for him carefully, making sure to monitor what was going on because of some of the other risks that were happening with him.

What happened one day was that he got a call while this outreach worker was with him that his grandfather who had raised him had passed away. He was obviously very, very distressed and it was incredibly traumatic for him. His initial state of intent was that he was going to fatally overdose on heroin. He said this out loud to the outreach worker. The outreach worker, of

course, called our case manager right away who came immediately and the two of them were able to work through to get him to a crisis response center. He agreed to then take steps for getting into a detox and eventually transition over into an in-patient mental health stabilization period, too. Had they not already had an established trusting relationship at both levels, I don't think that they would have been able to work through all of these things. It was incredibly traumatic for him. Really, really difficult. But they immediately could respond. And then the other great thing was that for follow-up, immediately following the hospitalization, we were able to then do a really great warm hand-off from each of these different service providers and help him get then back into his apartment and do some more adaptive harm reduction-based support, things like NARCAN, developing an individualized overdose prevention plan and a variety of other things, too.

I'm going to move over into talking more on this operant suicidality. Dolores is a 60-year-old female where she has severe anxiety, frequent panic attacks. By the way, neither of these names are real names. They've been changed. Some of the details have been changed. She has frequent panic attacks, heavy, heavy alcohol use, and some unrealistic ideas around what it does for her. She referred to it as a nutrient drink or it's really helping her in a variety of ways. She was very, very well known to her outreach workers when she first came to us. Her apartment –

>> JULIE GOLDSTEIN GRUMET: Hey, Matt. This is Julie. I'm so sorry to interrupt a great presentation. I think we're having a hard time hearing you. I'm wondering if you can pull the mic a little bit closer.

>> MATT TICE: Can you hear me better now?

>> JULIE GOLDSTEIN GRUMET: Yes. Thank you.

>> MATT TICE: Great. Apologies.

>> JULIE GOLDSTEIN GRUMET: Great. Keep going. Great.

>> MATT TICE: Okay, great. We had already known when she first came to us that this was a big piece of her presentation. And what we did initially at that point, she moved into an apartment where she didn't have a great support system, she would end up going to a variety of different crisis response centers, emergency departments. We found that that was really

not helpful for her. But she would talk about things like saying this chronic suicidal ideation, I feel like I'm going to die every day. What we did is we helped move her to a closer apartment near our office.

We then did a lot of coordination with the local emergency department near that office where she was doing a lot of presentation or showing up very frequently and talking through what a plan was, how we could come and support, how we could then be available to her. They actually helped put a lot of the supports that we had in place in her chart so that we knew exactly what to do. There was a peer also who had developed an excellent relationship with her that then could even at times be able to talk her through the feelings that she was having. More recently, we've been helping her to talk about some of the meaningful activities, even though she's still been working through a lot of things. Getting some things like plants and she's just recently got a cat – actually, a fish. She was wanting to work her way up to a cat, taking care of something else. There is still a lot to do with her, but we know that our – I think that what we've been able to offer is something very, very helpful for this particular individual.

With all of that, I'm going to hand it back over to Dr. Little and we'll go from there.

>> VIRNA LITTLE: Thank you so much. Great job. We really appreciate your sharing information. I think it's so helpful to give case examples. And, so, I know that we wanted to leave some time to be able to do some reflections. I wanted to just go back and ask you, you know, because it certainly sounds like you have also really done a great job involving community partners. I was wondering if you could speak a little bit to some engagement strategies. I know there has been some chat and we've talked a little bit about it. Maybe something creative that your organization has done that you think might be helpful to share or best practice with folks on the phone.

>> MATT TICE: About how we've been engaging some of the other partners?

>> VIRNA LITTLE: Or engaging patients into care or engaging partners. Either.

>> MATT TICE: Oh, sure. Well, engaging partners, some of it is just hitting the ground. Myself, I'm going out there and I'm talking with individuals. I'm talking with the social workers or

I'm talking with the providers there. I think a lot of our staff are some of the biggest advocates about who we are and what we do. I think that some of that is building a culture of descending and loving the approach that we have. Really, really respecting and loving the participants, too. Then at times when somebody may not be treated the way that we'd like to, we also become fierce, fierce advocates on their behalf, and then that stands out. We also then – I also really encourage all of my staff when they see things that are going well or that they like the interactions with somebody, they try and communicate that to me so then I can reach out to supervisors or I talk to whoever else within the funding sources within the city and then maintain those relationships because it's all about fostering how we can then do that on behalf of our participants later.

If I can clarify the question again on the outreach for participants, do you mean for engaging them in our services?

>> VIRNA LITTLE: I think engaging them. Certainly. Yes.

>> MATT TICE: I guess to get them engaged in our initial services, all of them are referrals from the city of Philadelphia, the Department of Behavioral Health. Unfortunately, we don't get to just take referrals or walk-ins from the street. But we have an excellent outreach worker who is then engaging with all of these outreach teams. They're already identifying some of the folks who are the highest needs for our services. And then for our screening for all the rest of these, it's in our initial intake. We are making sure that we are looking at all of the factors, which are pretty extensive. We talk with them in-depth about all of the things that are going on in their life and doing that on a regular basis. Because this is permanent supportive housing, we have the luxury of getting to know people long-term in a variety of ways.

>> VIRNA LITTLE: And that certainly is a huge advantage. And I really want to thank you. And I also want to note something that you said because I have found it to be true my entire career. Individuals who work with and care for the homeless population are some of the most committed, dedicated, and certainly some of the best advocates I have ever had the pleasure to work with. And, so, I'm quite certain that if all of you can embrace the idea of Zero Suicide and bring that back, I'm certain that we're going to see huge changes in your organization and how you care for patients who are at risk. So, thank you for sharing your story.

I am going to turn over. We're going to spend some time now taking questions. Before we do that, I want to encourage people again to use the chat box to share takeaways from either Matt's presentation or from either of our other presenters. We're going to take some time now over the next 15 minutes to be able to take questions from the audience.

>> JULIE GOLDSTEIN GRUMET: Thank you, Virna. So, please take a moment in the audience in the chat box. If you have a key takeaway from Matt's presentation, something that particularly resonated with you, as well as we'll begin to take questions for all of our presenters. But I do think each of our presenters today really offered a unique perspective in working with homeless patients. I think it's helpful to take a moment and think what is the key takeaway you're going to take? What are you going to do differently as a result of today's presentation that maybe you hadn't thought about before? So, I see a bunch of people typing. I'm going to give people a moment before we turn it to asking directly from our presenters.

I think Virna mentioned something about the passion and dedication and the talent of the staff who work with homeless individuals every day. From where I sit, I'm fortunate to hear about the work that people do across the country. And I have heard people talk about how when they attend to suicide care differently and they think about using all of these principles and best strategies and this real bundle of interventions and they really begin to see that suicide prevention is possible and care can be changed. I really heard many long-term staff, veterans of health care systems talk about how reinvigorated they feel because they're beginning to think about suicide care differently than maybe their system did 20 years ago. They feel the incredible support of their leadership. I hope that today's presentation will help you to feel that same thoughtfulness and reinvigoration.

I see several people are talking about veterans. I'm going to turn to that in just a moment. But I do see a couple people commenting about the association, that you had the resources to move to where the suicidal – I'm sorry, to move the suicidal client into an apartment closer to your office and that meant you'd be able to better engage the client and see them and how important that is.

Jerry Reed who works here at the SPRC at EDC talked about each presenter and moderator really demonstrated what caring, competent, and compassionate providers really sound like and how

grateful we are to know that people like you are working with those in need. I certainly echo that.

A couple people talking about veterans. So, why don't we turn that over at this point and open up the conversation about veterans specifically since several people have been asking about that? I've seen people talk about what percent. Veteran suicides are at 20 a day. What percent do you see of homeless veterans? And how do you draft – I'm not sure what moral injury is. But how do you address working with veterans. Somebody mentioned earlier – there was another question about a large number of homeless patients who are veterans and any best practices that you might be able to share, particularly those who also have PTSD. I'm going to open that up. I think I'm going to start with you, Dr. Sung, and then I certainly invite other presenters to share their thoughts.

>> JEFF SUNG: So, in terms of working with veterans, I hate to say it. One of the most difficult and challenging problems that we've had, I and my team, with working with veterans is that oftentimes we're working with people who have a history of service who are not eligible for VA services given the circumstances of their discharge. I wouldn't necessarily say the care that we're providing is so different under those circumstances. We're doing our best to maintain connections with them over time, doing our best to treat co-occurring mental health conditions, doing our best to counsel them on access to lethal means and develop safety planning. Certainly, for the people we have who are veterans and eligible for services, we do our best to get them connected with the local vet center or the VA.

>> JULIE GOLDSTEIN GRUMET: Okay, thank you. Dr. Greig or Matt, any other thoughts about veterans who are homeless and any kind of innovation you've had there?

>> ASTREA GREIG: Sure. Just like we would work with differing shelters across the city, we also are really partnered with a shelter that serves only the veteran homeless population in Boston. They're not associated with the VA. Well, they're not from the VA, but they are very associated with the VA. And, so, we'll often connect with outreach workers from the veteran shelter rather and they'll come and meet with us regularly so that we can kind of keep tabs on people who are in need of increased services. And then from that, we'll try to reach out to them and they'll try to encourage them to see us.

>> JULIE GOLDSTEIN GRUMET: Can somebody speak, whether it's about veterans or not, about confidentiality? I saw some people questioning. How do you let shelter staff know or some of these organizations with whom you're partnering about some of the individuals you've been talking about today who have suicidal ideation, keep an extra eye on them? How have you managed that confidentiality? Dr. Greig, we can start with you, but I really open this to anybody.

>> ASTREA GREIG: Sure. I'm happy to answer. To give a specific example, not too long ago I had a client who was living in supportive housing and he left multiple voicemails on my phone about how he wanted to end his life. I called back and I couldn't get a hold of him. Of course, I wanted to help this gentleman. And, so, given that he voiced an intent and a plan to commit suicide, I then have the ability to seek a higher level of care and break confidentiality legally. What I did though first was to call the BEST team, as I explained earlier, and to have them visit his location. However, unfortunately, since the way that they work, they need consent from the client that they want the BEST team to come to them. That's how the operate.

Since he couldn't tell them that he wanted them – tell the BEST team that he wanted them to come to him, what they suggested actually was for me to call his housing and have the housing call the BEST team. For whatever legal reasons, that was okay. I then disclosed to the housing staff at this client's – this client was suicidal with an active plan and intent and that they were being asked to call the BEST team on his behalf to help him get to a higher level of care. In a nutshell, when there is intent and a plan, most mandated reporters and clinicians are able to break confidentiality. In terms of when there isn't an attempted plan, of course always really be working towards having releases signed with partnering organizations, which is understandable if it's something that the client doesn't want to do, therefore you want to really work on building rapport and building an understanding of why that's important and why you're asking for it.

>> JULIE GOLDSTEIN GRUMET: Great. Go ahead.

>> MATT TICE: This is Matt. I'd echo that. I would say that one of the things that's been really important to us is recognizing some of those potential risk factors earlier on, especially for somebody that may not be in that current crisis status or current level. But then seeing that they have a connection with like a drug and alcohol provider, they have a

connection that they're seeing – they have this other person. We're asking for those releases long before we get to that crisis moment and continually asking, too. It's not just the one time. And doing it in a respectful way. We're not pushing it and saying you must do this. But our relationships are our bread and butter. If we can't have people trust us, then we're not going to be able to then support them when things do get much more at the emergency level later.

>> JULIE GOLDSTEIN GRUMET: How might in-patient hospitals connect with organizations like yours? I'm thinking about the same – you're talking about various ways to collaborate with systems and coordination of care if people are transitioning, whether they're acute or not so acute. How can an in-patient hospital system coordinate care with an organization like any of yours to ensure that their homeless patients will have really competent transitions and care?

>> MATT TICE: We're actually fortunate in Philadelphia that the in-patient hospitals have a performance measure that they're required to make sure that they're making contact with our case management staff and then that they're trying to make referrals for follow-up when somebody is leaving. This is what they're supposed to do. It doesn't always come out that way. We also hold our staff to the same expectation. So, then when we do hear that somebody is going in, there's also a system – there's this electronic system that will notify us the morning after when someone presents either at an emergency room or somewhere else. If we haven't been told, we'll at least loop back and always try and contact that person and do the follow-up care. And then if we're able to, then maybe potentially contact a social worker or someone else who was in that department if we can't get the information from the participant themselves. I know that's a system that might be specific to Philadelphia, so that would be distinctive for other places.

>> JULIE GOLDSTEIN GRUMET: And if you have a workflow about that or advice, we certainly have an active Zero Suicide Listserv. I'll say it again before we wrap up. But, certainly, we encourage this conversation to continue over the Zero Suicide Listserv that anybody can sign up for at zerosuicide.com because I think having protocols like the one you're describing in Philadelphia, while it may only be highly active in Philly, it could be replicated elsewhere. Maybe people could borrow some of the tools that you've developed and use it elsewhere.

I'm going to shift gears a tiny bit because several people talked about lethal means and how do you restrict access to lethal means in this population. I'll start with you, Dr. Sung. But again, I open it up to others.

>> JEFF SUNG: Yeah. I saw those questions coming in. I think that the first thing that I would do is try to make a distinction between restricting access to lethal means as distinct from counseling on access to lethal means because I think that the two might be different. I'll give an example. I had a patient who was homeless, overweight, osteoarthritis, and then ended up on opioid pain medication. She looked at her bottle and thought of overdosing. The restricting access to lethal means component of it was speaking with the primary care doctor to reduce the number of pills that were prescribed from 30-day prescriptions to two-week prescriptions. She literally had fewer pills. That would be restricting access. And then the counseling on access to lethal means component of it was working with her to understand that when she was entering into that state of mind that she would want to have alternative ways of storing her medication or safer storage in general. So, I think that distinction might be important.

>> JULIE GOLDSTEIN GRUMET: Thank you. Others? I think this question certainly came up a lot. Obviously, it's a challenge both for homeless and not homeless patients. Do others have any thoughts?

>> ASTREA GREIG: To piggyback on Matt's comment about really having strong relationships, I would definitely agree with that. That's really one of our main tools. So, with that strong relationship with our clients, we can then get releases signed that enable us to speak to all of our community partners. I'm thinking about multiple times where I've had a release signed way in advance, like Matt said, with a client and their housing staff and then later finding out later on in our care with this client that a woman has a weapon, a knife in her room, and is feeling suicidal, and so then I would be then able to talk to this housing staff and have them do more wellness checks on her by the case managers who work in her building. Also the same with local shelter staff as well.

>> JULIE GOLDSTEIN GRUMET: Great. But, also, in asking directly about lethal means, it sounds like you knew what you were looking for. You had the releases in place. It was really sinking through any gaps that could have existed should that

client have access to lethal means. You had those all ready to go so that you could keep that client safe.

>> ASTREA GREIG: Absolutely.

>> JULIE GOLDSTEIN GRUMET: I think that's great. I want to get to another question. There are a couple very specific questions about how some of you have done your work. So, Dr. Greig, the question was what is the rate of utilization of the psychiatrist's time for the walk-in hours? The person who shared this had a concern that it would be low utilization leading to problems sustaining this level of access.

>> ASTREA GREIG: That's definitely a concern. So, the walk-in that we have, the walk-in capability that we have for psychiatry is really within that group that I mentioned. People are already present for that group and then they are taken aside from that group and meet individually one-on-one with a prescriber and then they are then returned or they return to their group and continue with the group. So, they're already present. It's not like there is the capability of no showing because the client is already present. In terms of walk-in hours, generally we only have walk-in hours for our therapists. And then once they see a therapist, they'll actually then see a prescriber or a psychiatrist because we kind of know that they have buy-in. During the therapy appointments, there's often some motivational enhancement done where we really try to increase people's motivation to continue accessing care. So, yeah, those are the multiple ways that we've avoided no-shows.

>> JULIE GOLDSTEIN GRUMET: Again, I think it sounds proactive, thinking carefully about very client-centered needs. We've certainly seen many systems talk about that, that you can't necessarily schedule people on your timeframe. You have to wait. You have to ensure that you have open access for people to come and see you as opposed to getting frustrated that they're not returning. Think about what the obstacles are.

So, I really want to thank our incredible presenters today for helping think through the challenges in working with a very vulnerable population but one that you all encounter very frequently. I think you've had some great innovations, some great thoughts about how to hopefully address this population that hopefully the participants in today's webinar can try out. Again, I really encourage people to join the Zero Suicide discussion at the Listserv at zerosuicide.com. You can sign up there and join the community. You can also email us directly. If

you had a question that wasn't answered, we will help you post it to the Listserv so that we can keep this conversation going. This is an incredible group of people sharing their efforts. We're all in this together. Again, thank you to our presenters for a fabulous presentation. Thank you.