Webinar Tips for Attendees

Please review our webinar guidelines for frequently asked questions:

Our webinar presentation (and audio) will begin promptly at 2pm ET.
Suicidal Risk and Telepsychology:
From Supportive Resources to Clinical Treatment

David A. Jobes, PhD, ABPP

The Catholic University of America
Department of Psychology
Washington, DC

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Attendees Earn One Continuing Education Credit
The National Register is approved by the American Psychological Association to sponsor continuing education for psychologists.
The National Register maintains responsibility for this program and its content.
Dr. David Jobes is a Professor of Psychology, Director of the Suicide Prevention Laboratory, and Associate Director of Clinical Training at The Catholic University of America. He has published six books and numerous peer-reviewed journal articles. Dr. Jobes is a past President of the American Association of Suicidology (AAS) and is now a Board Member of the American Foundation for Suicide Prevention (AFSP) and serves on AFSP’s Scientific Council and the Public Policy Council. He is a Fellow of the American Psychological Association and is Board certified in clinical psychology (American Board of Professional Psychology).
Disclosures/Conflicts of Interest

• CAMS-related research supported by NIMH and AFSP grants

• Book royalties from APA Press and Guilford Press

• Founder/Partner, CAMS-care, LLC (a professional training and consultation company)
References/Citations


Learning Objectives

1. Describe the challenges of providing telehealth care to suicidal patients—from both a legal and ethical standpoint.

2. Utilize various online and other resources for support and self-soothing to help stabilize suicidal people.

3. Demonstrate a suicide-focused, evidence-based treatment framework that can be used to effectively treat suicidal risk within a telepsychology modality.
The Suicide Problem in the United States

50 Years Addressing Leading Causes of Death

Proportion Changes in Death Rates from 1968

48,344 deaths per year in the U.S. (2018)

The “iceberg” of serious suicidal ideation...

According to the Substance Abuse and Mental Health Serv-
ces Administration (SAMHSA) in the United States, 13.1
million American adults have serious thoughts of ending
their lives by suicide each year (SAMHSA, 2020). In the
same year, we further know that 1.4 million American
adults attempted suicide while approximately 47,000
acts of all ages died by suicide (Surgeon General & Mc
Cracken, 2010). While school-based and public health
efforts are dedicated to helping prevent and mitigate
suicidal ideation and attempts, we have too often failed to
reach those with suicidal ideation who are too often
enough the focused attention of their families, schools,
and the mental health community. Upon reflection, the
prevalence of suicidal ideation is truly frightening suf-
ing 2.47 million Americans experiences thoughts of
ending their lives is more than the population of the US
state of New Hampshire. Even on an international perspec-
tive, the numbers are staggering in light of the size of
the mental health community.

In scalable prevention strategies, we understand the
impact of observable suicidal ideation with implications
for morbidity and mortality. However, the morbidity
of suicidal ideation should not be underestimated. As a
broad concept, suicidal ideation might be a source of
epidemic, and often fatal, concern. The proportion of
people who experience serious suicidal thoughts ex-
eracts the larger scale of the suicidal ideation before the
face of the world. Suicide deaths and attempts represent
the tip of the iceberg, a problem that has not been
recognized, or even an issue that people understand
enough to do something about. The definition of suicidal ideation offered by the Centers
for Disease Control and Prevention in the United States
defined, “suicide ideation” is the belief that suicide is
either a source of current crisis or a strategy to
endover-rationalizing. In other words, ideation is the
expression of a phenomenon that is inclusive, but
not restricted to specific plans or an explicit intent to
take action. According to the research, about 10% of
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Critiques of Clinical Care for Suicidal Risk

1) Proper informed consent
2) Evidence-based assessment
3) Evidence-based treatment
4) Appropriate risk-management

An over-reliance on medications and hospitalizations...
Overview to Clinical Suicidology (with Telehealth Implications)

Management of Suicidal Risk

Treatment of Suicidal Risk
COVID-19 (SARS-CoV-2): Global pandemic of this novel coronavirus
New pandemic-driven demands on mental health

- Public health measures for the COVID-19 pandemic requires physical distancing and isolation to flatten the curve of viral spread.

- Perforce telepsychology (telehealth, telepsychotherapy, telemedicine, etc.) has become an important vehicle for the provision of all health care (mental health).

- While telepsychology has grown in recent years, guidelines recommended caution about using this modality with suicidal patients.

- The pandemic is requiring us to find ways to safely work with suicidal patients.

- There is a new ethical dilemma about sending a suicidal patient to the emergency department and inpatient psychiatric care during the pandemic.
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
Guidance on the use of telehealth with suicidal risk

Three different perspectives on telehealth and on-line responses to suicide risk during the COVID-19 pandemic

**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

**Presenter: Dr. Ursula Whiteside**

Ursula Whiteside, PhD
CEO, NowMattersNow.org
Clinical Faculty, University of Washington

**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

Suicide Crisis management

Self-help for suicidal risk

Treatment of suicidal risk
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 (e.g., 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.
### Suicidal Crisis Stabilization Planning

#### SAFETY PLAN: VA VERSION

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<th>Step 1: Warning signs:</th>
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<tbody>
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<td>2.</td>
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<thead>
<tr>
<th>Step 2: Internal coping strategies - Things I can do to take my mind off suicidal thoughts without contacting another person:</th>
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<tr>
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<tr>
<th>Step 3: People and social settings that provide distraction:</th>
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<tbody>
<tr>
<td>1. Name ___________________________ Phone ___________________</td>
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<tr>
<td>2. Name ___________________________ Phone ___________________</td>
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<tr>
<td>3. Place ___________________________ Phone ___________________</td>
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<tr>
<th>Step 4: People where I can ask for help:</th>
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<tbody>
<tr>
<td>1. Name ___________________________ Phone ___________________</td>
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<tr>
<td>2. Name ___________________________ Phone ___________________</td>
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<th>Step 5: Professionals or agencies I can contact during a crisis:</th>
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<tr>
<td>1. Clinician Name ___________________________ Phone ____________</td>
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<tr>
<td>2. Clinician Name ___________________________ Phone ____________</td>
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<tr>
<td>3. Clinical Pager or Emergency Contact ___________________________ Phone ____________</td>
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<tr>
<td>4. Local Urgent Care Services ___________________________ Address ___________________________________ Phone ____________</td>
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<tr>
<td>5. VA Suicide Prevention Resource Coordinator Name: ____________ Phone ____________</td>
</tr>
<tr>
<td>6. VA Suicide Prevention Resource Coordinator Phone: ____________</td>
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<th>Step 6: Making the environment safe:</th>
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**Warning Signs:** pacing, feeling irritable, thinking it might be better to end it all.

- Go for a walk 10 mins
- Watch Friends episodes
- Play with my dog
- Think about my kids - vacation to beach in Florida - Christmas Day 2012
- Call/text my Mom or Jennifer
- Call Dr. Brown: 555-555-5555 - leave msg w/ name, time, phone #
- 1-800-273-TALK
- Go to hospital
- Call 911
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.
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.
Resources

- Barbara Stanley’s email for further information: bhs2@cumc.Columbia.edu
- www.suicidesafetyplan.com
- References:
DBT Skills that can be obtained on-line
(Ursula Whiteside, Ph.D. & Shireen Rizvi, Ph.D.)
Dr. Ursula Whiteside: Now Matters Now

https://www.nowmattersnow.org/
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?")
- Mammalian Dive Response
- Vagal or Vagus Nerve
- "Cycle the Power"

**Cold Water**

**Free Training and Resources**

- Diary card and worksheets (new)
  - Use NowMattersNow.org Diary Card (PDF)
  - Weekly Practice Assignment (Google Doc) to track progress

- Curbing suicidal thoughts short 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)
https://www.youtube.com/watch?v=seKJvjCiT4w
Lived-Experience Peer-Based Support

https://www.nowmattersnow.org/

https://livethroughthis.org/

And the power of using technology to reach more suicidal people at risk...

https://livedexp.academy/
Effective treatments for suicide attempters

- Dialectical Behavior Therapy (DBT)

- Cognitive Therapy for Suicide Prevention (CT-SP)

- Brief Cognitive Behavior Therapy (BCBT)
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

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<th>Design &amp; Method</th>
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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—1900+ free downloads...
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 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
Telehealth Use of CAMS Case Example: EKU Psychology Clinic (Melinda Moore, Ph.D.)

80 active therapy cases
20 CAMS cases/12 CAMS clinicians
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
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

- Crisis Text Line: Text HOME to 741741

- TrevorLifeline: 866-488-7386

- Providing Suicide Care During COVID-19: http://zerosuicide.edc.org/covid-19

- Dr. Donald Meichenbaum’s *Roadmap to Resilience*: https://roadmappresilience.wordpress.com/

- CAMS-care, LLC: https://cams-care.com/
Questions & Answers

• Dr. Sammons will ask Dr. Jobes to select questions that were submitted via the Q&A feature throughout the presentation.

• Due to time constraints, we will not be able to address every question asked.