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NATIONAL REGISTER OF HEALTH SERVICE PSYCHOLOGISTS

CLINICAL WEBINARS
FOR HEALTH SERVICE PSYCHOLOGISTS

TRANSLATING RESEARCH TO PRACTICE

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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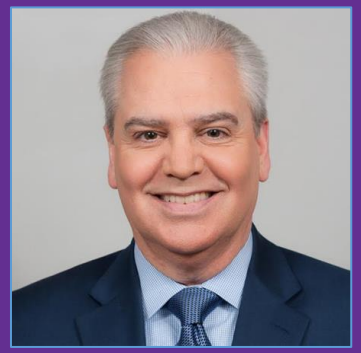

David A. Jobes, Ph.D., ABPP

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).

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Disclosures/Conflicts of Interest

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- Book royalties from APA Press and Guilford Press
- Founder/Partner, CAMS-care, LLC (a professional training and consultation company)

References/Citations

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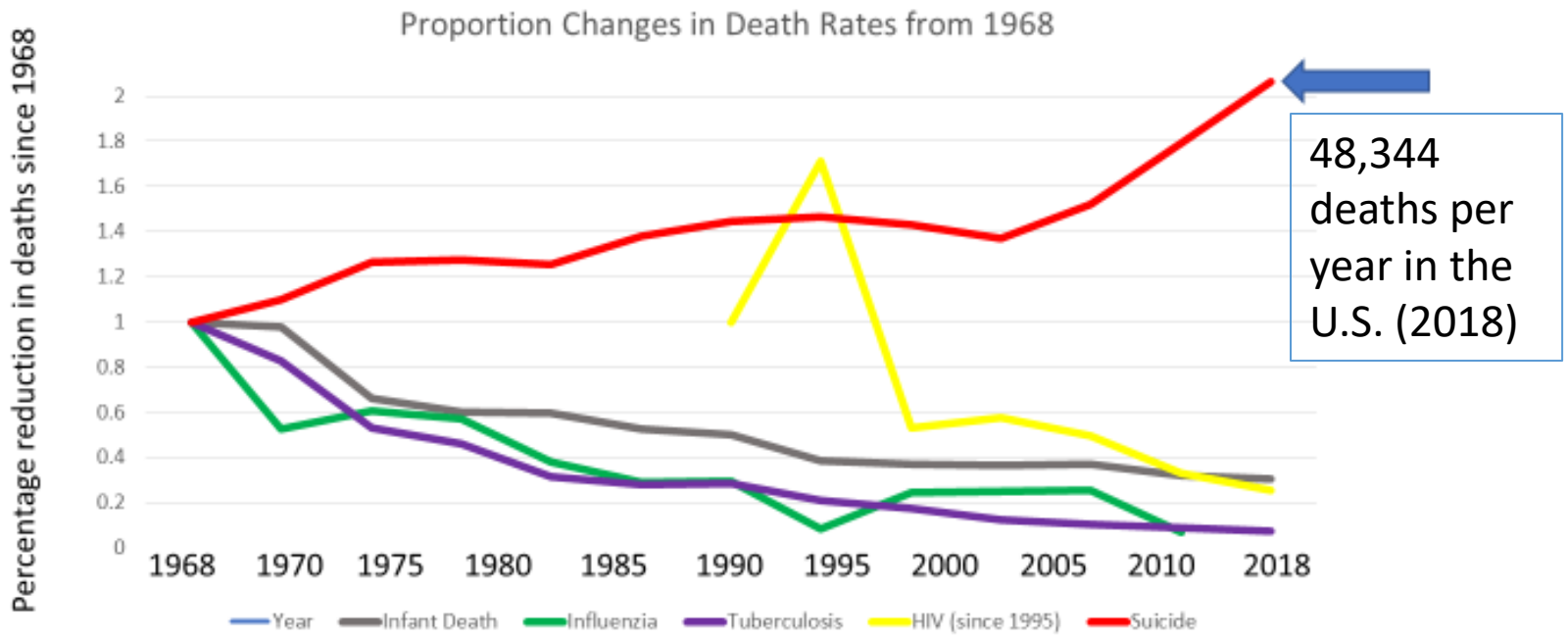
Learning Objectives

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

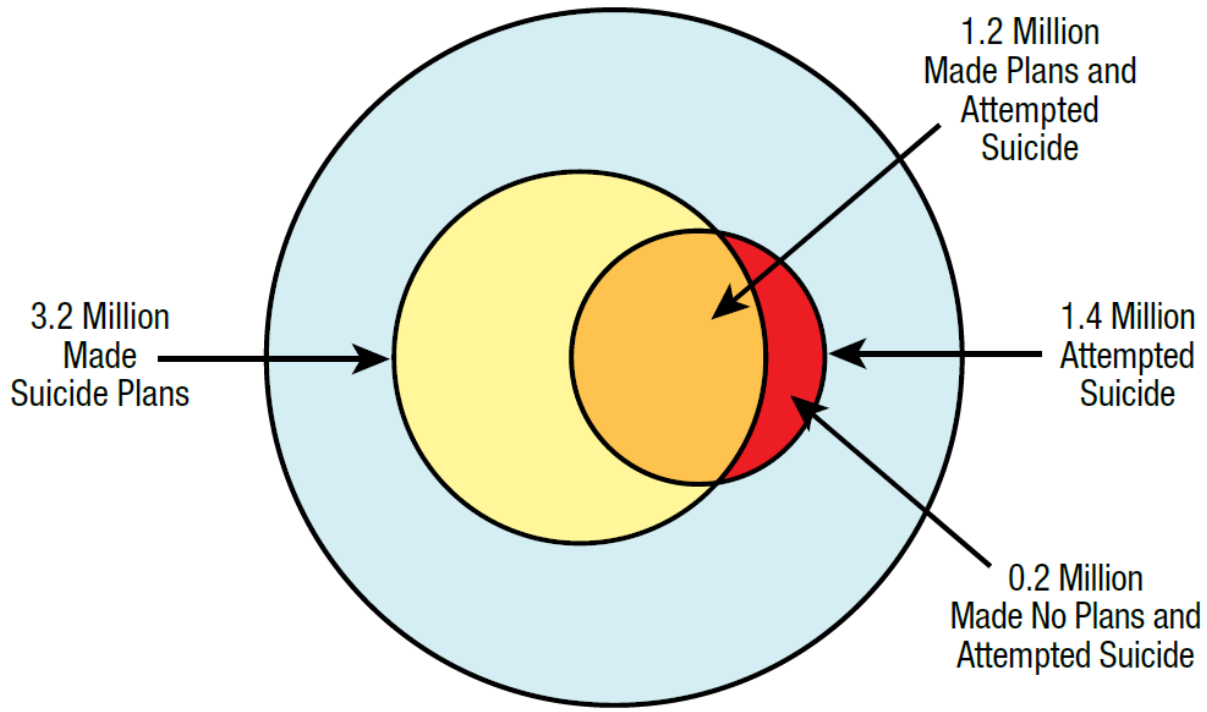
50 Years Addressing Leading Causes of Death



Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1968-2016 on CDC WONDER Online Database, released June 2017. Data are from the Compressed Mortality File 1999-2016 Series 20 No. 2U, 2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/cmf-icd10.html on Nov 10, 2019 7:07:31 PM

The “iceberg” of *serious* suicidal ideation…

Figure 58. Suicidal Thoughts, Plans, and Attempts in the Past Year among Adults Aged 18 or Older: Numbers in Millions, 2017



10.6 Million Adults Had Serious Thoughts of Committing Suicide

Editorial

Reflections on Suicidal Ideation

David A. Jobes[1] and Thomas E. Joiner[2]

[1]Department of Psychology, The Catholic University of America, Washington, DC, USA
[2]Department of Psychology, Florida State University, Tallahassee, FL, USA

According to the Substance Abuse and Mental Health Service Administration (SAMHSA) in the United States, 10.6 million American adults have serious thoughts of ending their lives by suicide each year (SAMHSA, 2018). In that same year, we further know that 1.4 million American adults attempted suicide while approximately 47,000 across all ages died by suicide (Drapeau & McIntosh, 2018). While suicidologists and public health officials are understandably preoccupied with suicides and suicide attempts, we have recently begun to reflect on those with suicidal ideation who too often escape the focused attention of our suicide prevention research, clinical treatments, and even national health-care policies. Upon reflection, the prevalence of suicidal ideation in the United States is truly staggering: 10,600,000 people experiencing thoughts of ending their lives is more than the population of the US state of Georgia. From an international perspective, this figure is roughly the size of the population of the Czech Republic.

As suicide prevention researchers, we understand the appeal of observable suicidal *behaviors* with implications for morbidity and mortality. However, the morbidity of suicidal ideation should not be underestimated. As a focus of research, suicidal ideation tends to be a more elusive, ephemeral, and often fluid construct. But the proportion of people who experience serious suicidal thoughts represents the larger mass of the suicide iceberg below the surface of the water. Suicide deaths and attempts represent the tip of this iceberg, which is dwarfed by the much larger problem, at least with regard to numbers, of all the people beneath the surface who are experiencing suicidal misery, often in silence.

The definition of suicidal ideation offered by the Centers for Disease Control and Prevention in the United States (Crosby, Ortega, & Melanson, 2011), echoing the US National Strategy for Suicide Prevention, is: “...Thoughts of engaging in suicide-related behavior.” This is an appropriately broad definition for a phenomenon that includes, but is not limited to, specific plans to die and explicit intent to die imminently. As we argue here, all aspects of suicidal ideation deserve attention; these two specific instances certainly do, since they signal imminent danger for self-inflicted death.

In a meta-analysis conducted by Franklin and colleagues (2017), the number-one risk factor for future episodes of suicidal ideation was prior suicidal ideation. While this finding is unsurprising, it highlights the recurrent and chronic nature of suicidal ideation, and underscores key aspects of its morbidity. In terms of predicting death by suicide, the same meta-analysis found that suicidal ideation was the third most potent predictor of future death by suicide, behind only prior psychiatric hospitalizations and prior suicide attempts. It should be added that in the Franklin et al. meta-analysis, all predictors were relatively weak (e.g., odds ratios between approximately 2 and 4, even for those in the top five). It is important to note that prior psychiatric hospitalizations were the leading predictor of later suicide death; notably, suicide ideation is one of the most common reasons for hospitalizations (e.g., Bowers, 2005). The same logic can be applied to risk for suicide attempt in the Franklin et al. meta-analysis; suicidal ideation was not among the top five predictors of future attempt, but psychiatric hospitalizations were. Again, hospitalizations are often prompted by suicidal ideation.

It is peculiar, upon reflection, to in any way diminish an ideational morbidity. Behavioral morbidity deserves its due. But ideational morbidity is a regular emphasis in mental health, regarding, for example, worry in generalized anxiety disorder, obsessions in obsessive-compulsive disorder, grandiosity in the manic phase of bipolar conditions, and delusions in psychotic disorders. One may counter that these ideational factors have behavioral consequences, to which we reply that so do suicidal ideational factors.

Some believe that suicidal behavior can occur in the absence of prior ideation. We are skeptical, for at least two reasons. First, it is not at all clear that those who attempt suicide, survive, and are then queried about their prior

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Critiques of Clinical Care for Suicidal Risk

FOCUS ON ETHICS
Jeffrey E. Barnett, Editor

Ethical and Competent Care of Suicidal Patients: Contemporary Challenges, New Developments, and Considerations for Clinical Practice

David A. Jobes
The Catholic University of America

M. David Rudd
Texas Tech University

James C. Overholser
Case Western Reserve University

Thomas E. Joiner Jr.
Florida State University

Clinical work with suicidal patients has become increasingly challenging in recent years. It is argued that contemporary issues related to working with suicidal patients have come to pose a number of considerable professional and even ethical hazards for psychologists. Among various concerns, these challenges include providing sufficient informed consent, performing competent assessments of suicidal risk, using empirically supported treatments/interventions, and using suitable risk management techniques. In summary, there are many complicated clinical issues related to suicide (e.g., improvements in the standard of care, resistance to changing practices, alterations to models of health care delivery, the role of research, and issues of diversity). Three experts comment on these considerations, emphasizing acute versus chronic suicide risk, the integration of empirical findings, effective documentation, graduate training, maintaining professional competence, perceptions of medical versus mental health care, fears of dealing with suicide risk, suicide myths, and stigma/blame related to suicide. The authors' intention is to raise awareness about various suicide-related ethical concerns. By increasing this awareness, they hope to compel psychologists to improve their clinical practices with suicidal patients, thereby helping to save lives.

Keywords: suicide, informed consent, risk assessment, treatment, risk management

Clinical Work With Suicidal Patients: Emerging Ethical Issues and Professional Challenges

David A. Jobes

Clinical work with suicidal patients is fraught with professional challenges. Some of these challenges include psychologists' inability to predict behaviors with low base rates (such as suicide attempts and completions), the decision to commit a person to an inpatient setting, intense countertransference issues, and the potential life-or-death implications of treatment (Jobes & Berman, 1993; Jobes & Mahlsberger, 1995; Maltsberger & Buie, 1974). Although these concerns continue, additional challenges have recently emerged, which make providing this care even thornier. In this article, I examine various present-day issues that clinicians face with suicidal patients, with an eye to ultimately enhancing the ethical and effective clinical care of suicidal patients. The following fictitious cases capture a sampling of current concerns.

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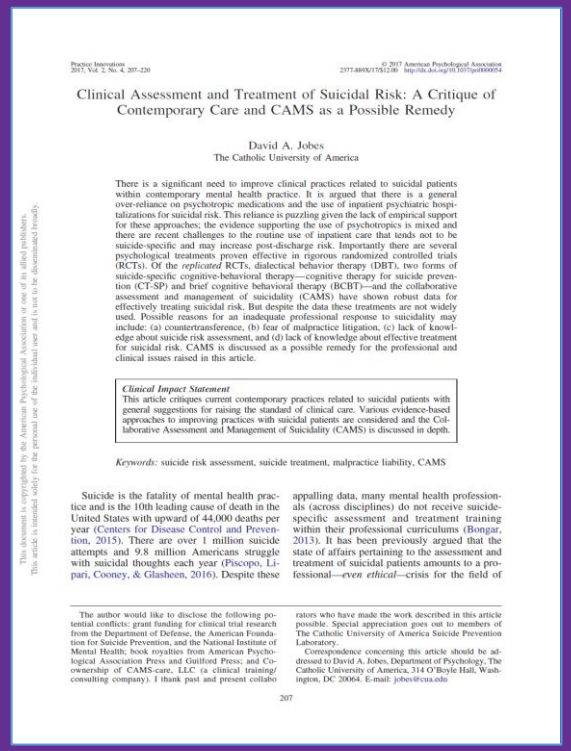
0735-7028/08/$12.00 DOI: 10.1037/a0012896



Practice Innovations
2017, Vol. 2, No. 4, 207–220

2377-8893/17/$12.00 http://dx.doi.org/10.1037/pri0000054

Clinical Assessment and Treatment of Suicidal Risk: A Critique of Contemporary Care and CAMS as a Possible Remedy

David A. Jobes
The Catholic University of America

There is a significant need to improve clinical practices related to suicidal patients within contemporary mental health practice. It is argued that there is a general over-reliance on psychotropic medications and the use of inpatient psychiatric hospitalizations for suicidal risk. This reliance is puzzling given the lack of empirical support for these approaches; the evidence supporting the use of psychotropics is mixed and there are recent challenges to the routine use of inpatient care that tends not to be suicide-specific and may increase post-discharge risk. Importantly there are several psychological treatments proven effective in rigorous randomized controlled trials (RCTs). Of the *replicated* RCTs, dialectical behavior therapy (DBT), two forms of suicide-specific cognitive-behavioral therapy—cognitive therapy for suicide prevention (CT-SP) and brief cognitive behavioral therapy (BCBT)—and the collaborative assessment and management of suicidality (CAMS) have shown robust data for effectively treating suicidal risk. But despite the data these treatments are not widely used. Possible reasons for an inadequate professional response to suicidality may include: (a) countertransference, (b) fear of malpractice litigation, (c) lack of knowledge about suicide risk assessment, and (d) lack of knowledge about effective treatment for suicidal risk. CAMS is discussed as a possible remedy for the professional and clinical issues raised in this article.

Clinical Impact Statement
This article critiques current contemporary practices related to suicidal patients with general suggestions for raising the standard of clinical care. Various evidence-based approaches to improving practices with suicidal patients are considered and the Collaborative Assessment and Management of Suicidality (CAMS) is discussed in depth.

Keywords: suicide risk assessment, suicide treatment, malpractice liability, CAMS

Suicide is the fatality of mental health practice and is the 10th leading cause of death in the United States with upward of 44,000 deaths per year (Centers for Disease Control and Prevention, 2015). There are over 1 million suicide attempts and 9.8 million Americans struggle with suicidal thoughts each year (Piscopo, Lipari, Cooney, & Glasheen, 2016). Despite these appalling data, many mental health professionals (across disciplines) do not receive suicide-specific assessment and treatment training within their professional curriculums (Bongar, 2013). It has been previously argued that the state of affairs pertaining to the assessment and treatment of suicidal patients amounts to a professional—*even ethical*—crisis for the field of

The author would like to disclose the following potential conflicts: grant funding for clinical trial research from the Department of Defense, the American Foundation for Suicide Prevention, and the National Institute of Mental Health; book royalties from American Psychological Association Press and Guilford Press; and Co-ownership of CAMS-care, LLC (a clinical training/consulting company). I thank past and present collaborators who have made the work described in this article possible. Special appreciation goes out to members of The Catholic University of America Suicide Prevention Laboratory.

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1) Countertransference
2) Fears of malpractice
3) Effective assessment
4) Effective treatment

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

An over-reliance on medications and hospitalizations…

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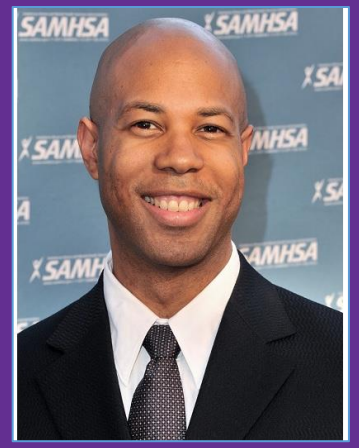
Overview to Clinical Suicidology (with Telehealth Implications)

Management of Suicidal Risk

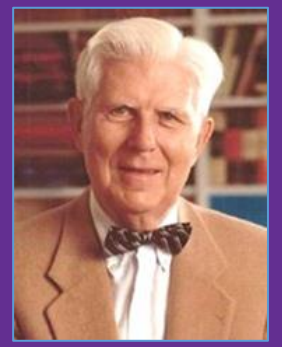


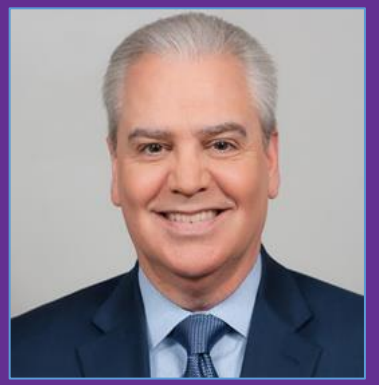


Treatment of Suicidal Risk





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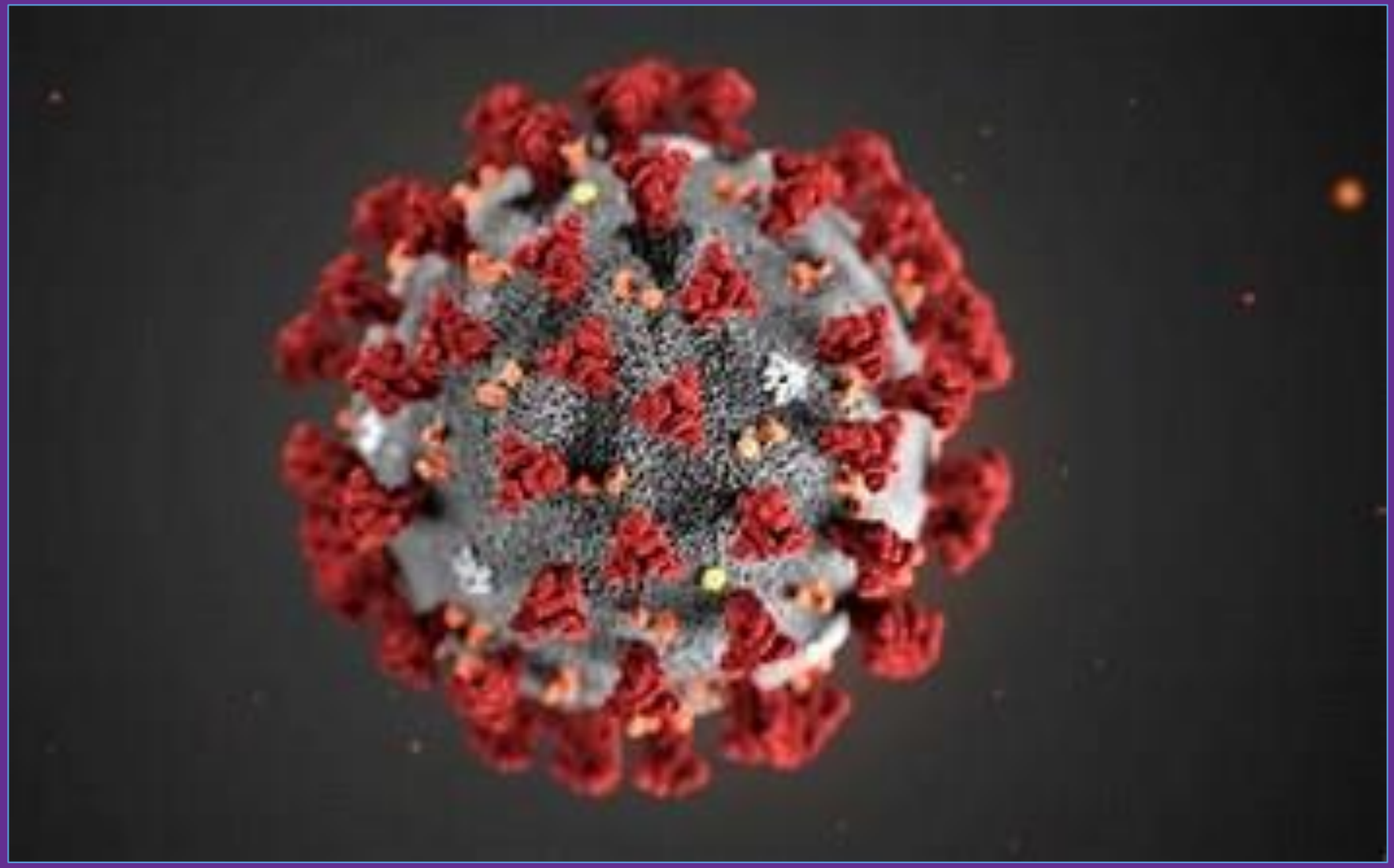
COVID-19 (SARS-CoV-2): Global pandemic of this novel coronavirus



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.

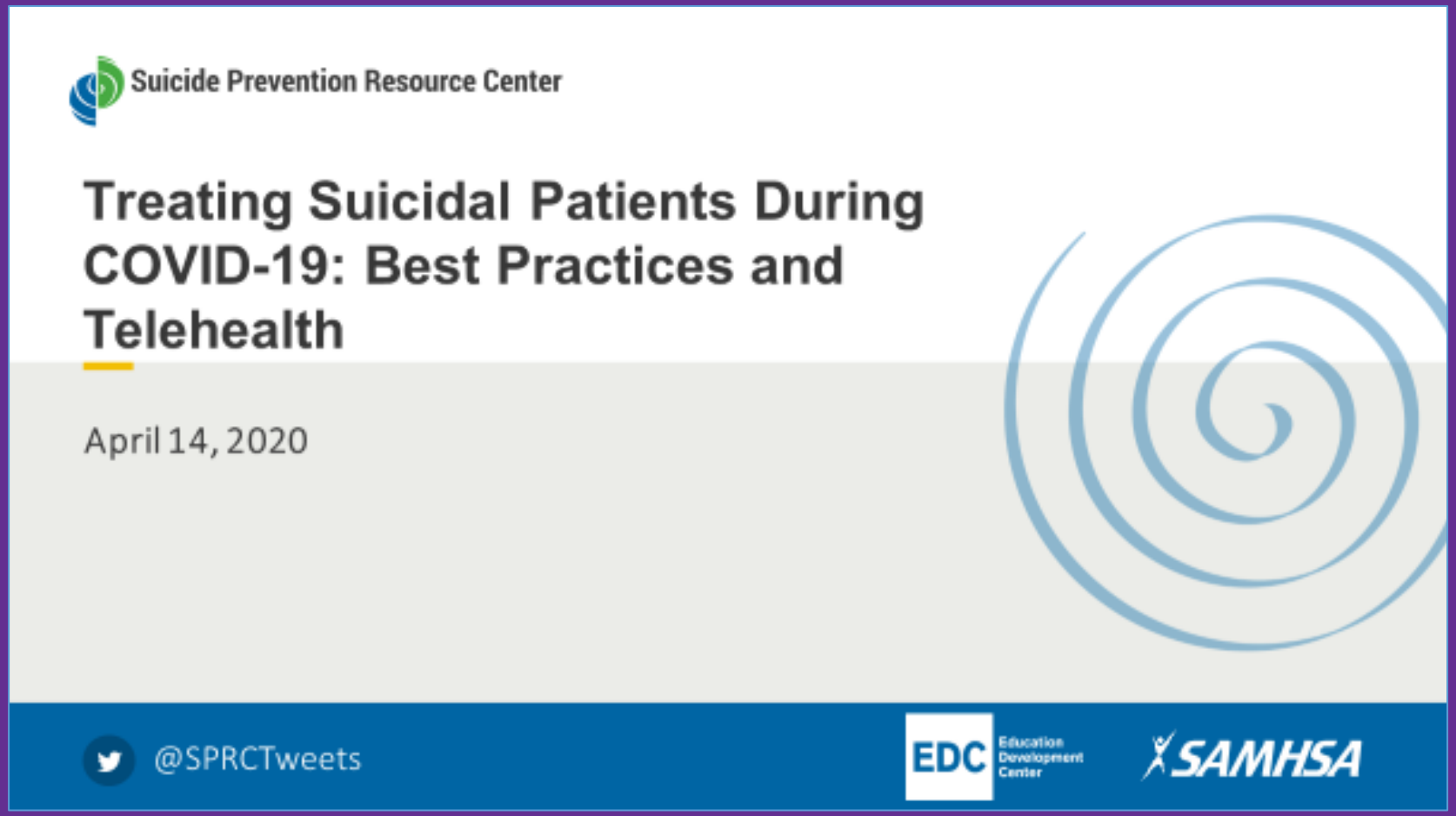
What is Telepsychology?

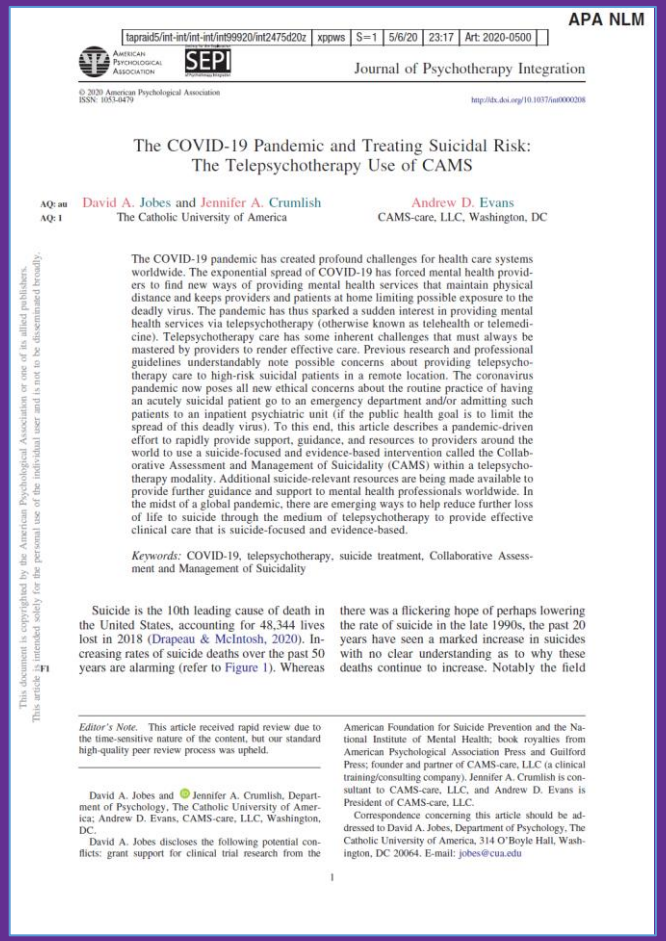
- Telepsychology is broadly defined and includes the provision of psychological services using the full range of telecommunications technologies of different types
- Includes: telephones, mobile devices, videoconferencing, email, chat, text, and use of the internet (blogs, websites, and self-help)
- 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





http://www.sprc.org/events-trainings/treating-suicidal-patients-during-covid-19-best-practices-telehealth

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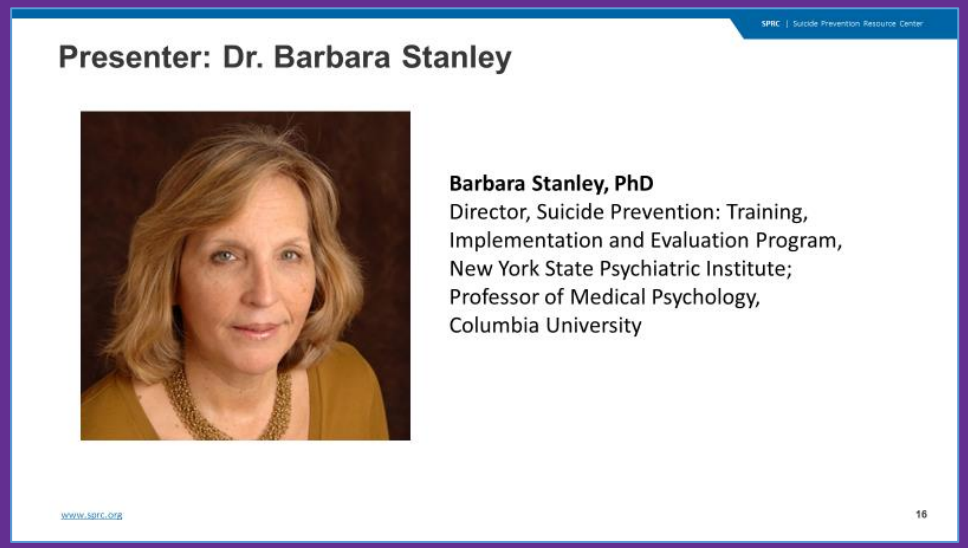
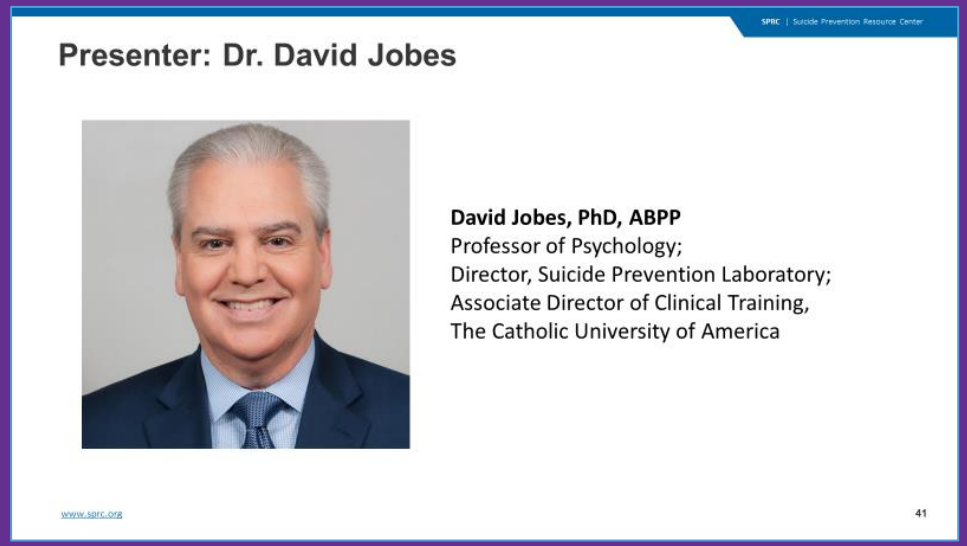
Three different perspectives on telehealth and on-line responses to suicide risk during the COVID-19 pandemic



Suicide Crisis management

Self-help for suicidal risk



Treatment of suicidal risk

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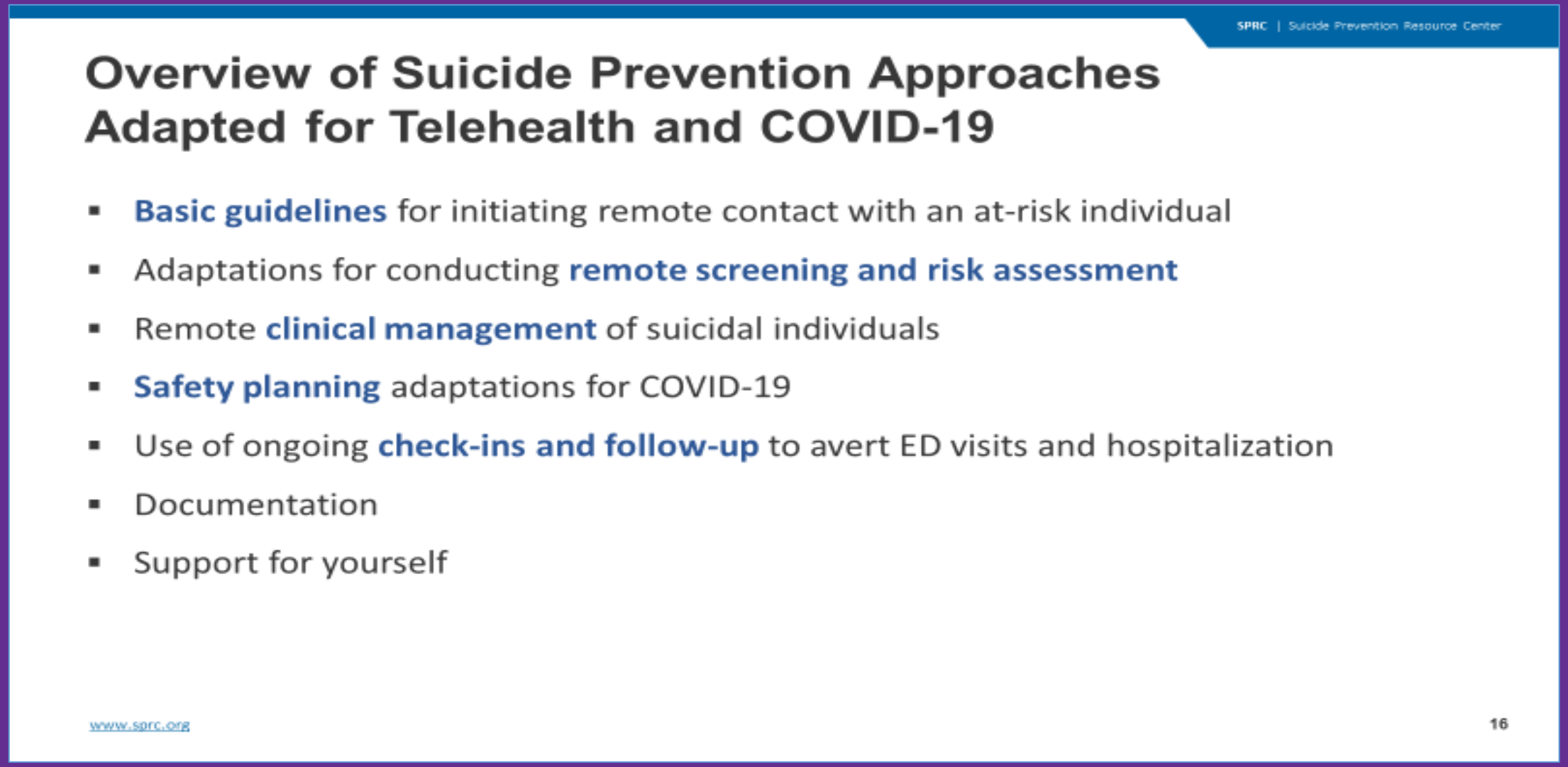
Suicide Crisis Management (Barbara Stanley, Ph.D.)



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.

Screening for Suicidal Risk

Lisa Horowitz, Ph.D., M.P.H.
NIMH Staff Scientist

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

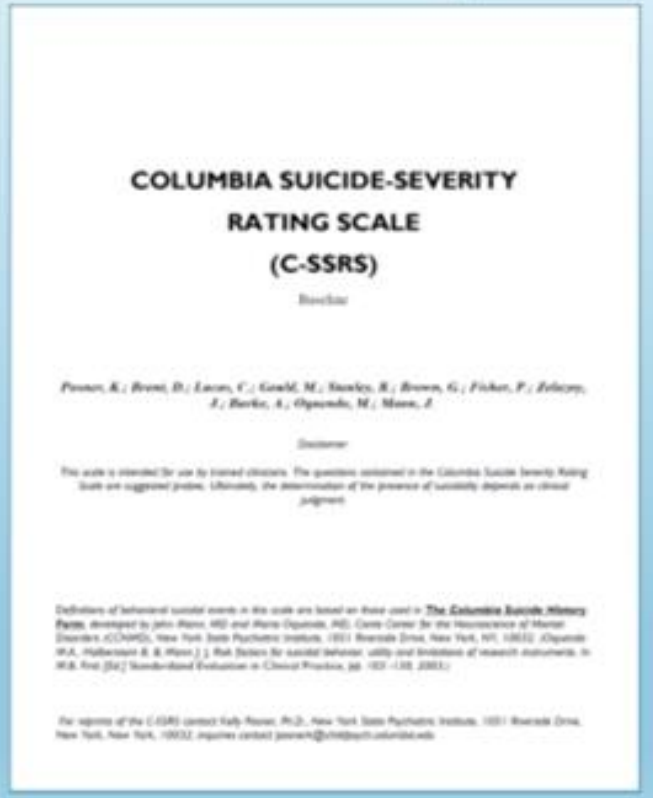
NAME: _____ DATE: _____

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	
	TOTAL			

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all
- Somewhat difficult
- Very difficult
- Extremely difficult



COLUMBIA SUICIDE-SEVERITY RATING SCALE

(C-SSRS)

Baseline

Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.

Disclaimer

This scale is intended for use by trained clinicians. The questions contained in the Columbia Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidality depends on clinical judgment.

Definitions of behavioral suicidal events in this scale are based on those used in **The Columbia Suicide History Form**, developed by John Mann, MD and Maria Oquendo, MD, Conte Center for the Neuroscience of Mental Disorders (CCNMD), New York State Psychiatric Institute, 1051 Riverside Drive, New York, NY, 10032. (Oquendo M.A., Halberstam B. & Mann J. J. Risk factors for suicidal behavior: utility and limitations of research instruments. In M.B. First (Ed.) Standardized Evaluation in Clinical Practice, pp. 103 -130, 2003.)

For reprints of the C-SSRS contact Kelly Posner, Ph.D., New York State Psychiatric Institute, 1051 Riverside Drive, New York, New York, 10032. Inquiries contact posnerk@nyspi.columbia.edu

asQ Suicide Risk Screening Tool

Ask Suicide-Screening questions

Ask the patient

1. In the past few weeks, have you wished you were dead? ☐ Yes ☐ No
2. In the past few weeks, have you felt that you or your family would be better off if you were dead? ☐ Yes ☐ No
3. In the past week, have you been having thoughts about killing yourself? ☐ Yes ☐ No
4. Have you ever tried to kill yourself? ☐ Yes ☐ No

If yes, how? _____

When? _____

If the patient answers Yes to any of the above, ask the following acuity question:

5. Are you having thoughts of killing yourself right now? ☐ Yes ☐ No

If yes, please describe: _____

Next steps

- If patient answers "No" to all questions 1 through 5, screening is complete (see resources to aid questions #5).
  No more action is necessary ("Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 5, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:
  - ☐ "Yes" to question #5 — acute positive screen (consider risk stratification)
    - Patient requires a STAT safety/full mental health evaluation.
    - Patient cannot leave until evaluated for safety.
    - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
  - ☐ "No" to question #5 — non-acute positive screen (consider risk stratification)
    - Patient requires a prompt suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.
    - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741741

asQ Suicide Risk Screening Toolkit — National Institute of Mental Health (NIMH)

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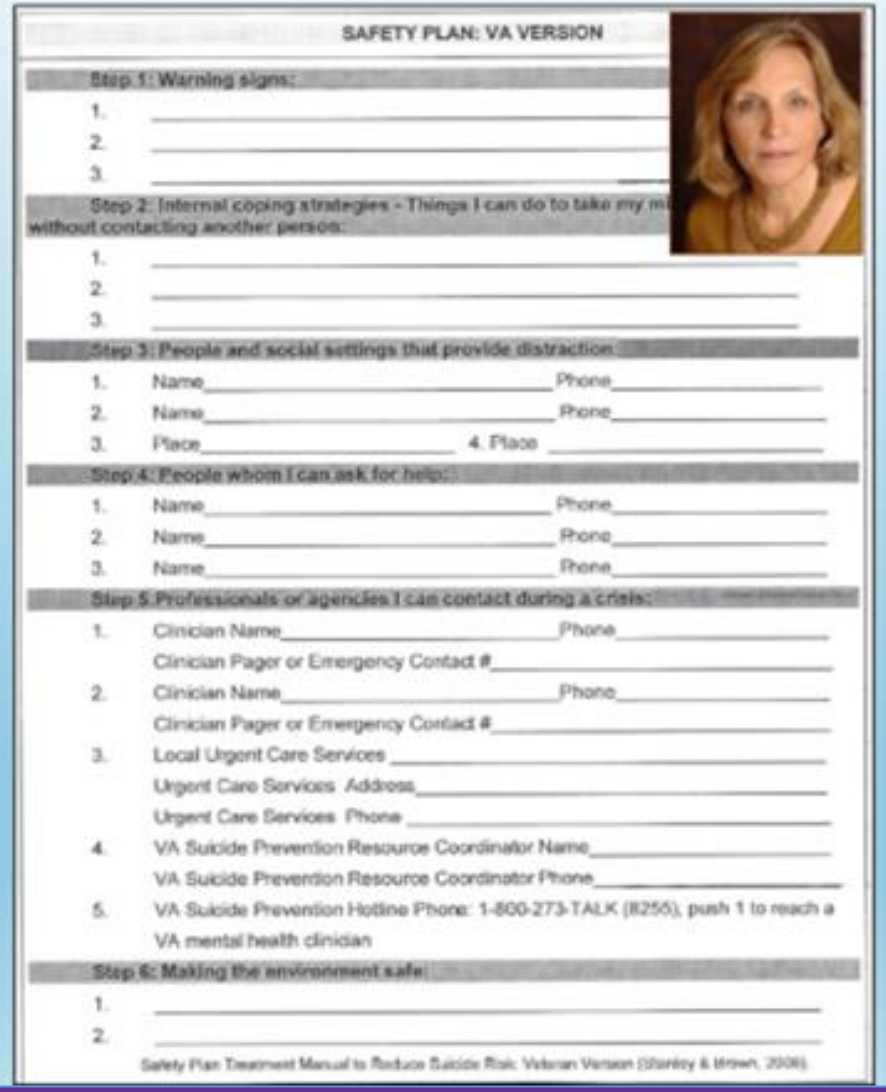
Adaptations for Clinical Management

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

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mi... 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_____

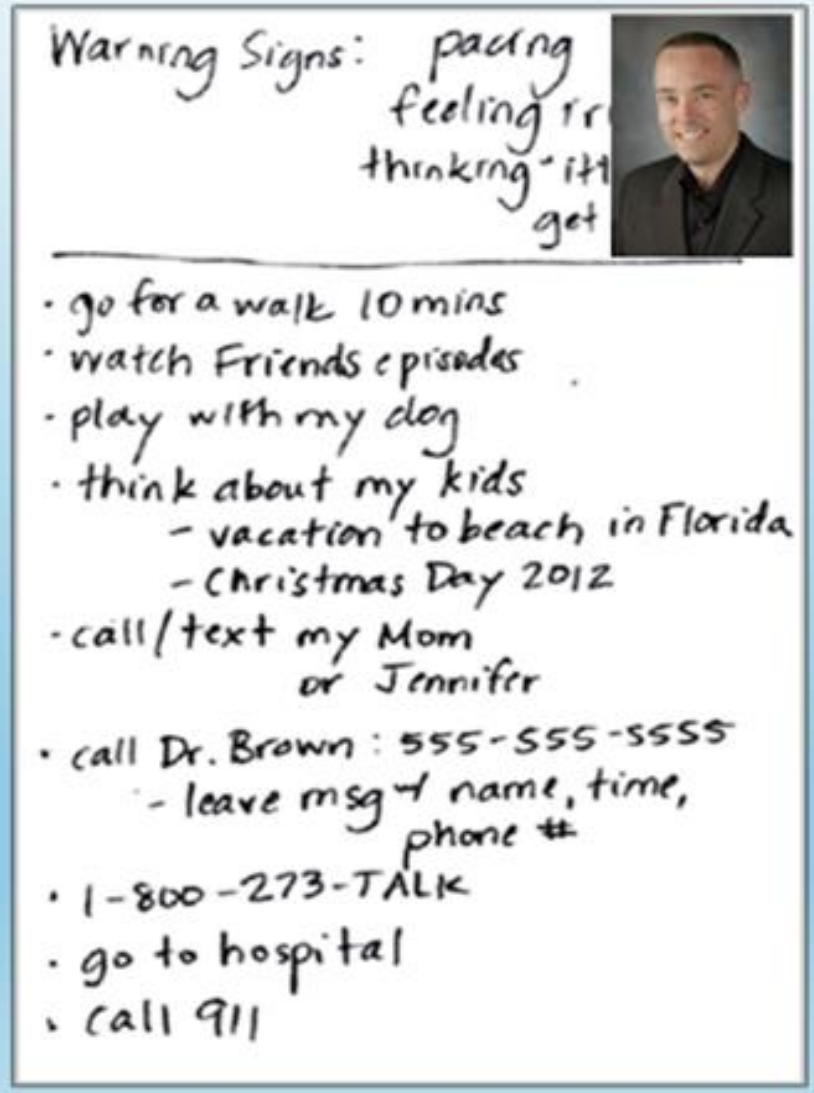
Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008)



Warning Signs: pacing
feeling r
thinking "it
get

- 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 + 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:**

  - **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

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.
www.sprc.org

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

DBT Skills that can be obtained on-line (Ursula Whiteside, Ph.D. & Shireen Rizvi, Ph.D.)

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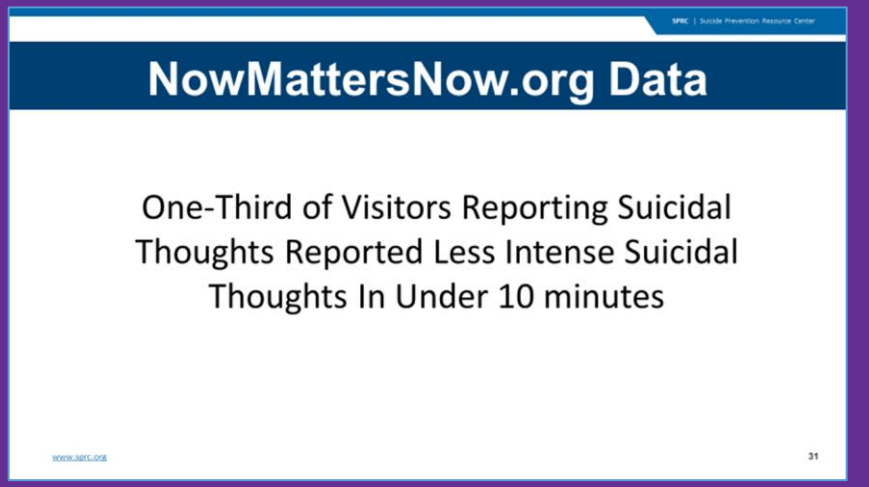
Dr. Ursula Whiteside: Now Matters Now



https://www.nowmattersnow.org/

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Phone and Video Work

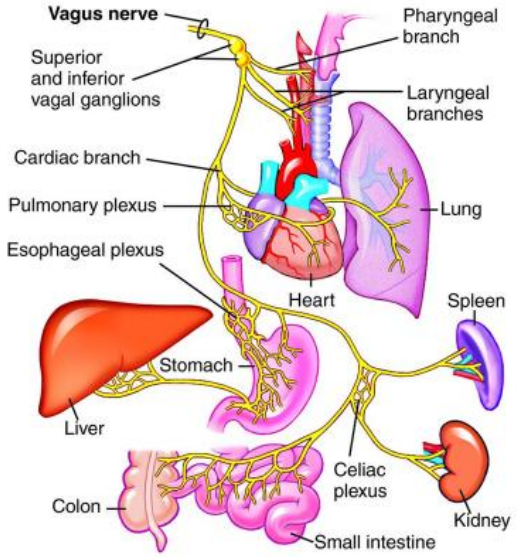
- PHQ9 and GAD7, administer first and reference throughout
- Check about smartphone and internet access
- Ask them to get a pen and paper
- Regularly check in to see that they are still with you
- Accessibility to materials before and after to reinforce concepts
- Follow-up after teaching skills

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

HOME FREE TRAINING & RESOURCES ABOUT TEAM HELP

now matters now

diary card and worksheets (new!)

Use NowMattersNow.org Diary Card (**PDF**, **Word**)

Practice Assignment (**Google Doc**) to make ... ful.

Google Docs latest version and print best with ...

curbing suicid...

Share this **Fl...** ...attersNow.org.

Websi... **...educe suicidal thoughts short**

...gs summary and **one story**).

...d DBT skills core evidence.

stress model

Stress Model explains why, for some of us, it is harder to manage the emotional pain of living (Stress Model **PDF**).

MORE for you and your patients

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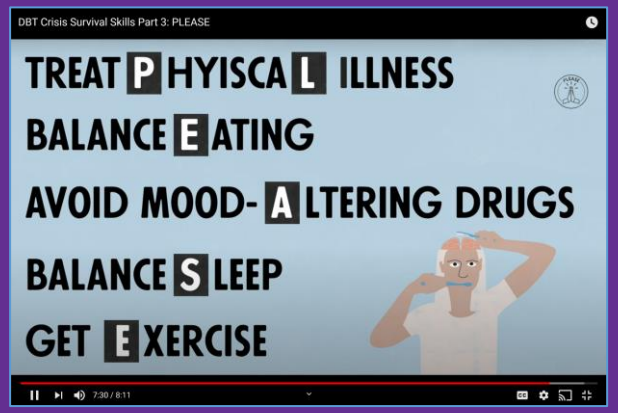

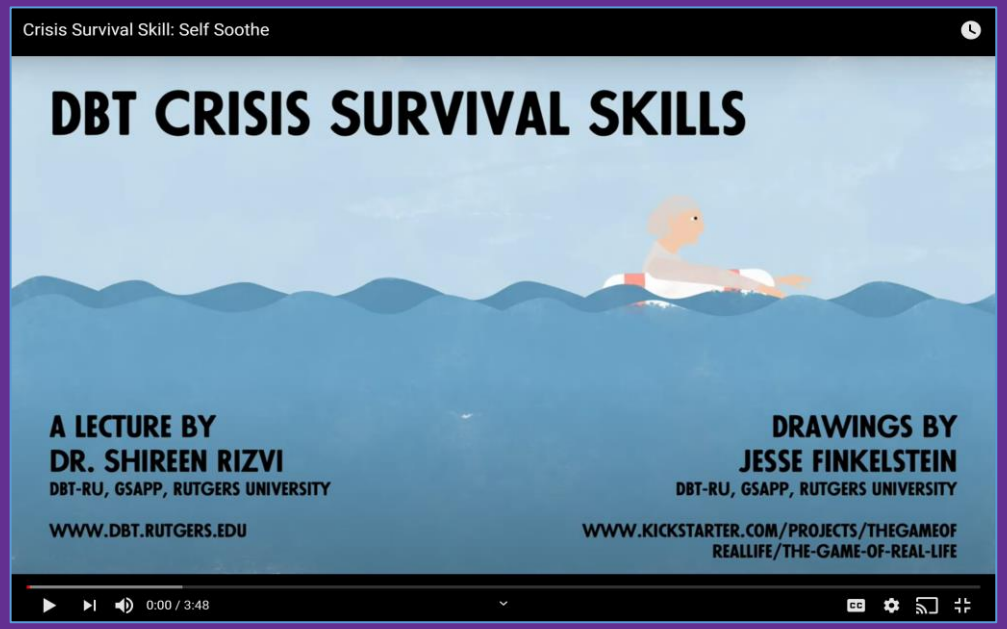

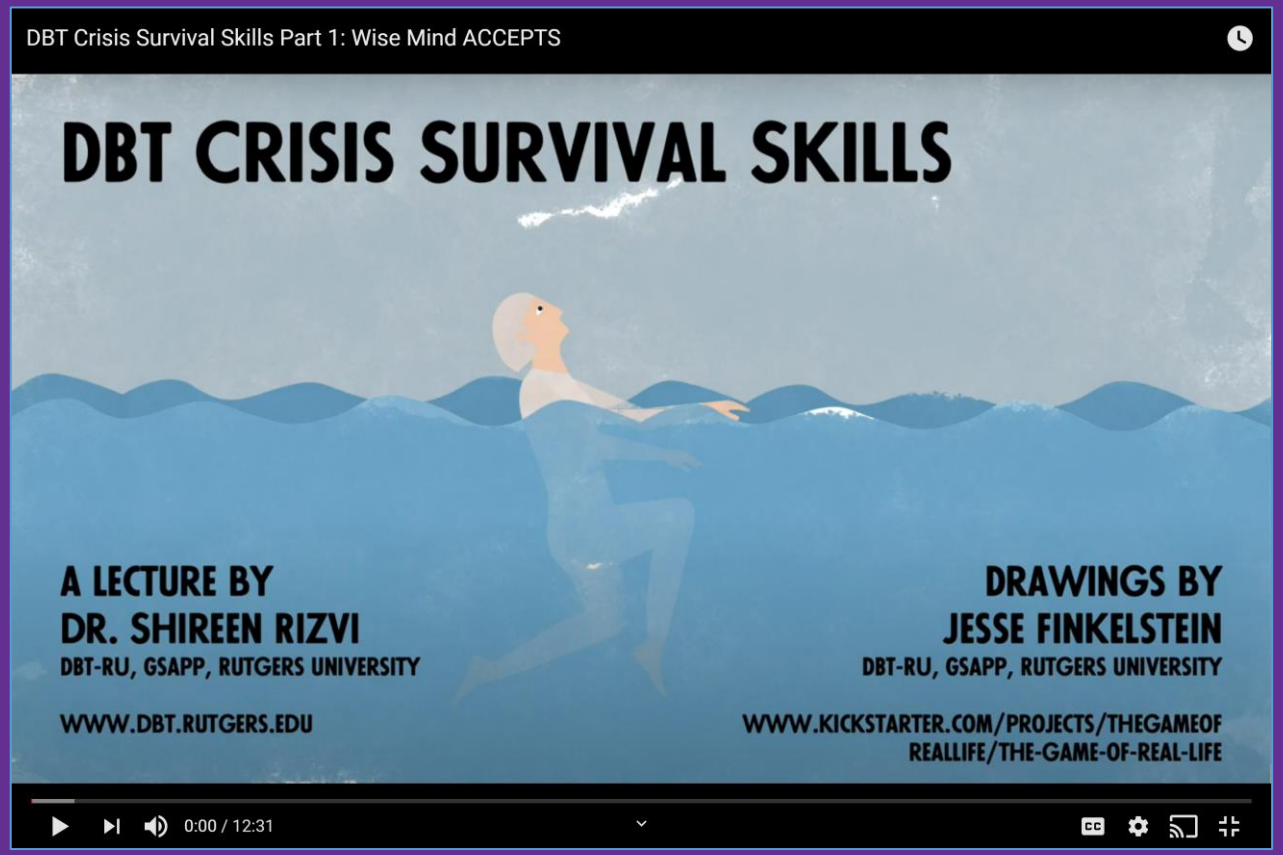

https://www.youtube.com/watch?v=seKJvjCiT4w

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Lived-Experience Peer-Based Support

https://www.nowmattersnow.org/

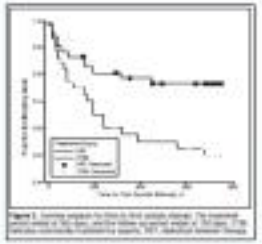
https://livethroughthis.org/

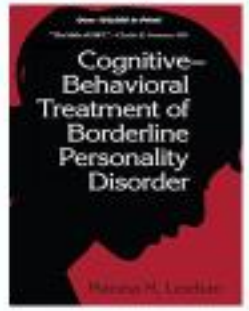
https://livedexp.academy/

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

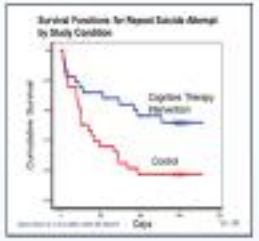
Effective treatments for suicide attempters

- Dialectical Behavior Therapy (DBT)

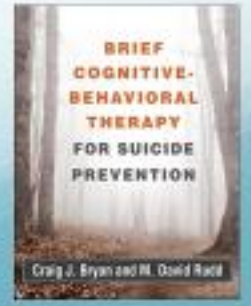




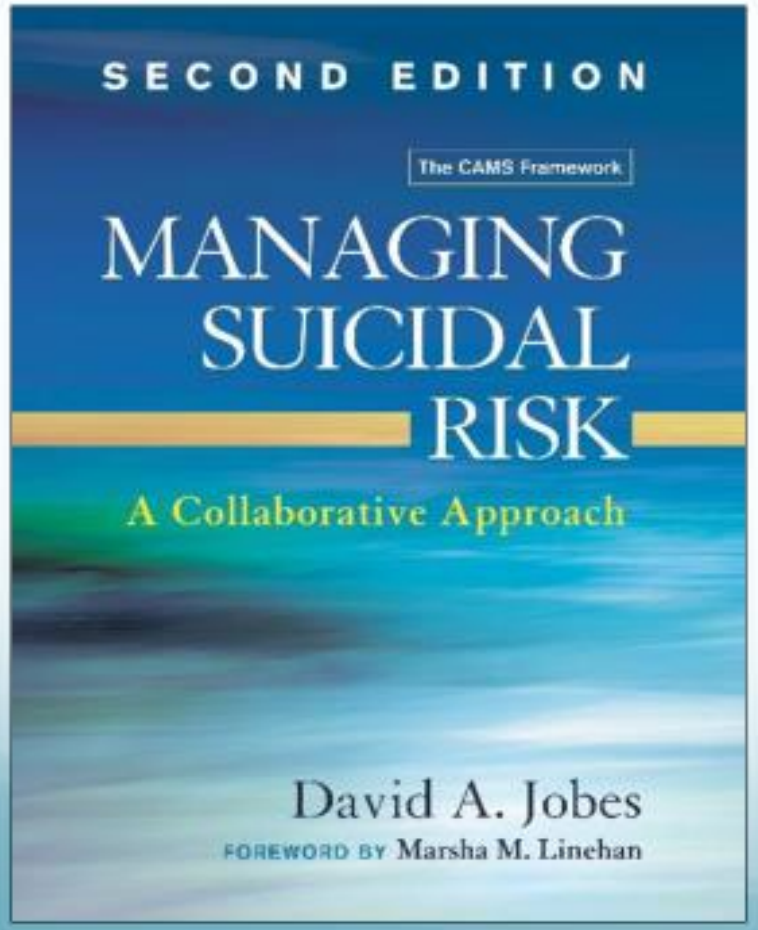
- Cognitive Therapy for Suicide Prevention (CT-SP)

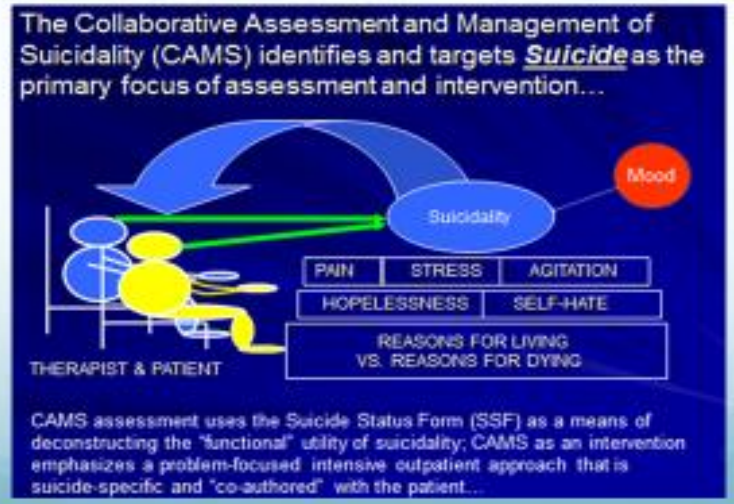


- Brief Cognitive Behavior Therapy (BCBT)



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

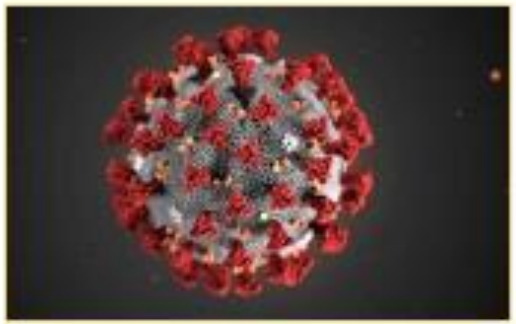

CAMS Outcome/Disposition Session



Published Randomized Controlled Trials of CAMS

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 & 2020 Published articles

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

CAMS-care

Preventing suicide

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 (Wolfram, Landey, Pujol, & 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 dispositions 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 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 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 assess 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.

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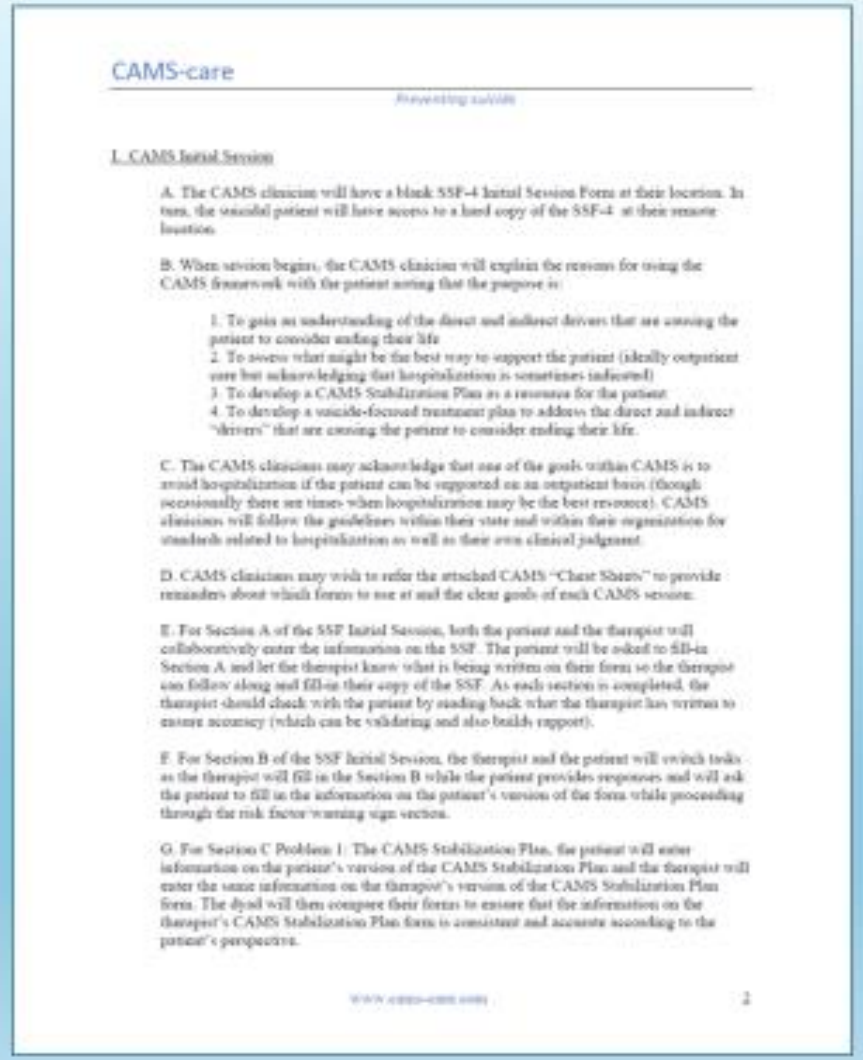
Key Points

- 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

National Register of Health Service Psychologists

CAMS Initial Session



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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

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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 on-going 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 thus 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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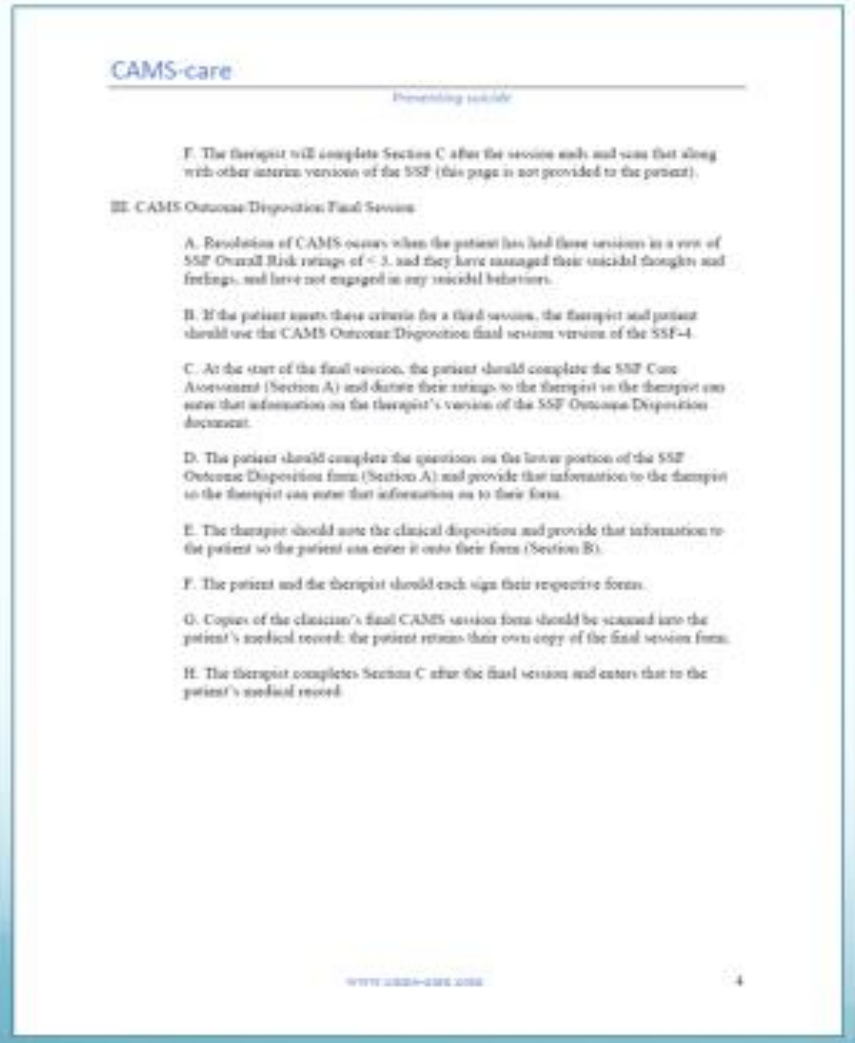
Key Points

- 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 save 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

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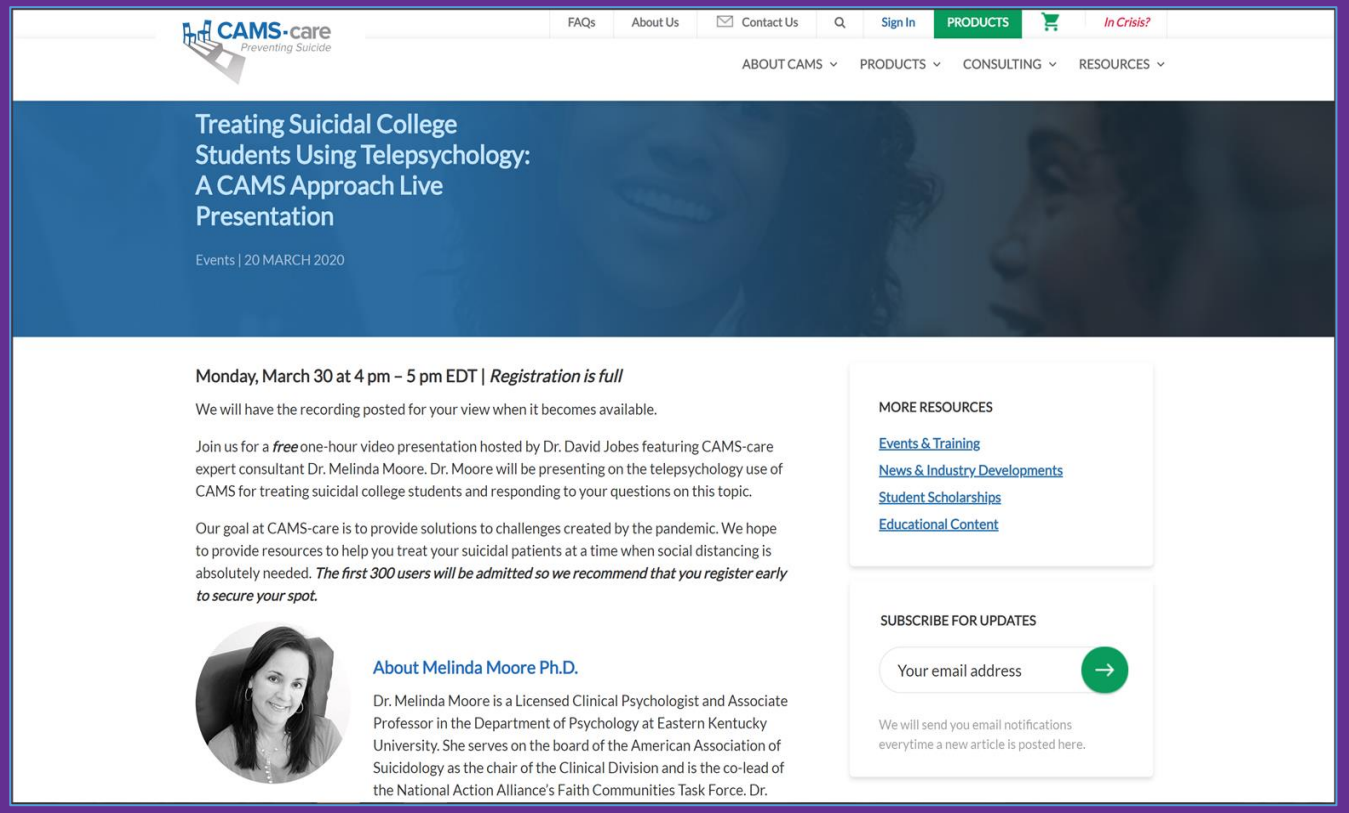
Telehealth Use of CAMS Case Example: EKU Psychology Clinic (Melinda Moore, Ph.D.)



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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

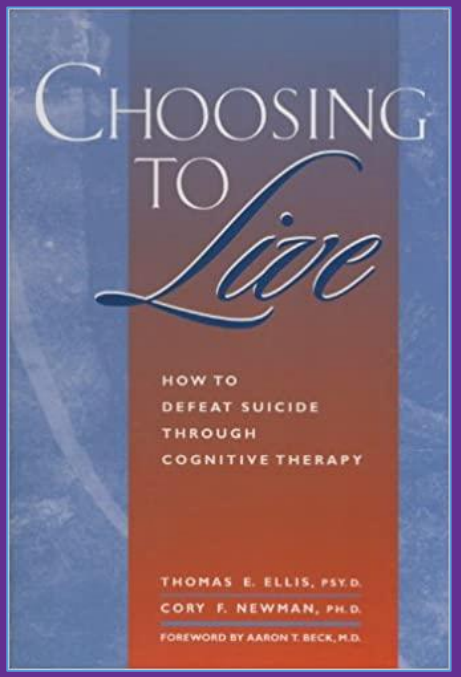
- Needs to be in private, quiet room
- Technical issues – audio issues; not use speakers, but headphones
- Internet connectivity – important to discuss upfront
- Clients must sometimes use relatives' computers
- Nosy parents or siblings:
- SSFs screen shared, but not sent in advance or physically present
- 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

- Ellis, T. E. & Newman, C. F. (1996). *Choosing to Live: How to Defeat Suicide Through Cognitive Therapy*. Oakland, CA: New Harbinger Publications, Inc.



- 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://roadmaptoresilience.wordpress.com/
- CAMS-care, LLC: https://cams-care.com/

Questions & Answers

- Dr. Sammons will ask Dr. Jobes 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.