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

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

April 14, 2020
Funding and Disclaimer

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

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

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

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

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

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

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

• Get key implementation steps and research information
• Explore tools, readings, webinars, and other public resources
• Access templates from implementors across the country
• Connect with national implementors on the Zero Suicide Email List
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

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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_________________________ Phone___________________________
4. Place_________________________ Phone___________________________

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. _____________________________________________________________
```

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
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](https://www.aa.org))
  - AA Online Intergroup ([www.aa-intergroup.org](http://www.aa-intergroup.org))
  - Narcotics Anonymous ([www.na.org](http://www.na.org))
  - Online house of worship services
  - Supportive chat groups

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

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

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

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

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

- Discuss **sharing the plan** with others.
Identify Emergency Contacts

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

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

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

- Make sure contact social contact information on steps 3-5 is virtual rather than in person unless they are currently living with the person.
  - “Contact information” can include telephone numbers, video chat, social media, game consoles, internet forums, etc.

- Virtual contact may “feel” different or mean different things to your client.
  - Discuss types of remote contact that best suit your client’s emotional needs.
  - For example, some prefer phone calls or texts for disclosure of distress but video chats for distraction.
Reducing Access to Means

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The four pillars of the CAMS framework:
1) Empathy
2) Collaboration
3) Honesty
4) Suicide-focused

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

CAMS Tracking/Update Sessions

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

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

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

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

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

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

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 WiFi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Name / Signature:

Patient Name:

Signature of Parent(s)/Patient's Legal Representative:

Date: 

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

H. For Section C, Problems 2 and 3 of 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 progresses throughout the medical record progression notes.

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 therapist should enter the same information on the patient’s version of the SSF; the therapist’s 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 the 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.
Outcome/Disposition Final Session

Key Points

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

**Treating Suicidal College Students Using Telepsychotherapy: A CAMS Approach Live Presentation**

Events | 20 March 2020

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

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

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

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

**About Melinda Moore Ph.D.**

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

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

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

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

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

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

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

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

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

bit.ly/SuicideExp

Or

surveymonkey.com/r/SuiExp
ZERO Suicide 
IN HEALTH AND BEHAVIORAL HEALTH CARE
Recommended Standard Care for People with Suicide Risk: MAKING HEALTH CARE MORE E
A Care Pathway
Two Themes

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

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

11/11/19 Important Update

Dear Site Visitors,

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

When I began in 2001, there was no one on the internet for DBT graduates available for families and professors.
DBT SKILLS

DBT Skills with support works!

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

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\textsuperscript{3}Kaiser Permanente Washington Health Research Institute, Seattle, WA, United States
\textsuperscript{4}Department of Health Services, University of Washington, Seattle, WA, United States
\textsuperscript{5}Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, WA, United States
One-Third of Visitors Reporting Suicidal Thoughts Reported Less Intense Suicidal Thoughts In Under 10 minutes
NowMattersNow.org Data

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

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

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

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

Reinforce Learning or Confirm Use of Skills

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

Linking to Cold-Water Skill
Cold Water

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

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

- 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, Word) and Practice Assignment (Google Doc) to make sessions more powerful.

Google Docs latest version and print best with comments.

curbing suicide
Website: www.N amongst thoughts short
ings 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).

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.
Q & A
Resources

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

- National Suicide Prevention Lifeline: 800-273-8255

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

- Crisis Text Line: Text HOME to 741741

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