Welcome to “Treating Suicidal Patients During COVID-19: Best Practices and Telehealth”

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Treating Suicidal Patients During COVID-19: Best Practices and Telehealth

April 14, 2020
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.

The views, opinions, and content expressed in this product do not necessarily reflect the views, opinions, or policies of CMHS, SAMHSA, or HHS.
Moderator: Julie Goldstein Grumet

Julie Goldstein Grumet, PhD
Director, Zero Suicide Institute
Director, Health and Behavioral Health Initiatives, Suicide Prevention Resource Center Education Development Center
Learning Objectives

- Describe the use of three best practices in caring for individuals at risk for suicide that can be delivered easily and effectively via telehealth.
- Educate participants on how to start using these practices in treatment.
- Provide resources that can be shared with individuals at risk for suicide immediately.
Overview

- Delivering safe and effective suicide care remains critical right now and is possible.
- With social isolation in place, telehealth is a new care environment for many clinicians and individuals at risk for suicide.
- Telehealth can be as effective as face-to-face care.
- Online skills-building resources to support clinicians and individuals at risk for suicide exist, are accessible, and are effective.
- System-wide focus on suicide prevention will help support the continued delivery evidence-based care.
Zero Suicide

• Is an aspirational goal
• Started in behavioral health—that’s the core
• Aims to keep people alive so they can experience recovery
• Focuses on error reduction and safety in health
• Is a systems approach to care
Zero Suicide Toolkit www.zerosuicide.com

The Zero Suicide Toolkit offers free and publicly available tools, strategies, and resources, plus link and information to:

• Get key implementation steps and research information
• Explore tools, readings, webinars, and other public resources
• Access templates from implementors across the country
• Connect with national implementors on the Zero Suicide Email List
Barbara Stanley, PhD
Director, Suicide Prevention: Training, Implementation and Evaluation Program, New York State Psychiatric Institute; Professor of Medical Psychology, Columbia University

Presenter: Dr. Barbara Stanley
Introduction

- The COVID-19 pandemic necessitates **social distancing and isolation**.
- Telehealth has become an important vehicle for the provision of health care.
- This extends to the provision of mental health services.
- While telehealth for psychotherapy has expanded in recent years, individuals who are suicidal are usually excluded from telehealth services.
- Current conditions demand finding ways to safely work with suicidal clients using telehealth.
Treating individuals at risk for suicide is anxiety producing under the best of circumstances.

Using telehealth with suicidal individuals present unique challenges.

People who have been suicidal before could have a spike in suicidal risk under the current circumstances.

The purpose of this presentation is to provide pragmatic guidance for evaluating and managing suicide risk via telehealth.
Overview of Suicide Prevention Approaches Adapted for Telehealth and COVID-19

- **Basic guidelines** for initiating remote contact with an at-risk individual
- Adaptations for conducting **remote screening and risk assessment**
- Remote **clinical management** of suicidal individuals
- **Safety planning** adaptations for COVID-19
- Use of ongoing **check-ins and follow-up** to avert ED visits and hospitalization
- Documentation
- Support for yourself
Initiating contact when your client may be suicidal: Basic guidelines

- Request the person’s location (address, apartment number) at the start of the session in case you need to contact emergency services.
- Request or make sure you have emergency contact information.
- Develop a contact plan should the call/video session be interrupted.
- Assess client discomfort in discussing suicidal feelings.
- Secure the client’s privacy during the telehealth session as much as possible.
- Prior to contact, develop a plan for how to stay on the phone with the client while arranging emergency rescue, if needed.
Adaptations for Suicide Risk Assessment

- In addition to standard risk assessment, **assess for the emotional impact of the pandemic on suicide risk.**

- Possible **COVID-related risk factors**: social isolation; social conflict in sheltering together; financial concerns; worry about health or vulnerability in self, close others; decreased social support; increased anxiety and fear; disruption of routines and support.

- **Inquire about increased access to lethal means** (particularly stockpiles of medications, especially acetaminophen (Tylenol) and psychotropic medications).
Adaptations for Clinical Management

*Given the strain on hospitals and EDs and the importance of remaining home for health reasons, identifying ways of staying safe short of going to the ED is critical.*

- Make provisions for **increased clinical contact** (even brief check-ins) until risk de-escalates; remember risk fluctuates.

- Provide **crisis hotline (1-800-273-8255)** and **crisis text (Text “Got5 to 741741)** information.

- **Identify individuals in the client’s current environment** to monitor the client’s suicidal thoughts and behaviors in-person or remotely; seek permission and have direct contact with those individuals.

- **Develop a safety plan** to help clients manage suicide risk on their own.

- **Collaborate** to identify additional alternatives to manage risk.
In case of unmanageable imminent risk...

- If risk becomes imminent and cannot be managed remotely or with local supports, arrange for client to go to the nearest ED or call 911.
- If risk is imminent, stay on the phone if possible until the client is in the care of a professional or supportive other person who will accompany them to the hospital.
Adaptations to Safety Planning

- The remote safety planning process is similar to conducting it in person.
- Assess whether client has previously completed a safety plan and ask them to obtain it, if possible, for review.
- Otherwise, let client know that you want to develop a safety plan with them to help maintain their safety, and that it will take about 30 minutes to do.
- Emphasize that having a safety plan is particularly important now as a way to stay safe without going to the ED or a medical facility. Remind clients that hospitals have limited resources to care for them at this point and that managing at home is safer for them.
Safety Planning Intervention Form can be used

- Arrange a way for the client to get a copy of the plan.
  - Clients can write responses as you work together
  - Clinician can write responses, take a picture or scan, and e-mail or text to the client

<table>
<thead>
<tr>
<th>SAFETY PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1: Warning signs:</strong></td>
</tr>
<tr>
<td>1. _____________________________________________________________</td>
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<tr>
<td>2.</td>
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<td>3.</td>
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<td><strong>Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:</strong></td>
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<td><strong>Step 3: People and social settings that provide distraction:</strong></td>
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<td>1. Name_________________________ Phone_________________________</td>
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<td>2. Name_________________________ Phone_________________________</td>
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<td>3. Place_________________________</td>
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<td>4. Place_________________________</td>
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<td><strong>Step 4: People whom I can ask for help:</strong></td>
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<td>1. Name_________________________ Phone_________________________</td>
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<td>2. Name_________________________ Phone_________________________</td>
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<td>3. Name_________________________ Phone_________________________</td>
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<tr>
<td><strong>Step 5: Professionals or agencies I can contact during a crisis:</strong></td>
</tr>
<tr>
<td>1. Clinician Name_________________________ Phone_________________________ Clinician Pager or Emergency Contact #</td>
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<tr>
<td>2. Clinician Name_________________________ Phone_________________________ Clinician Pager or Emergency Contact #</td>
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<tr>
<td>3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)</td>
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<td>4. Local Emergency Service</td>
</tr>
<tr>
<td>Emergency Services Address_________________________</td>
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<tr>
<td>Emergency Services Phone_________________________</td>
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<tr>
<td><strong>Making the environment safe:</strong></td>
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Safety Planning Adaptations: First Identify Warning Signs

- Identify warnings signs that a crisis is developing and the safety plan needs to be used.
- Any new warning signs associated with COVID-19?
  - Examples: extreme fear of illness, coping with illness in self or others, social isolation, loneliness, family conflict
- To help determine if things are getting out of control, have client take an emotional temperature
  - On a scale of 1 to 10, where 1 is completely calm and 10 is the most distressed you can imagine, how angry, anxious, or frustrated are you?
  - It’s easier to “bring the temperature down” when it’s not high. Ask, Can you identify when your temperature starts to enter the “yellow zone”? Can you do something to make yourself feel better to keep yourself from seeing “red”?
- If you start feeling your emotions getting out of control, it’s time to act!
Identify Coping Strategies That Can Be Done Alone

- **Identify internal coping skills** that can distract from suicidal thoughts and de-escalate crises, taking into account limited access to resources.
- Make sure internal coping strategies do not increase suicidal risk (such as watching news or browsing social media).
- Examples:
  - Take a time out
  - Use mindfulness apps; deep breathing
  - Do an activity that will change your physical state
  - Use distracting activities: knitting, video games, engaging television (limit exposure to news and some social media)
  - Self-soothing. Do something nice for yourself!
  - Contribute virtually
Identify Social Contacts that Can Help Distract from a Suicidal Crisis

- Social distraction options have been limited by social distancing.

- **Focus on virtual activities:**
  - Virtual travel tours, opera, theater performances, concerts, museums, or zoos
  - Virtual “meet-up” programs, like online painting, cooking, or karaoke
  - Virtual hang-outs with friends via Skype/FaceTime/Zoom to watch movies or play board games
  - Interactive online games or forums

- **Focus on current social environment** (i.e., who the client lives with).
Engage Social Support to Distract and Reduce Risk

- Brainstorm ideas for virtual meeting spaces:
  - Alcoholics Anonymous (https://www.aa.org)
  - AA Online Intergroup (www(aa)-intergroup.org)
  - Narcotics Anonymous (www.na.org)
  - Online house of worship services
  - Supportive chat groups

- Identify public places where social distancing is practiced:
  - Parks, Hiking trails
  - Grocery store or pharmacy (if practicing social distancing)
Identify Social Supports Who Can Help Handle a Suicidal Crisis

Determine who is currently available to help the client (in-person or remotely).

- Determine together with the client who is the best source of support and who the client feels comfortable turning to.

- Seek permission to contact and initiate contact with one or two key people who will provide support to make sure they are willing to do so and have some tips on how to help the client.

- Be specific when listing adaptive options. When client suggests an option – ask if this is likely to make them less upset or more distressed. If more distressed, find something else.

- Discuss sharing the plan with others.
Identify Emergency Contacts

- Explore virtual meeting services with current health care professionals such as therapist or psychiatrist.

- Provide the National Suicide Prevention Lifeline (800 273-8255; suicidepreventionlifeline.org) and crisis text (text “Got5” to 741741; crisistextline.org) information.

- Have Emergency Room listed as last resort. Help client determine what current procedures for emergency room admission are.
Social Contact Adaptations

- Make sure contact social contact information on steps 3-5 is virtual rather than in person unless they are currently living with the person.
  - “Contact information” can include telephone numbers, video chat, social media, game consoles, internet forums, etc.
- Virtual contact may “feel” different or mean different things to your client.
  - Discuss types of remote contact that best suit your client’s emotional needs.
  - For example, some prefer phone calls or texts for disclosure of distress but video chats for distraction.
Reducing Access to Means

- This step is particularly important due to possible changes in the person’s living environment and preparations they have made to stay inside and stock up on OTC and prescription medicines.

- Discuss increased access to lethal means (particularly stockpiles of Tylenol or other medications), how to reduce access and if there is someone with whom the client is living who can help secure lethal means.

- Ensure firearms, if present, are stored safely or removed.
Optional Adaptation to Safety Planning

- If there is time, encourage and collaborate with client to develop a plan to maintain stability and build mental reserves during this time:
  - Develop a **daily plan** and follow it.
  - Keep a **regular schedule** - sleep, eat, exercise.
  - Go outdoors at least once daily in a safe manner.
  - Encourage acceptance of the range of feelings.
  - Build **mastery**, identify and encourage pleasurable activities.
Check-ins and Ongoing Contact (1/2)

- **Conduct a suicide screen at all contacts for those at elevated risk.**
  - Use a standardized screen such as the C-SSRS. Screening takes <2 minutes and should be done in conversational manner.

- **Review any changes in risk or protective factors**
  - Changes in physical health in the individual or a loved one
  - New access to lethal means
  - Interpersonal conflict in close quarters
  - Social isolation and feelings of loneliness
  - Mistrust of the intentions of others
Check-ins and Ongoing Contact (2/2)

- **Review and update the safety plan** as needed. Check in about whether the safety plan has been used.
- **Plan the next contact.** Schedule contact while speaking with client.
- Determine when contact should be **based on acuity of the risk.**
- Check in with **daily plan** to build reserves and maintain stability.
Documentation and Supervision/Support for Clinician

- **Document all interactions** and your clinical thinking/rationale.
- **Consult with supervisors and peers** on challenging clinical decisions and document the consultations. This could include peer consultation groups.
  - Document consultations.
- During this time when many clinicians are working remotely, it is important to **attend to clinician isolation and mental health**.
Support for the Clinician

- Working with suicidal clients creates additional burden for clinicians in a time of great stress.
- Clinician **self-care activities** are crucial.
- **Arrange periods of coverage, if possible.** Allowing for time off is crucial.
- **Informing suicidal clients in advance of when time away will occur and making alternate provisions enhances care and safety.**
- Clients typically respond positively and respectfully when clinicians explain that they will be unavailable for a period of time.
Resources

- Barbara Stanley’s email for further information: bhs2@cumc.Columbia.edu
- www.suicidesafetyplan.com

References:


Audience:

Using the chat box, please share one key takeaway from Barbara’s presentation.
Presenter: Dr. David Jobes

David Jobes, PhD, ABPP
Professor of Psychology;
Director, Suicide Prevention Laboratory;
Associate Director of Clinical Training,
The Catholic University of America
Disclosures

- CAMS-related treatment research supported by two NIMH grants and one AFSP grant
- Book royalties (APA Press and Guilford Press)
- Founder/Partner, CAMS-care, LLC (professional training and consultation)
- The views expressed in this presentation are those of the presenter and do not necessarily reflect the official policy of the Department of Defense, the Department of the Army, the US Army Medical Department, Veteran’s Affairs, or the United States Government.
COVID-19 (SARS-CoV-2): Telepsychology use of CAMS

During a two weeks in mid-March we presented to over 600+ providers from at least five countries on four free Zoom presentations—1100+ free downloads…
The Collaborative Assessment and Management of Suicidality (CAMS)

The four pillars of the CAMS framework:

1) Empathy
2) Collaboration
3) Honesty
4) Suicide-focused

Goal: Build a strong therapeutic alliance that increases patient-motivation; CAMS targets and treats patient-defined suicidal “drivers”
First session of CAMS—SSF Assessment, Stabilization Planning, Driver-Focused Treatment Planning, and HIPAA Documentation

CAMS Tracking/Update Sessions

CAMS Outcome/Disposition Session
## Published Randomized Controlled Trials of CAMS

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Setting &amp; Population</th>
<th>Design &amp; Method</th>
<th>Sample Size</th>
<th>Publications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comtoois (Jobes)</td>
<td>Harborview/Seattle CMH outpatients</td>
<td>CAMS vs. TAU Next day appts.</td>
<td>32</td>
<td>2011 Published article</td>
</tr>
<tr>
<td>Andreasson (Nordentoft)</td>
<td>Copenhagen Denmark CMH outpatients</td>
<td>DBT vs. CAMS Superiority Trial</td>
<td>108</td>
<td>2016 Published article</td>
</tr>
<tr>
<td>Jobes (Comtois)</td>
<td>Ft. Stewart, GA U.S. Army Soldiers</td>
<td>CAMS vs. E-CAU Outpatient Clinic</td>
<td>148</td>
<td>2017 &amp; 2018 Published articles</td>
</tr>
<tr>
<td>Ryberg (Fosse)</td>
<td>Oslo Norway Outpatients/Inpatients</td>
<td>CAMS vs. TAU</td>
<td>78</td>
<td>2019a &amp; 2019b Published articles</td>
</tr>
<tr>
<td>Pistorello (Jobes)</td>
<td>Univ. of Nevada—Reno College students</td>
<td>SMART Design CAMS vs. TAU</td>
<td>62</td>
<td>2017 &amp; in press Published articles</td>
</tr>
</tbody>
</table>
Ongoing CAMS Randomized Controlled Trials

San Diego VA randomized controlled trial: “Rapid Referral Study”

The CAMPUS Study: NIMH-funded ($11M) multisite SMART of n=700 suicidal college students at four universities (University of Oregon, University of Nevada-Reno, Duke University, and Rutgers University).
What is Telepsychology?

- Telepsychology is broadly defined and includes the provision of psychological services using the full range of telecommunications technologies of different types.
- Includes: telephones, mobile devices, videoconferencing, email, chat, text, and use of the internet (blogs, websites, and self-help).
- Synchronous use (phone or videoconference).
- Asynchronous use (email, online bulletin boards).
APA Telepsychology Guidelines

- Competence
- Standard of care in delivery of telepsychological services
- Informed consent
- Confidentiality of data and information
- Security and transmission of data and information
- Disposal of data and information and technologies
- Testing and assessment
- Interjurisdictional practice
Telepsychology Resources from APA

OFFICE & TECHNOLOGY CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

- Screen your patient(s) to determine whether video-conferencing services are appropriate for them.
- Consider patient’s clinical & cognitive status – can the patient effectively participate?
- Does the patient have technology resources for a video-conference – e.g. webcam or smartphone?
- Consider patient's comfort in using technology – can they login and effectively use the technology?
- Does the patient have physical space for a private telepsychology session?
- Is parental/guardian permission required? If so, obtain it.
- Consider patient safety (e.g., suicidal) and health concerns (e.g. viral risk; mobility; immune function), community risk, and psychologist health when deciding to do tele-sessions instead of in-person.

Technology:
- Is your technology platform consistent with HIPAA-compliant practices?
- Do you have a Business Associate Agreement (BAA) for that technology vendor?
- Do you and the patient have adequate internet connectivity for video-conferencing?
- Did you discuss with the patient how to login and use the technology?
- Are you using a password-protected, secure internet connection, not public or unsecured Wi-Fi? What about your patient? (If not, it increases the risk of being hacked.)
- Did you check that your anti-virus/ malware is up-to-date to prevent being hacked? What about your patient?

Office Setup:
- Is the location private? Is it reasonably quiet?
- Make sure the room is well lit. Example: a window in front of you might cast a shadow or create low visibility.
- To improve eye contact, position your camera so that it’s to easy to look at the camera and the patient on screen.
- Consider removing personal items or distractions in the background.
- Check the picture and audio quality. Can you see and hear each other? Make sure nobody is muted.
- As much as possible, both people should maintain good eye contact and speak clearly.

Pre-session:
- Psychologist should be competent to deliver tele-health services. Consider taking the Telepsychology Best Practice (2021) online CE course. Review APA’s Telepsychology Practice Guidelines.
- Discuss the potential risks/benefits of telehealth sessions with the patient(s).
- Get a signed informed consent from your patient(s) or patient’s legal representative. If the psychologist or patient is quarantined, informed consent must be signed electronically; consider Dropbox or GoogleDrive.
- Do you have a back-up plan in case of technical difficulties? In case of a crisis situation? What contact information do you have? Do you know the local resources (e.g. ER) where the patient is?
- Did you discuss how this session will be billed? Will the patient be billed if late/no-show?
- In the case of minors, determine where the adult will be at that location.

Beginning of virtual session:
- Verify the patient’s identity, if needed.
- Confirm patient’s location and a phone number where the patient can be reached.
- Review importance of privacy at your location and patient’s location.
- All individuals present for the virtual visit must be within view of the camera so the psychologist is aware of who is participating.
- Confirm that nobody will record the session without permission.
- Turn off all apps and notifications on your computer or smartphone. Ask patient to do the same.
- Conduct the session mostly like you would an in-person session. Be yourself.

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission of the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/ free WiFi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Name / Signature:
Patient Name:
Signature of Patient/ Patient’s Legal Representative:
Date:
Protocol for Using CAMS within Telepsychology

Key Points

- CAMS has been successfully used within telepsychology
- Army use of CAMS telepsychology at the Warrior Resiliency Program
- Early use of CAMS telepsychology in Wyoming (rural and frontier)
- Plans to use CAMS telepsychology in prison/forensic settings
- Use of CAMS telepsychology in current San Diego VA RCT
- INFORMED CONSENT!
- Use of SSF in parallel with patient

CAMS-care, LLC
Protocol for Using the CAMS Framework within Telepsychology

Overview

The Collaborative Assessment and Management of Suicidality (CAMS) has been successfully administered using telepsychology in a variety of settings (Joes, 2016). For example, the U.S. Army has successfully used a telepsychology version of CAMS within the Warrior Resiliency Program in San Antonio Texas for suicidal Soldiers in geographically remote locations for the past several years (Waltman, Landry, Pujoel, & Moore, 2019). The exploratory use of CAMS via telepsychology in rural and frontier regions of the intermountain West of the United States is also now underway. The use of telepsychology and CAMS in forensic (prison) settings is also being explored. Finally, it is important to note the telepsychology use of CAMS is now being done with an ongoing randomized controlled trial (RCT) at the San Diego Veterans Affairs Medical Center with suicidal veterans.

Basically, the common denominator for using CAMS within a telepsychology modality requires the parallel use of the Suicide Status Form (SSF). The SSF functions as the CAMS roadmap of the framework for assessment of suicidal risk, stabilization planning, suicide-focused treatment planning, the referral tracking of suicidal risk, to clinical outcomes and dispositions. To this end, it is critical that both the patient and clinician have access to copies of the SSF-4 which they can then refer to as they engage in CAMS-guided assessment, the ongoing treatment of patients defined “survivors” (those who’ve been found to be at risk for suicide), and ongoing treatment planning until outcomes/dispositions phase of CAMS-guided care is realized.

What we have seen in recent uses of telepsychology and CAMS is that patients have the opportunity to check the clinician’s completion of the SSF as accurate reflecting both the correct assessment and treatment information that the patient experiences. In this regard, the clinician’s accurate completion of the SSF can be a clarifying and even validating experience for the suicidal patient. Thus, it is crucial for a suicidal CAMS patient to have access to the appropriate hardcopy of the CAMS SSF-4 prior to each CAMS session. At some point in the future the e-SSF that has been developed with the help of Microsoft engineers will be commercially available to supplement the CAMS telepsychology experience. But for now, we will rely on annual access to the hard copy version of the SSF-4 and will then use it in parallel within telepsychology.

Informed consent to engage in telepsychology is crucial. Particular considerations informed consent considerations are jurisdictionally defined by boards of mental health disciplines. There are also complex issues as to what to do remotely for a patient in imminent danger. Discussions of this prospect may need to be included as part of informed consent (e.g., that if suicidal patient cannot be contacted for an emergency reunite if that it is warranted to assert a patient’s safety). What follows are general guidelines for using CAMS within telepsychology across each phase of the CAMS therapeutic framework, including: (a) the CAMS initial session, (b) the CAMS tracking/updates/interim sessions of care, and (c) the CAMS outcome-disposition final session when the full range of clinical outcomes are reached and documented by the Suicide Status Form.
CAMS Initial Session

Key Points

• Initial session Section A—patient assessment

• Initial session Section B—clinician assessment

• Initial session Section C—CAMS Stabilization Plan and treatment planning for two patient-defined suicidal drivers

• Verify and affirm all patient’s responses (validation)

• Patient’s SSF is for their use

• Clinician SSF copy becomes the medical record progress note

• Complete Section D after session
CAMS Tracking /Update Interim Session

Key Points

• Tracking session; patient completes SSF Core Assessment (Section A)

• Tracking session; treat patient-defined suicidal drivers

• Tracking session; update CAMS Stabilization Plan and driver-focused treatment plan (Section B)

• Verify and affirm all patient’s responses (validation)

• Patient’s SSF is for their use

• Clinician SSF copy serves as the medical record progress note

• Complete Section C after session
Outcome/Disposition Final Session

Key Points

- Patient completes SSF Core Assessment (Section A)
- Clinician completes outcome and disposition (Section B)
- Verify and affirm patient’s assessment responses and their understanding of their treatment outcome and disposition
- Patient’s SSF is for their use
- Clinician SSF copy serves as the medical record progress note
- Complete Section D after session
- Conclude the use of CAMS
Case example of shifting to telehealth

Treating Suicidal College Students Using Telepsychology: A CAMS Approach Live Presentation

Events | 20 March 2020

Monday, March 30 at 4 pm – 5 pm EDT | Registration is full

We will have the recording posted for your view when it becomes available.

Join us for a free one-hour video presentation hosted by Dr. David Jobes featuring CAMS-care expert consultant Dr. Melinda Moore. Dr. Moore will be presenting on the telepsychology use of CAMS for treating suicidal college students and responding to your questions on this topic.

Our goal at CAMS-care is to provide solutions to challenges created by the pandemic. We hope to provide resources to help you treat your suicidal patients at a time when social distancing is absolutely needed. The first 300 users will be admitted so we recommend that you register early to secure your spot.

About Melinda Moore Ph.D.

Dr. Melinda Moore is a Licensed Clinical Psychologist and Associate Professor in the Department of Psychology at Eastern Kentucky University. She serves on the board of the American Association of Suicidology as the chair of the Clinical Division and is the co-lead of the National Action Alliance's Faith Communities Task Force. Dr.
What CAMS Clinicians Say

- Doxy.me is much clearer than Zoom
- Can see those non-verbal cues and facial expressions
- “It is still difficult to read nonverbal cues at times, which leads to people talking over each other”
- “Client prefers this . . . She feels exposed in the clinic”
- “She can sit with her dog.”
- “College age and teenage clients use tech so often”
- However, one clinician who has 65 year old client:
- “Wasn’t certain if technology was going to work with her,” but she is “really excited about it”
Challenges for Client

- Needs to be in private, quiet room
- Technical issues – audio issues; not use speakers, but headphones
- Internet connectivity – important to discuss upfront
- Clients must sometimes use relatives’ computers
- Nosy parents or siblings:
  - SSFs screen shared, but not sent in advance or physically present
  - Completed SSF scanned in and sent to client later
- White noise played on downloadable app on a phone placed by the door (e.g., Calm’s nature sounds) or towel under door
Clinic Set-Up Challenges

- Space – private rooms
- Hardware – computers, dedicated phone lines, etc.
- Initial Doxy.me account = $500/year, but had to negotiate unique Business Associate Agreement (BAA), because university couldn’t accept standard indemnification clause
- EKU had to use own legal counsel to write contract
- Emergency additional Doxy.me accounts = $1,000/year for 4 additional account added (50% discount)
- Insurance coverage considerations
- Interjurisdictional considerations
Next Steps for CAMS and Telehealth

- Continue to publish RCT data; a new meta-analysis of CAMS trials is now being undertaken by Dr. Chris DeCou at the University of Washington.
- Study mediators and mechanisms what makes CAMS effective
- Significantly expand the use telehealth CAMS in the on-going San Diego VA RCT
  - Modify CAMS training to provide even more on-line training (e.g., Zoom-based role-playing)
  - Study the impact of Zoom-based training vs. live training
Next Steps for CAMS and Telehealth

- Promote additional resources and guidance on the training website
- Publish papers about the pandemic response and telehealth use of CAMS
- Continue to develop the e-SSF (developed with Microsoft Office group) for broad clinical use
Thank You!

Find us online at:
www.cams-care.com
Audience:

Using the chat box, please share one key takeaway from David’s presentation.
Presenter: Dr. Ursula Whiteside

Ursula Whiteside, PhD
CEO, NowMattersNow.org
Clinical Faculty, University of Washington
Do No Harm
Brief Survey: Personal Experiences with Suicide

bit.ly/SuicideExp

Or

 surveymonkey.com/r/SuiExp
ZERO Suicide
IN HEALTH AND BEHAVIORAL HEALTH CARE
Recommended Standard Care Pathway for People with Suicide Risk

Making Health Care Safe for Those in Crisis

A Care Pathway
Two Themes

1. Service Providers feel powerless
2. Patients find simple things helpful
This website is a service for people who are seeking information about DBT (Dialectical Behavior Therapy).

This site was written primarily by PEOPLE WHO HAVE BEEN THROUGH DBT, not DBT professionals. For this reason, consider the source of any given document. We cannot give advice, but we can talk about our experiences on our DBT journey. In this regard, I hope we can help one another.

11/11/19 Important Update

Dear Site Visitors,

Eighteen years have passed since it's almost like giving birth to an adulthood. I have loved this website.

When I began in 2001, there was nothing on the internet for DBT graduates available for families and professionals.
DBT SKILLS

DBT Skills with support works!

Free Evidence-Based Resource
Videos, Downloadables, Training, Crisis Lines
Development and Evaluation of a Web-Based Resource for Suicidal Thoughts: NowMattersNow.org

Ursula Whiteside¹,², MS, PhD; Julie Richards³,⁴, MPH; David Huh²,⁵, PhD; Rianna Hidalgo¹,⁶, BA; Rebecca Nordhauser¹, MS; Albert J Wong¹, BS; Xiaoshan Zhang¹, MS; David D Luxton¹,², PhD; Michael Ellsworth⁷, BA; DeQuincy Lezine¹,⁸, PhD

¹NowMattersNow.org, Seattle, WA, United States
²School of Social Work, University of Washington, Seattle, WA, United States
³Kaiser Permanente Washington Health Research Institute, Seattle, WA, United States
⁴Department of Health Services, University of Washington, Seattle, WA, United States
⁵Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, WA, United States
NowMattersNow.org Data

One-Third of Visitors Reporting Suicidal Thoughts Reported Less Intense Suicidal Thoughts In Under 10 minutes
NowMattersNow.org Data

Website visits are associated with decreased intensity of suicidal thoughts (and negative emotions).

This includes people whose rated their thoughts as “completely overwhelming”

Everyone, as well as these groups: middle age men, 12 to 18, 12-24, Suicide Attempt Survivors
Phone and Video Work

- PHQ9 and GAD7, administer first and reference throughout
- Check about smartphone and internet access
- Ask them to get a pen and paper
- Regularly check in to see that they are still with you
- Accessibility to materials before and after to reinforce concepts
- Follow-up after teaching skills
Virtual Techniques

Reinforce Learning or Confirm Use of Skills

– Ask to describe back to you or to teach someone
– Summarize again at the end of the call
– Send summary, review at beginning of next call
– Ask them to
• record some or part of the call on their phone
• complete a worksheet, review the worksheet
• take a photo of the notes they took
• watch a video with you (“what stood out to you?”)
Role Play - Sarah

Linking to Cold-Water Skill
Cold Water

Skill for being “On Fire” Emotionally
Being “On Fire” Emotionally

Do you know what to do in an emotional emergency? How do you survive a full on crisis?
The Cold-Water skill is what to use when tolerating painful events, urges, and emotions when you cannot make things better right away.
Being “On Fire” Emotionally

These skills help REDUCE INTENSE EMOTIONS fast
Important Concepts

- Mammalian Dive Response
- Vagal or Vagus Nerve
- “Cycle the Power”
Cold Water
diary card and worksheets (new!)  
Use NowMattersNow.org Diary Card (PDF, Word) and Practice Assignment (Google Doc) to make your patients more mindful.

Google Docs latest version and print best with Google Chrome.

curbing suicide  
Share this Fredonia.edu/NowMattersNow.org.  
Website recommends: reduce suicidal thoughts short essays summary and one story).

stress model  
Stress Model explains why, for some of us, it is harder to manage the emotional pain of living (Stress Model PDF)
How to Be

1. Don’t Panic
2. Be Present
3. Offer Hope
Audience:

Using the chat box, please share one key takeaway from Ursula’s presentation.
Q & A
Resources

- SAMHSA’s Disaster Distress Helpline
  - Call: 800-985-5990
  - Text/SMS: Text TalkWithUs or Hablanos (for Spanish) to 66746 (subscription-based)
  - Full details at: https://www.samhsa.gov/find-help/disaster-distress-helpline

- National Suicide Prevention Lifeline: 800-273-8255

- The Trevor Project
  - TrevorLifeline: 866-488-7386
  - TrevorText: Text START to 678678
  - TrevorChat: https://www.thetrevorproject.org/get-help-now/

- Crisis Text Line: Text HOME to 741741

- Providing Suicide Care During COVID-19: http://zerosuicide.edc.org/covid-19
Thank you for joining this webinar.
Suicide Prevention Resource Center

Treating Suicidal Patients during COVID-19: Best Practices and Telehealth Webinar
Supplemental Resources

- **Suicide Prevention Resource Center and Zero Suicide Resources**
  The Suicide Prevention Resource Center (SPRC) has created and gathered a variety of resources related to behavioral healthcare delivery during the COVID-19 pandemic.
  - Providing Suicide Care During COVID-19: [http://zerosuicide.edc.org/covid-19](http://zerosuicide.edc.org/covid-19)
  - Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe: [https://theactionalliance.org/resource/recommended-standard-care](https://theactionalliance.org/resource/recommended-standard-care)

- **Safety Planning Intervention**
  A fill-in-the-blank template for developing a safety plan with a patient at increased risk for a suicide attempt. It is available via the links below for print-out, as well as in app format for both Apple and Android devices.

- **Collaborative Assessment and Management of Suicide Risk (CAMS)**
  CAMS, the Collaborative Assessment and Management of Suicidality, is an evidence-based suicide-specific clinical intervention that has been shown through extensive research to effectively assess, treat and manage suicidal patients in a wide range of clinical settings.
  - Access on-demand presentations related to the use of CAMS, specifically in telemental health settings is available by visiting the CAMS-care website: [https://cams-care.com/](https://cams-care.com/)
  - For more information regarding the CAMS approach:

- **Crisis Intervention/Response Tools and Resources**
  There are a variety of resources available for behavioral health practitioners that can provide guidance on providing care to those experiencing crises and/or increased risk of suicide during the COVID-19 pandemic, as well as resources for use by patients, clients, and anyone who may be in need from which support can be accessed 24/7.
  - The below resources were created by Dr. Ursula Whiteside and provide guidance to behavioral health practitioners who are providing mental health services and supports to patients and clients experiencing crises via telehealth, but are also applicable during in-person visits.

April 2020
Suicide Prevention Resource Center

- Suicide Care Pathway: Linking Assessment and Brief Intervention:

- The Now Matters Now website provides information, skills, and training that can be helpful for both practitioners and individuals who are experiencing crises and/or increased risk of suicide:
  https://www.nowmattersnow.org/skills

- There are a variety of services providing 24/7/365 crisis services for those experiencing crises and/or increased suicide risk:
  - SAMHSA’s Disaster Distress Helpline
    ▪ Call: 800-985-5990
    ▪ Text/SMS: Text TalkWithUs or Hablanos (for Spanish) to 66746 (subscription-based)
    ▪ Full details at: https://www.samhsa.gov/find-help/disaster-distress-helpline
  - National Suicide Prevention Lifeline: 800-273-8255
  - The Trevor Project
    ▪ TrevorLifeline: 866-488-7386
    ▪ TrevorText: Text START to 678678
    ▪ TrevorChat: https://www.thetrevorproject.org/get-help-now/
  - Crisis Text Line: Text HOME to 741741

- Telepsychology/Telemental Health
  Below are a number of resources containing practice guidelines for practitioners providing behavioral health services in telehealth settings.
  - Office and Technology Checklist for Telepsychological Services:

- Telecommunications Information