Suicide Prevention Resource Center

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

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Suicide Prevention Resource Center

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

April 14, 2020

Funding and Disclaimer

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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

Presenter: Dr. Barbara Stanley

Barbara Stanley, PhD
Director, Suicide Prevention: Training, Implementation and Evaluation Program, New York State Psychiatric Institute; Professor of Medical Psychology, Columbia University

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.

Telehealth with Suicidal Clients

- 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

SAFETY PLAN

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____
4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service _____
   Emergency Services Address_____
   Emergency Services Phone _____

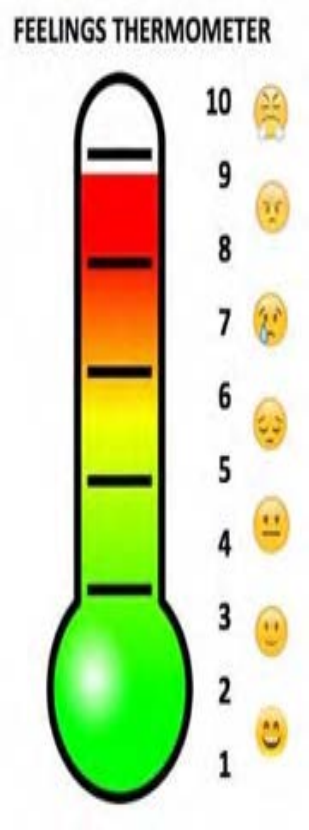
Making the environment safe:

1. _____
2. _____

Adapted from Stanley, B. & Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice. 19*, 256–264

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:**

  - **Stanley, B**., Brown, G. K., Brenner, L. A., Galfalvy, H. C., Currier, G.W., Knox, K. L., Chaudhury, S. R., Bush, A.L., Green, K. L. (2018). Comparison of the Safety Planning Intervention with Follow-up vs usual Care of Suicidal Patients Treated in the Emergency Department. *JAMA Psychiatry*. doi:10.1001/jamapsychiatry.2018.1776. PMID: 29998307
  - **Stanley, B**., & Brown, G. K. (2012). Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk. *Cognitive and Behavioral Practice, 19*(2), 256-264. doi:10.1016/j.cbpra.2011.01.001
  - Stewart, K.L., Darling, E.V., Yen S., **Stanley, B.**, Brown, G.K., Weinstock, L.M. (2018). Dissemination of the Safety Planning Intervention (SPI) to University Counseling Center Clinicians to Reduce Suicide Risk among College Students. *Arch Suicide Res*. doi:1080/13811118.2018.1531797

Audience:

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

Presenter: Dr. David Jobes

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Disclosures

- CAMS-related treatment research supported by two NIMH grants and one AFSP grant
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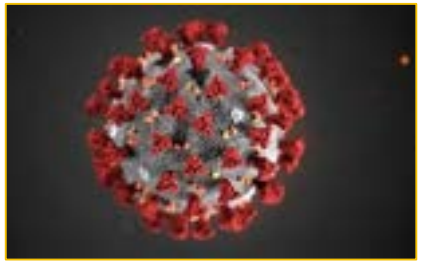
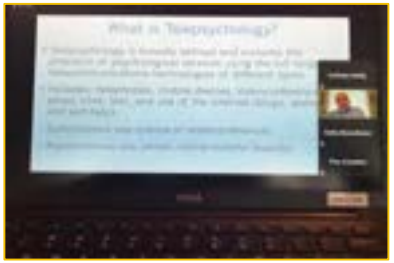
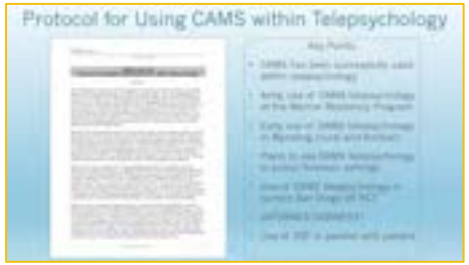
- Founder/Partner, CAMS-care, LLC (professional training and consultation)
- The views expressed in this presentation are those of the presenter and do not necessarily reflect the official policy of the Department of Defense, the Department of the Army, the US Army Medical Department, Veteran's Affairs, or the United States Government.

COVID-19 (SARS-CoV-2): Telepsychology use of CAMS

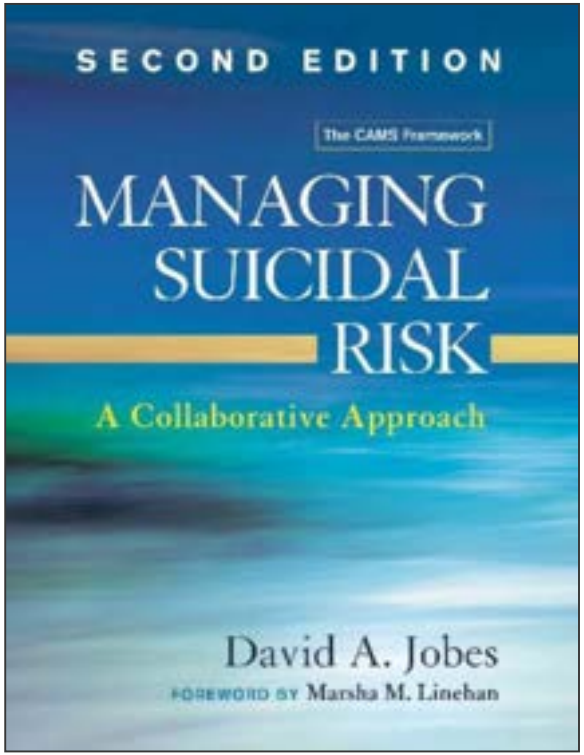


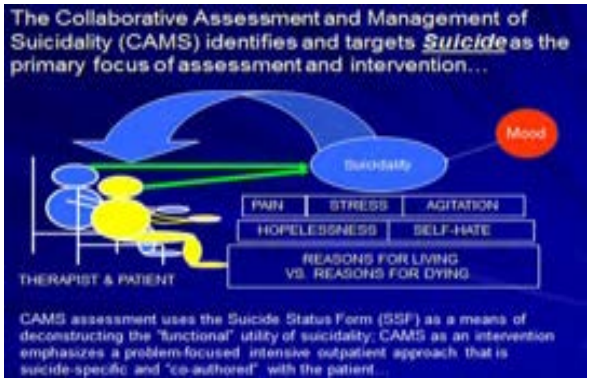




During a two weeks in mid-March we presented to over 600+ providers from at least five countries on four free Zoom presentations—1100+ free downloads…

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

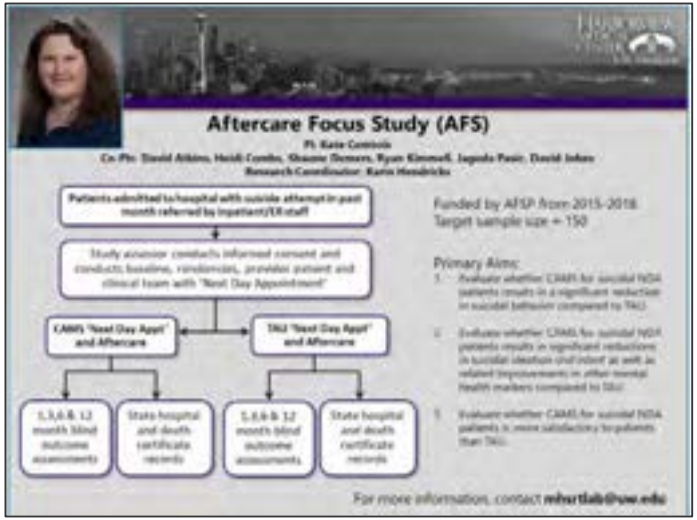

CAMS Outcome/Disposition Session

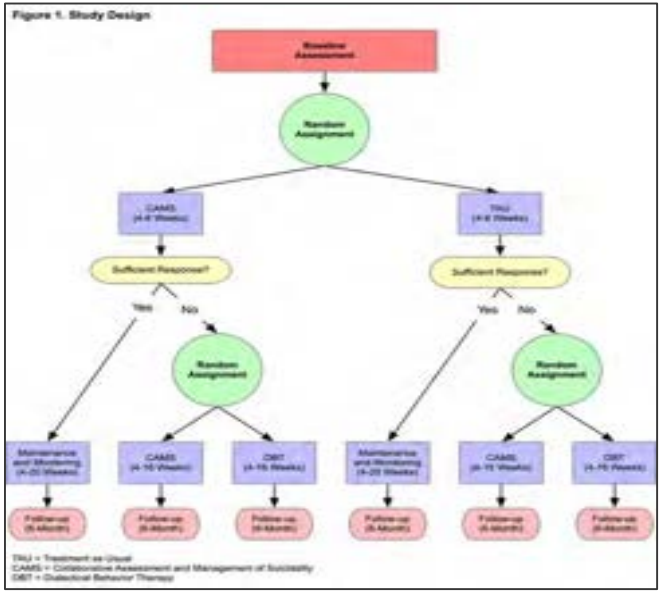


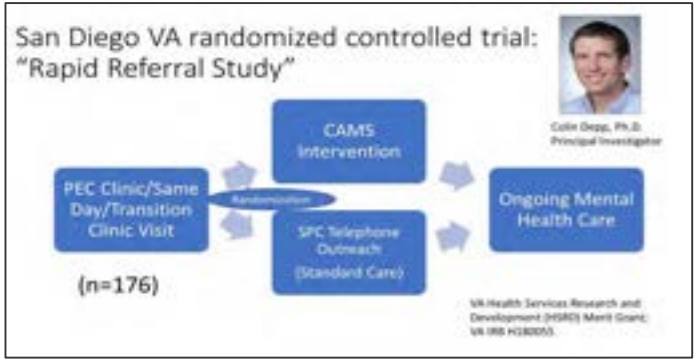
Published Randomized Controlled Trials of CAMS

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

Ongoing CAMS Randomized Controlled Trials







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

American Psychological Association Services, Inc.

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 parent/guardian permission required? If so, obtain it.
- Consider patient safety (e.g., suicidality) 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 WiFi? 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 Set-up:
- 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 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 101" 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 DocHub or DocuSign.
- 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.

(For information purposes only. Not for use in clinical records.)

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 from 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 Wi-Fi.
- 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

CAMS-care

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 (Jobes, 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 (Wahlman, Lindley, Pejul, & 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 on-going 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 interim 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 on-going treatment of patient-defined "drivers" (those issues/problems that compel patients to consider suicide), and on-going treatment planning until outcome/disposition phase of CAMS-guided care is realized.

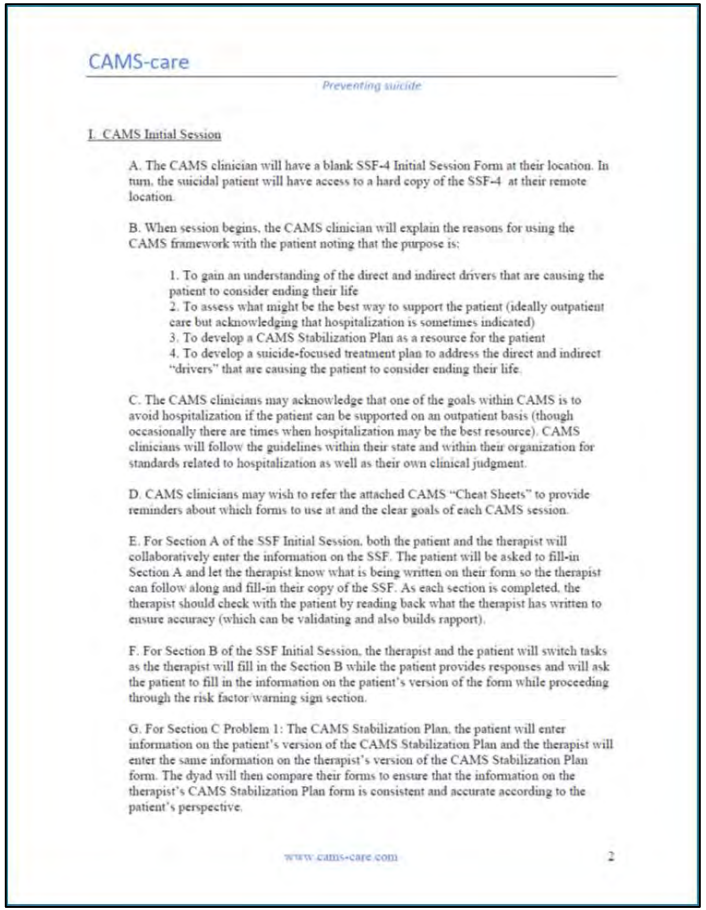
What we have seen in current uses of telepsychology and CAMS is that patients have the opportunity to check the clinician's completion of the SSF as accurate reflecting both the correct assessment and treatment information that the patient experiences. In this regard, the clinician's accurate completion of the SSF can be a clarifying and even validating experience for the suicidal patient. Thus, it is unusual 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 4+ 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 mutual 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, discussion of this prospect may need to be included as part of informed consent (e.g., that 911 may need to be contacted for an emergency rescue if that is warranted to secure 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/update-interim sessions of care, and (c) the CAMS outcome/disposition final session when the full range of clinical outcomes are realized and documented by the Suicide Status Form.

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 Initial Session



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Preventing suicide

I. CAMS Initial Session

A. The CAMS clinician will have a blank SSF-4 Initial Session Form at their location. In turn, the suicidal patient will have access to a hard copy of the SSF-4 at their remote location.

B. When session begins, the CAMS clinician will explain the reasons for using the CAMS framework with the patient noting that the purpose is:

1. To gain an understanding of the direct and indirect drivers that are causing the patient to consider ending their life
2. To assess what might be the best way to support the patient (ideally outpatient care but acknowledging that hospitalization is sometimes indicated)
3. To develop a CAMS Stabilization Plan as a resource for the patient
4. To develop a suicide-focused treatment plan to address the direct and indirect "drivers" that are causing the patient to consider ending their life.

C. The CAMS clinicians may acknowledge that one of the goals within CAMS is to avoid hospitalization if the patient can be supported on an outpatient basis (though occasionally there are times when hospitalization may be the best resource). CAMS clinicians will follow the guidelines within their state and within their organization for standards related to hospitalization as well as their own clinical judgment.

D. CAMS clinicians may wish to refer the attached CAMS "Cheat Sheets" to provide reminders about which forms to use at and the clear goals of each CAMS session.

E. For Section A of the SSF Initial Session, both the patient and the therapist will collaboratively enter the information on the SSF. The patient will be asked to fill-in Section A and let the therapist know what is being written on their form so the therapist can follow along and fill-in their copy of the SSF. As each section is completed, the therapist should check with the patient by reading back what the therapist has written to ensure accuracy (which can be validating and also builds rapport).

F. For Section B of the SSF Initial Session, the therapist and the patient will switch tasks as the therapist will fill in the Section B while the patient provides responses and will ask the patient to fill in the information on the patient's version of the form while proceeding through the risk factor/warning sign section.

G. For Section C Problem 1: The CAMS Stabilization Plan, the patient will enter information on the patient's version of the CAMS Stabilization Plan and the therapist will enter the same information on the therapist's version of the CAMS Stabilization Plan form. The dyad will then compare their forms to ensure that the information on the therapist's CAMS Stabilization Plan form is consistent and accurate according to the patient's perspective.

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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

CAMS-care

Preventing Suicide

H. For Section C Problems 2 and 3 the therapist and patient will explore what "drivers" the treatment should focus on and complete the CAMS Treatment Plan accordingly. Both patient and therapist will enter the information on their respective versions of the forms.

I. The patient and therapist will each sign their respective versions of the SSF, and the therapist's signed version will be scanned into the patient's medical record. The patient will have their own completed version of the SSF and the CAMS Stabilization Plan to refer to as ongoing care proceeds.

J. The therapist will complete Section D of the Initial Session SSF after ending the session with the patient and will scan the relevant documents into the patient's medical record as it functions the official medical record progress note.

II. CAMS Tracking Update Interim Care

A. Both therapist and patient will have a blank copy of the SSF Tracking Update-Interim Care version of the form at the start of the session.

B. The patient will complete Section A (the SSF Core Assessment) ratings on their form at the start of the session and will dictate their ratings to the therapist so the therapist can enter the information on the therapist's copy of the SSF (including considerations of the overall risk of suicide and whether the patient managed their suicidal thoughts and feelings and remained behaviorally safe over the past week).

C. Once the SSF Core Assessment is completed, the therapist will shift to working on the treatment modalities identified in the first session to target and treat the patient-defined suicidal drivers. They are then essentially engaging in a standard therapy session with the focus on treating the patient-defined drivers of their suicidality.

D. When there is about 10-15 minutes remaining in the interim session, the therapist should shift to checking in about the utility of the CAMS Stabilization Plan (if not done earlier) and then update and complete the CAMS Treatment Plan (Section B). The patient should enter the same information on the patient's version of the SSF; the therapist version of the SSF is always entered into the patient's medical record. Both parties should check with each other to make sure the information on each of their forms is always accurate and identical.

E. The patient and therapist each sign the forms in their possession and copies of the clinician's form are scanned into the patient's medical record. The patient will retain and can refer to their copy of the interim SSF's as treatment proceeds.

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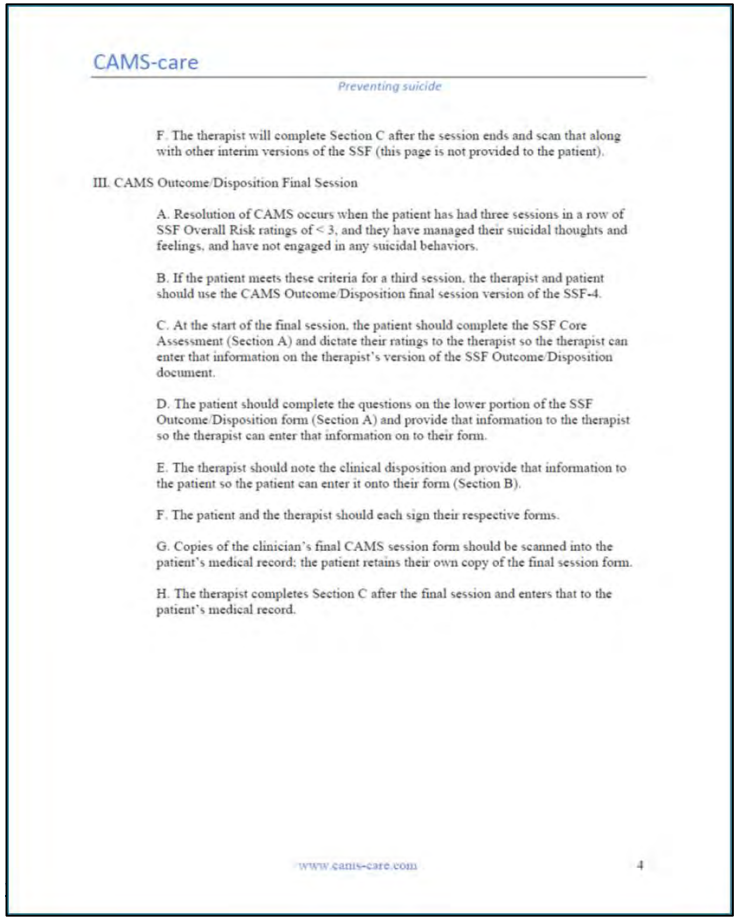
Key Points

- 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



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F. The therapist will complete Section C after the session ends and scan that along with other interim versions of the SSF (this page is not provided to the patient).

III. CAMS Outcome/Disposition Final Session

A. Resolution of CAMS occurs when the patient has had three sessions in a row of SSF Overall Risk ratings of < 3, and they have managed their suicidal thoughts and feelings, and have not engaged in any suicidal behaviors.

B. If the patient meets these criteria for a third session, the therapist and patient should use the CAMS Outcome/Disposition final session version of the SSF-4.

C. At the start of the final session, the patient should complete the SSF Core Assessment (Section A) and dictate their ratings to the therapist so the therapist can enter that information on the therapist's version of the SSF Outcome/Disposition document.

D. The patient should complete the questions on the lower portion of the SSF Outcome/Disposition form (Section A) and provide that information to the therapist so the therapist can enter that information on to their form.

E. The therapist should note the clinical disposition and provide that information to the patient so the patient can enter it onto their form (Section B).

F. The patient and the therapist should each sign their respective forms.

G. Copies of the clinician's final CAMS session form should be scanned into the patient's medical record; the patient retains their own copy of the final session form.

H. The therapist completes Section C after the final session and enters that to the patient's medical record.

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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

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
- Write 3rd edition of *Managing Suicidal Risk: A Collaborative Approach* (2021-2022)

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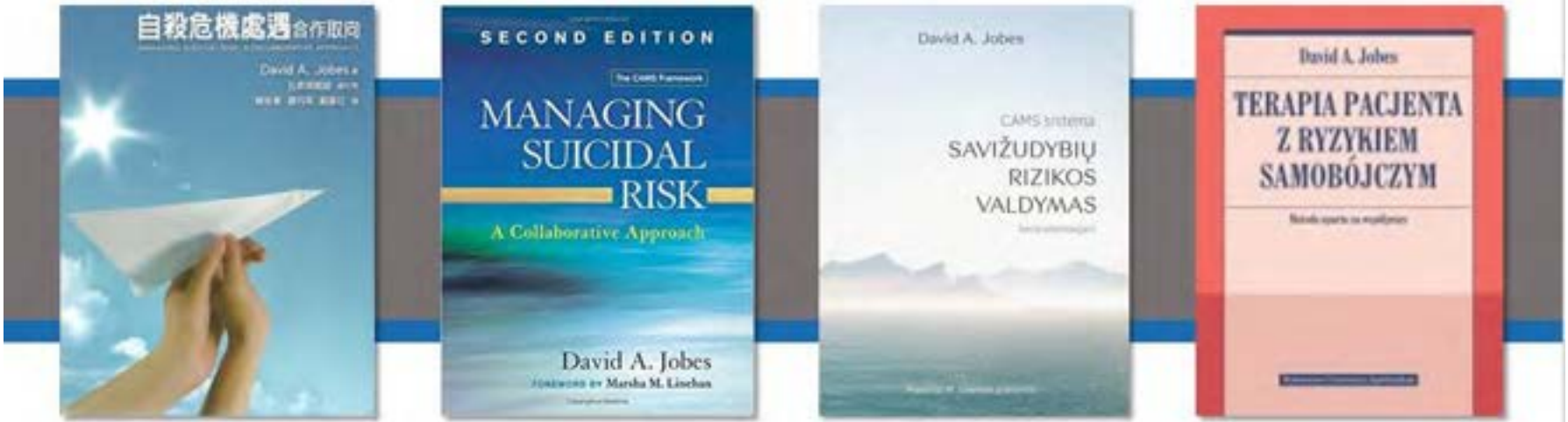
Preventing Suicide

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


Panasonic
SMITH,JOE
1-222-333-4444
Bluetooth
CELL
VOL


Geoff Waters
Aerolabs, Inc.
HM
Harry McAllister
Aerolabs, Inc
JP
Jennifer Peters
Aerolabs, Inc
James Keller
Aerolabs, Inc.
San Francisco
Adeline Bowers
Aerolabs, Inc.

Do No Harm

Brief Survey: Personal Experiences with Suicide

bit.ly/SuicideExp

Or

surveymonkey.com/r/SuiExp


ZEROSuicide
IN HEALTH AND BEHAVIORAL HEALTH CARE

Recommended Standard Care for People with Suicide Ris

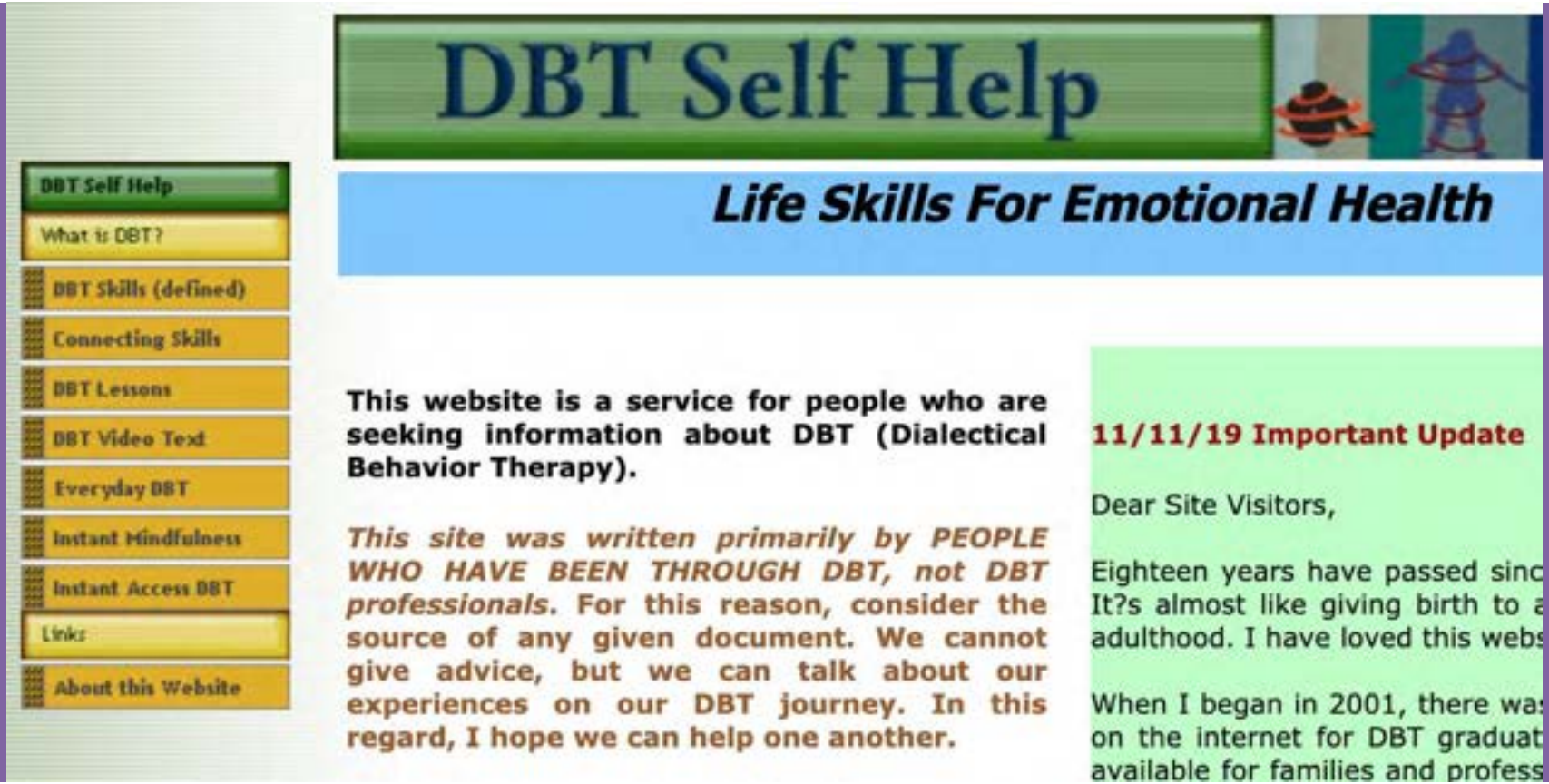
MAKING HEALTH CA

A Care Pathway

NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

Two Themes

1. Service Providers feel powerless
2. Patients find simple things helpful


DBT Self Help
Life Skills For Emotional Health
DBT Self Help
What is DBT?
DBT Skills (defined)
Connecting Skills
DBT Lessons
DBT Video Text
Everyday DBT
Instant Mindfulness
Instant Access DBT
Links
About this Website
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 sinc
It?s almost like giving birth to a
adulthood. I have loved this webs
When I began in 2001, there wa
on the internet for DBT graduat
available for families and profess

DBT SKILLS

DBT Skills with support works!

Linehan, M. M., et al. (2015). *Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: a randomized clinical trial and component analysis.*
JAMA Psychiatry, 72(5), 475-482.

NowMattersNow.org

Free Evidence-Based Resource

Videos, Downloadables, Training, Crisis Lines

This paper is in the following e-collection/theme issue:

Web-based and Mobile Health Interventions Behavior Change Depression and Mood Disorders: Suicide Prevention

Original Paper

Development and Evaluation of a Web-Based Resource for Suicidal Thoughts: NowMattersNow.org

Ursula Whiteside[1,2], MS, PhD ; Julie Richards[3,4], MPH ; David Huh[2,5], PhD ; Rianna Hidalgo[1,6], BA ; Rebecca Nordhauser[1], MS ; Albert J Wong[1], BS ; Xiaoshan Zhang[1], MS ; David D Luxton[1,2], PhD ; Michael Ellsworth[7], BA ; DeQuincy Lezine[1,8], PhD

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Downloa

NowMattersNow.org Data

One-Third of Visitors Reporting Suicidal Thoughts Reported Less Intense Suicidal Thoughts In Under 10 minutes

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

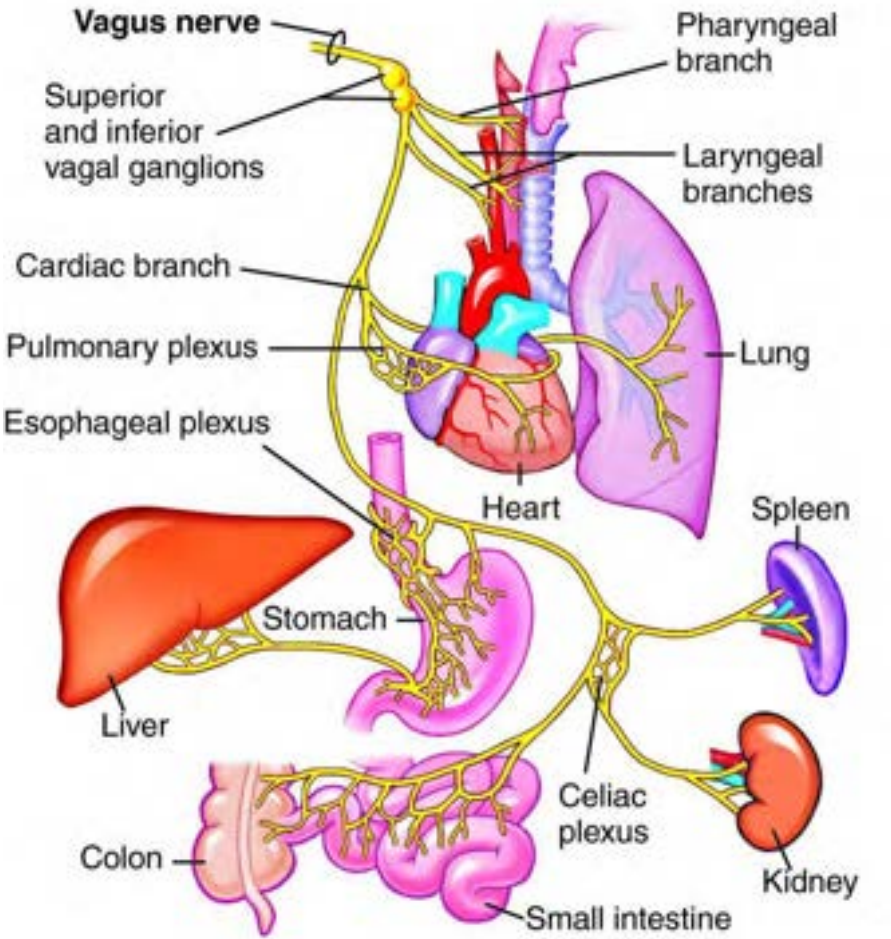
Do you know what to do in an emotional emergency? How do you survive a full on crisis?

Being “On Fire” Emotionally

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*

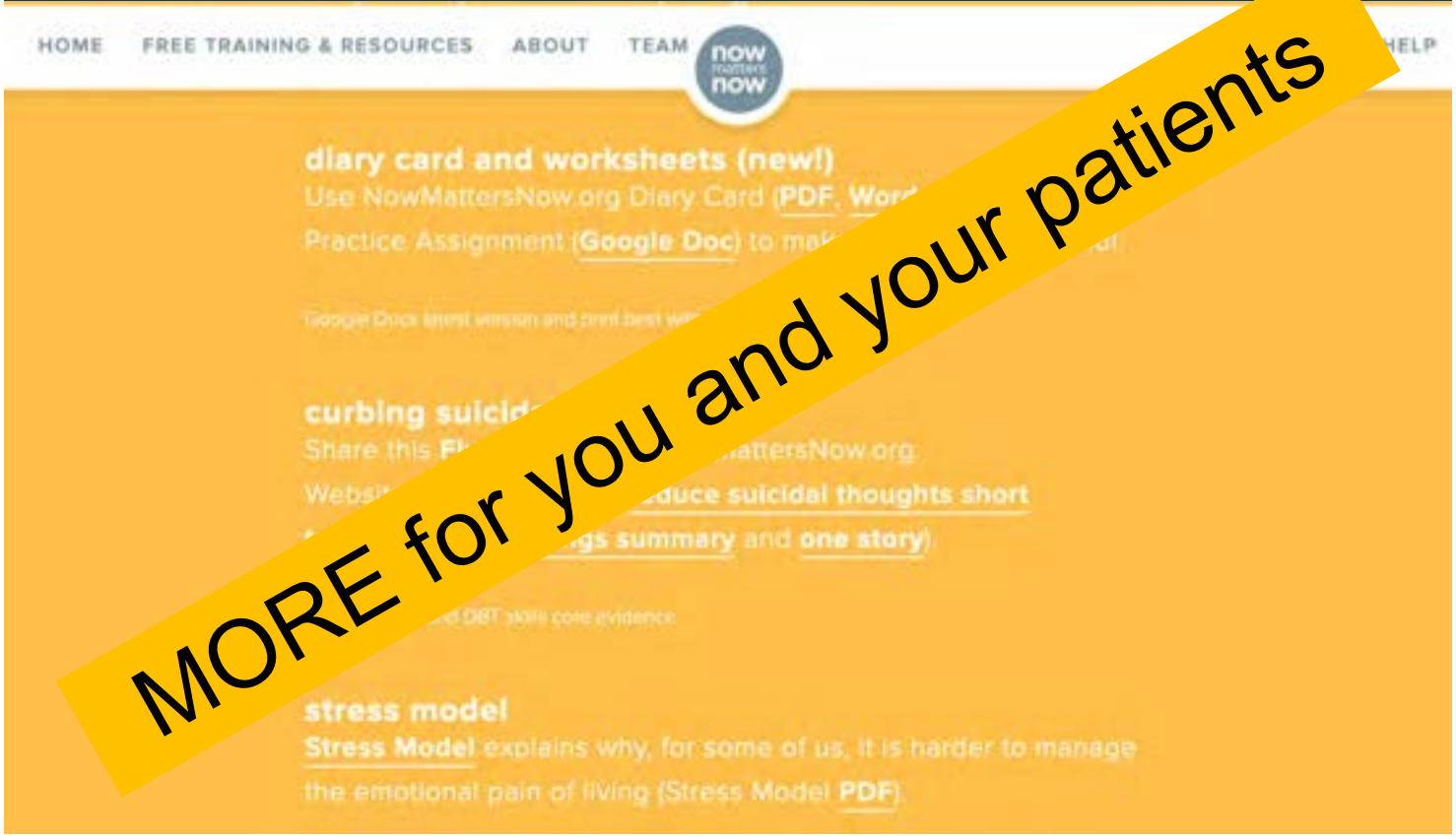

Vagus nerve
Superior and inferior vagal ganglions
Pharyngeal branch
Laryngeal branches
Cardiac branch
Pulmonary plexus
Lung
Esophageal plexus
Heart
Spleen
Stomach
Liver
Celiac plexus
Kidney
Colon
Small intestine

Important Concepts

- Mammalian Dive Response
- Vagal or Vagus Nerve
- “Cycle the Power”

Cold Water

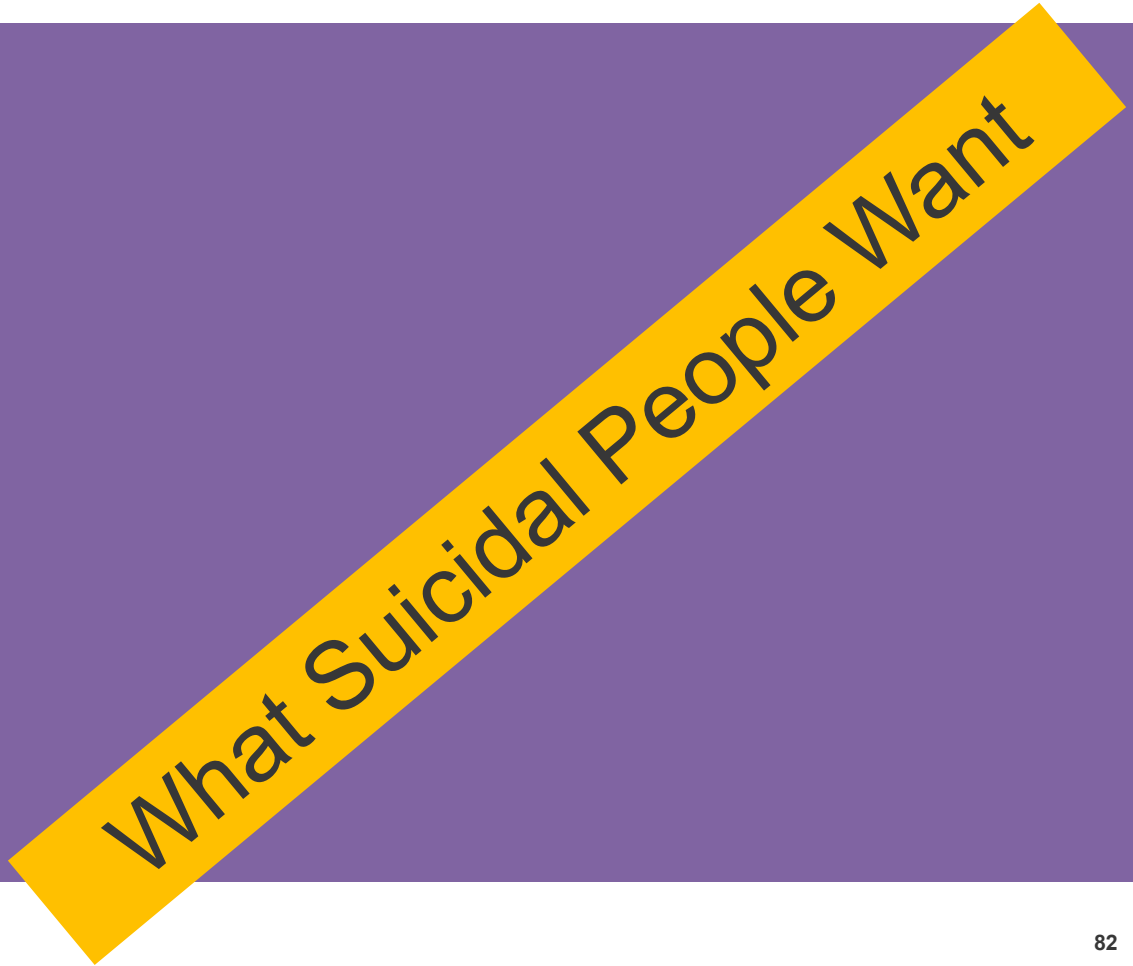
Free Training and Resources



MORE for you and your patients

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.

Suicide Prevention Resource Center

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

Suicide Prevention Resource Center

Thank you for joining this webinar.