# Telehealth: A Critical Tool for Treating Suicidal Risk

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CAMS-care Webinar
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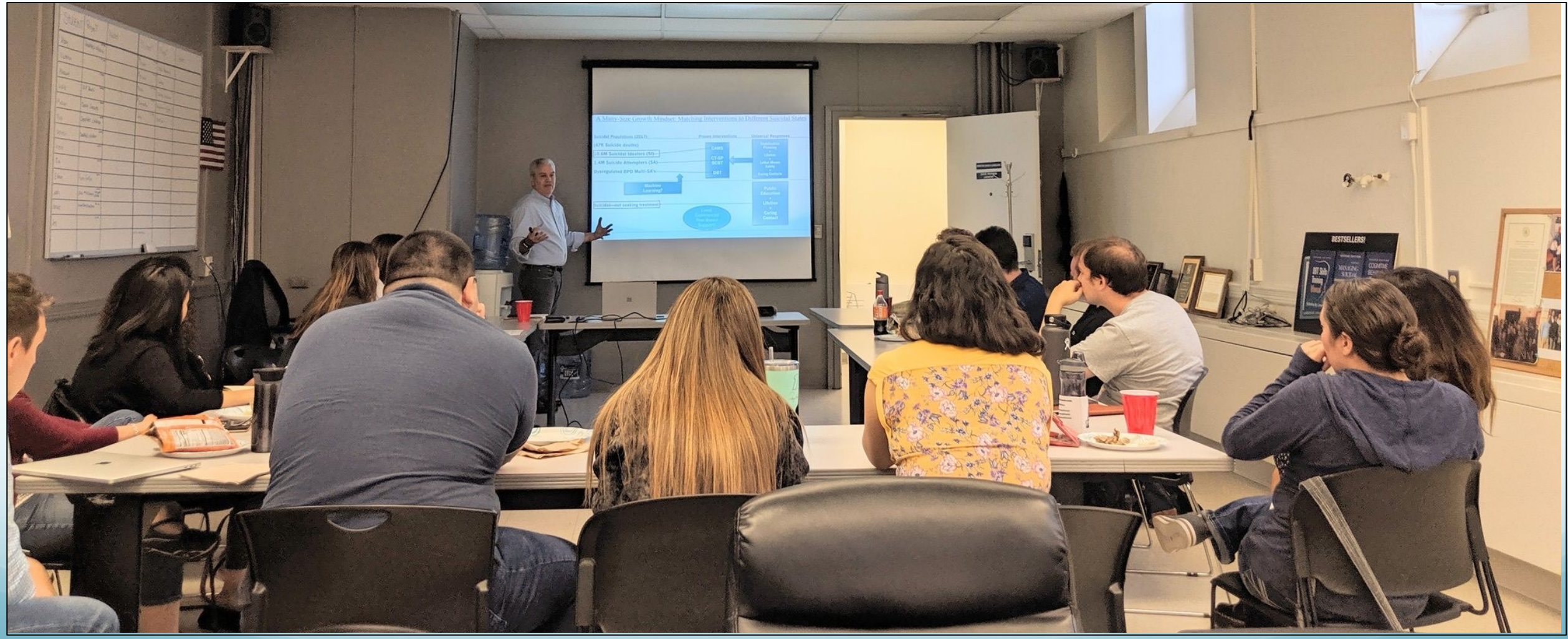
THE CATHOLIC UNIVERSITY of AMERICA

# Disclosures

- Three NIMH treatment research grants; one NIAAA grant
- Book royalties (APA Press and Guilford Press)
- Co-Founder and Partner, CAMS-care, LLC (a professional training and consultation company)
- 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.

# Fall 2019: The CatholicU Suicide Prevention Lab



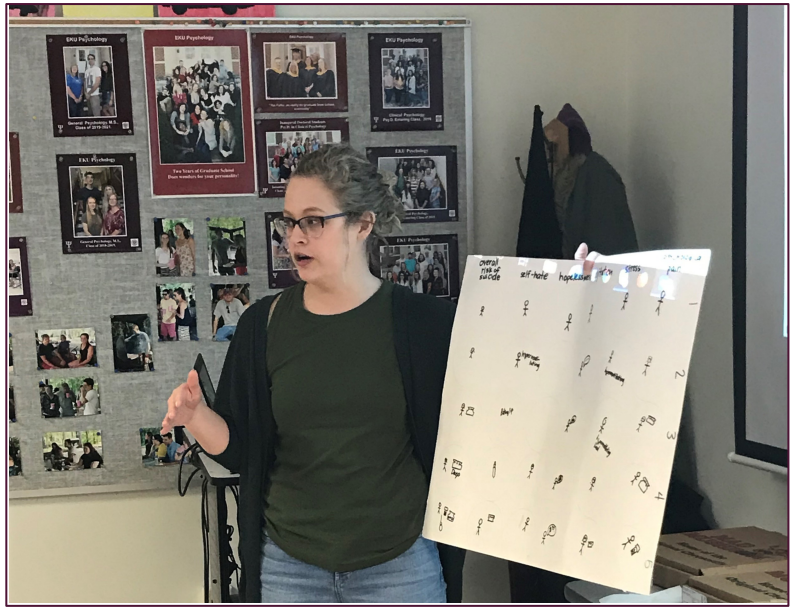
# Randomized Controlled Trials of CAMS

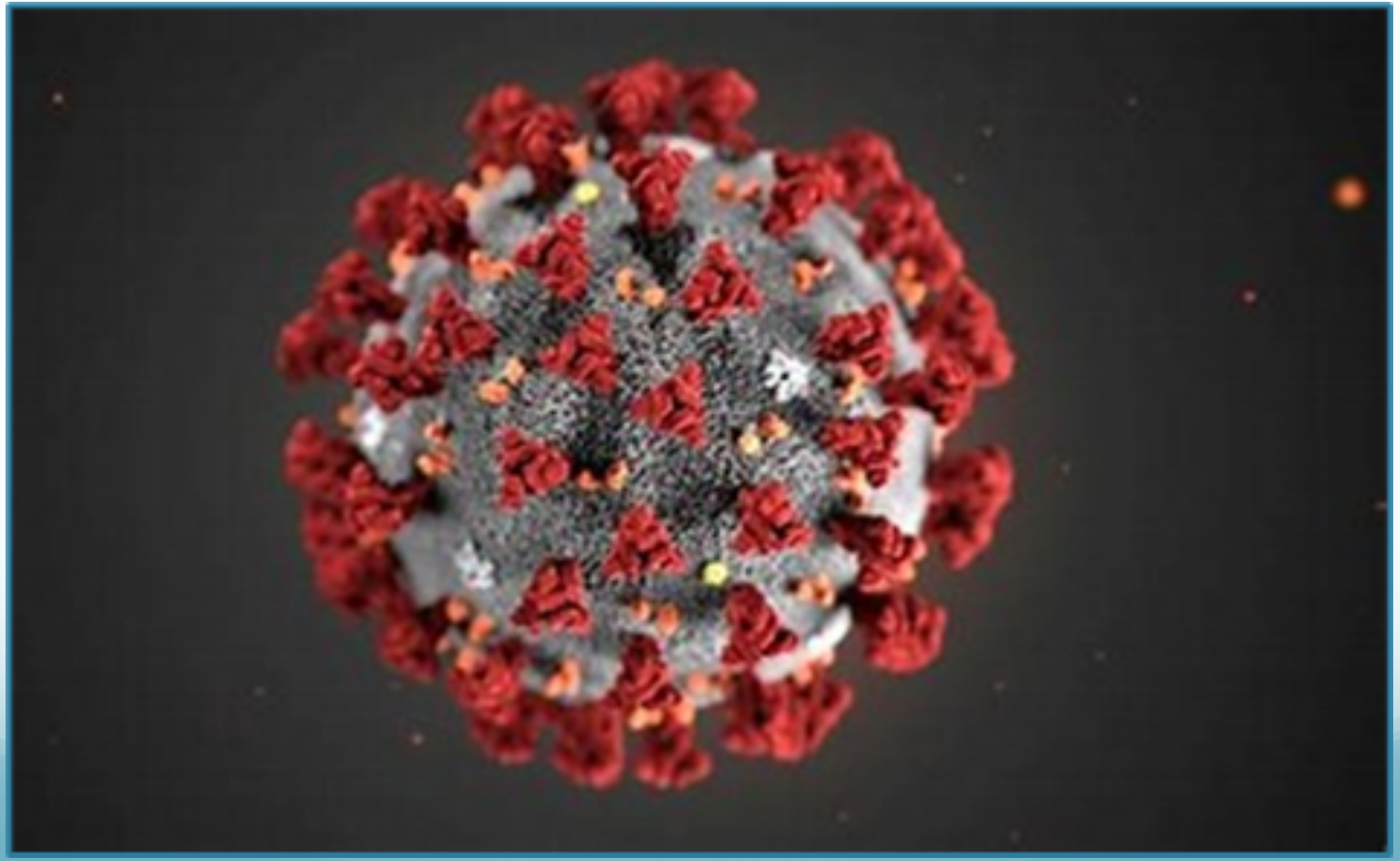
| Principal Investigator | Setting & Population | Design & Method | Sample Size | | Status Update |
|---|---|---|---|---|---|
| Comtois (Jobes) | Harborview/Seattle CMH patients | CAMS vs. TAU Next-day appts. | 32 | ★ | 2011 published article |
| Andreasson (Nordentoft) | Danish Centers CMH patients | DBT vs. CAMS superiority trial | 108 | ★ | 2016 published article |
| Jobes (Comtois et al) | Ft. Stewart, GA US Army Soldiers | CAMS vs. E-CAU | 148 | ★ | 2017 published article |
| Ryberg (Fosse) | Norwegian Centers Outpatient/inpatient | CAMS vs. TAU | 78 | ★ | 2019 published articles |
| Pistorello (Jobes) | Univ. Nevada (Reno) College Students | SMART Design CAMS/TAU/DBT | 62 | ★ | 2017 and 2020 - articles |
| Comtois (Jobes) | Harborview/Seattle Suicide attempters | CAMS vs. TAU Post-Hosp. D/C | 150 | | ITT complete; on-going assess |
| Santel et al | German Crisis Unit Inpatients | CAMS vs. TAU | 60 | | ITT complete; on-going assess |
| Depp et al | San Diego VAMC Walk-in Veterans | CAMS vs. Outreach Same day services | 176 | | ITT underway (telehealth) |

# DR. MELINDA MOORE EASTERN KENTUCKY UNIVERSITY

## CAMS CONSULTATION GROUP—FEBRUARY 2020

- 80 active therapy cases
- 20 CAMS cases
- 12 CAMS clinicians



# Covid in the Spring 2020—what do we do?


- What will be the impact? Could there be a possible resilience response? Or will there be a spike of covid-related suicides?
- With public health measures and increased social isolation, we might expect increases in suicidal risk.
- The routine practice of sending a person who is suicidal to an emergency department or hospitalizing someone was suddenly ethically dubious.
- Prior to the pandemic the use of telehealth was remarkably limited, and best professional guidance suggested to *not* work with suicidal risk online.
- But then we could not wait for the pandemic to resolve to get back to working with suicidal risk!

# The Impact of COVID-19 on Mental Health

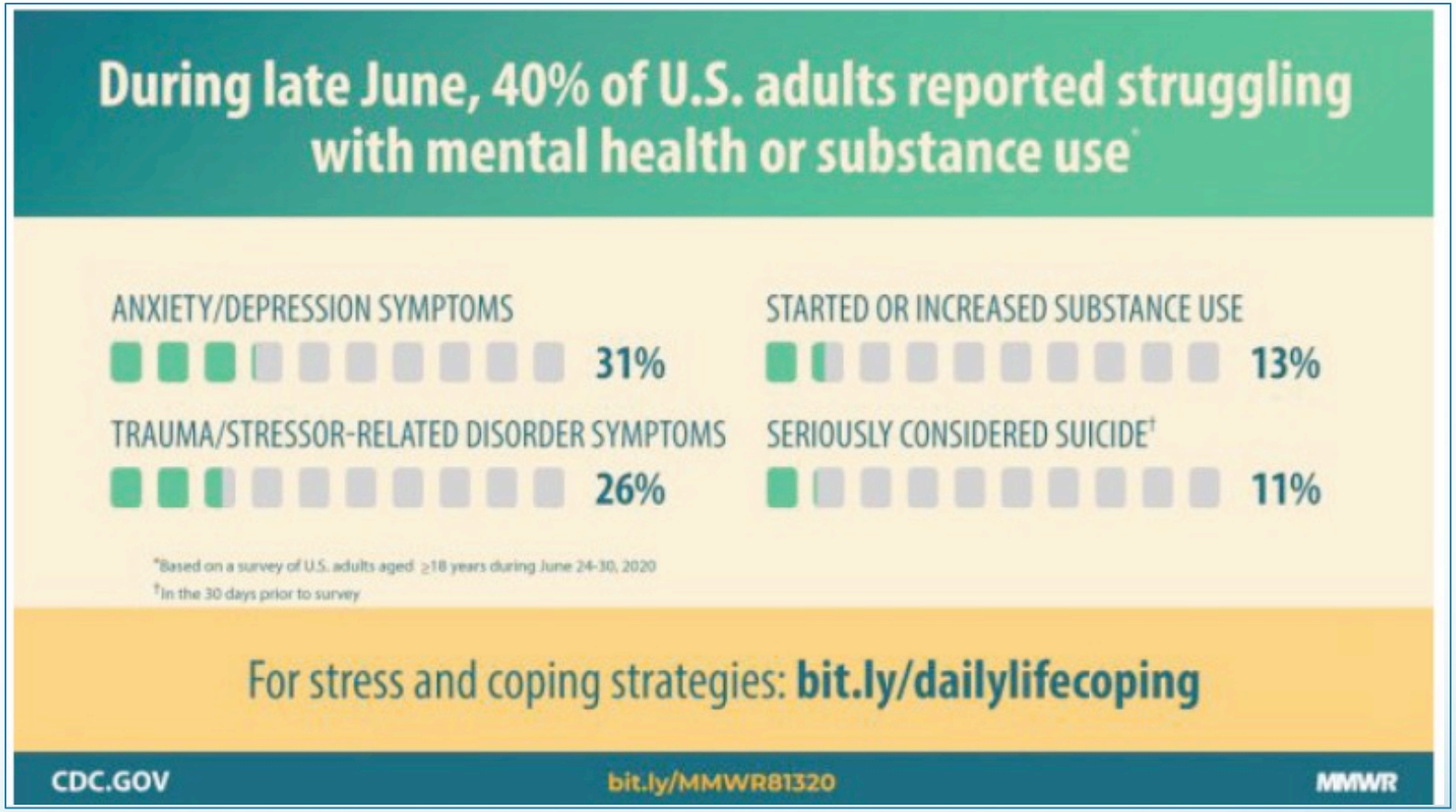
SAMHSA

Disaster Technical Assistance Center Supplemental Research Bulletin

A Preliminary Look at the Mental Health and Substance Use-related Effects of the COVID-19 Pandemic

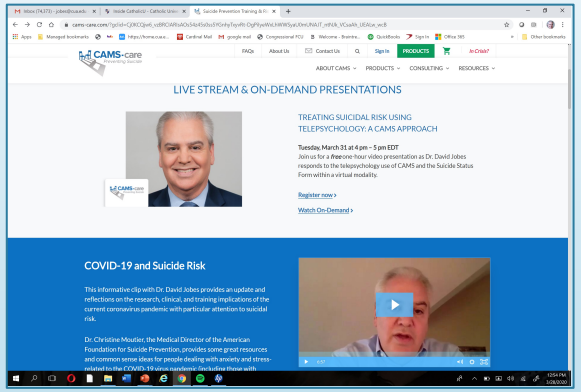
*May 2021*

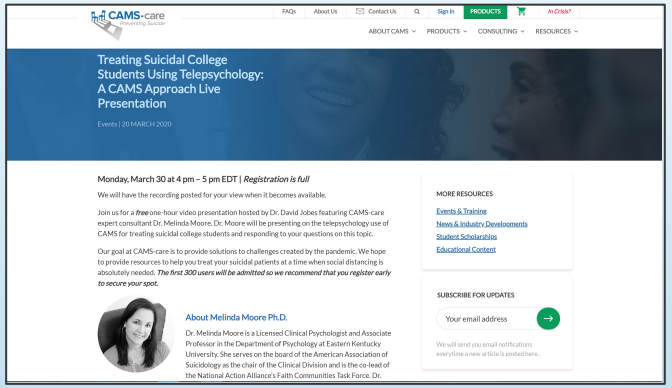
SAMHSA
Substance Abuse and Mental Health Services Administration

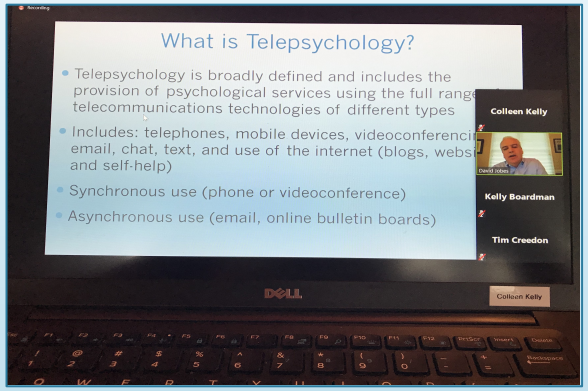



An apparent impact on mental health overall—but the impact on completed suicides and increased suicidal risk is still not entirely clear…

# On-line training and telehealth use of CAMS Spring 2020

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The COVID-19 Pandemic and Treating Suicidal Risk: The Telepsychotherapy Use of CAMS

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The COVID-19 pandemic has created profound challenges for health care systems worldwide. The exponential spread of COVID-19 has forced mental health providers to find new ways of providing mental health services that maintain physical distance and keeps providers and patients at home limiting possible exposure to the deadly virus. The pandemic has thus sparked a sudden interest in providing mental health services via telepsychotherapy (otherwise known as telehealth or telemedicine). Telepsychotherapy care has some inherent challenges that must always be mastered by providers to render effective care. Previous research and professional guidelines understandably note possible concerns about providing telepsychotherapy care to high-risk suicidal patients in a remote location. The coronavirus pandemic now poses all new ethical concerns about the routine practice of having an acutely suicidal patient go to an emergency department and/or admitting such patients to an inpatient psychiatric unit (if the public health goal is to limit the spread of this deadly virus). To this end, this article describes a pandemic-driven effort to rapidly provide support, guidance, and resources to providers around the world to use a suicide-focused and evidence-based intervention called the Collaborative Assessment and Management of Suicidality (CAMS) within a telepsychotherapy modality. Additional suicide-relevant resources are being made available to provide further guidance and support to mental health professionals worldwide. In the midst of a global pandemic, there are emerging ways to help reduce further loss of life to suicide through the medium of telepsychotherapy to provide effective clinical care that is suicide-focused and evidence-based.

*Keywords:* COVID-19, telepsychotherapy, suicide treatment, Collaborative Assessment and Management of Suicidality

Suicide is the 10th leading cause of death in the United States, accounting for 48,344 lives lost in 2018 (Drapeau & McIntosh, 2020). Increasing rates of suicide deaths over the past 50 years are alarming (refer to Figure 1). Whereas there was a flickering hope of perhaps lowering the rate of suicide in the late 1990s, the past 20 years have seen a marked increase in suicides with no clear understanding as to why these deaths continue to increase. Notably the field

*Editor's Note.* This article received rapid review due to the time-sensitive nature of the content, but our standard high-quality peer review process was upheld.

David A. Jobes and Jennifer A. Crumlish, Department of Psychology, The Catholic University of America; Andrew D. Evans, CAMS-care, LLC, Steamboat Springs, Colorado.

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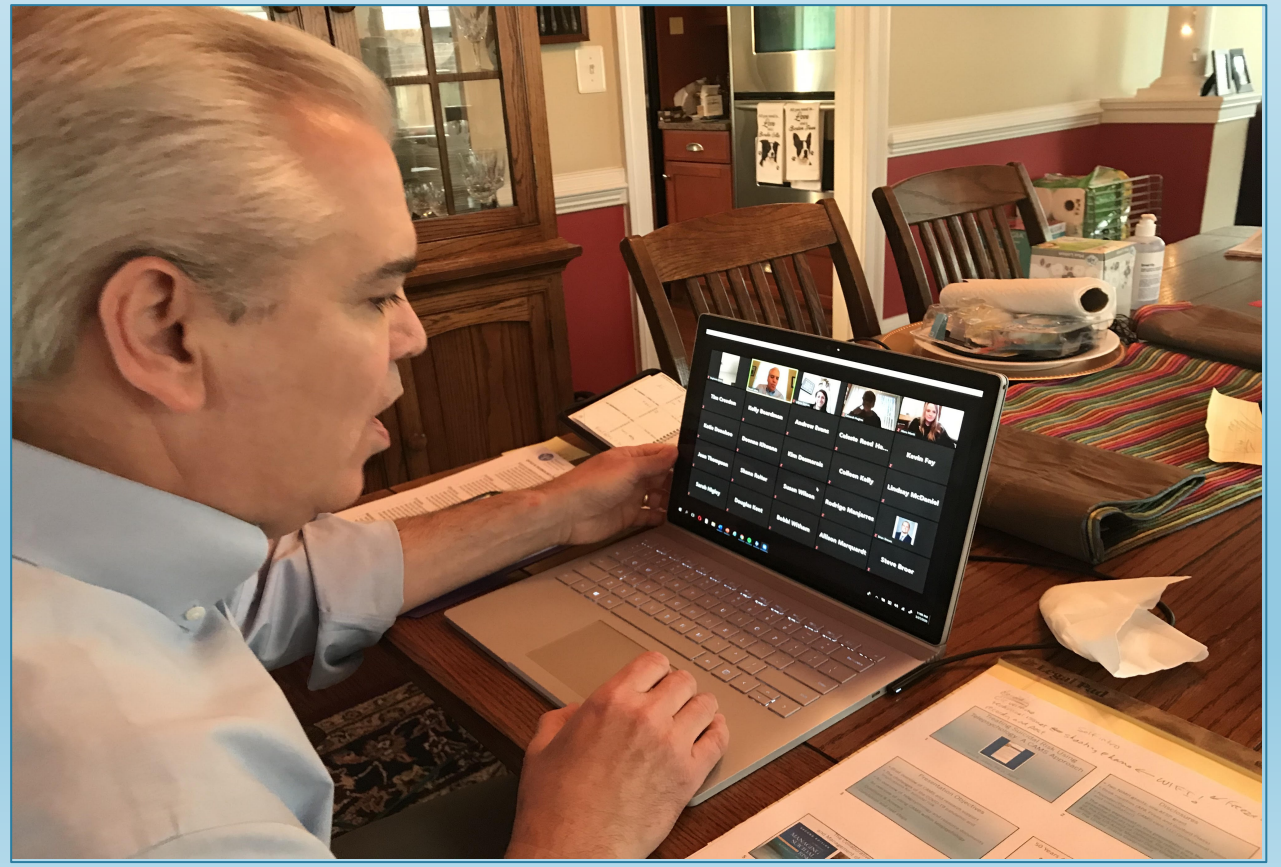

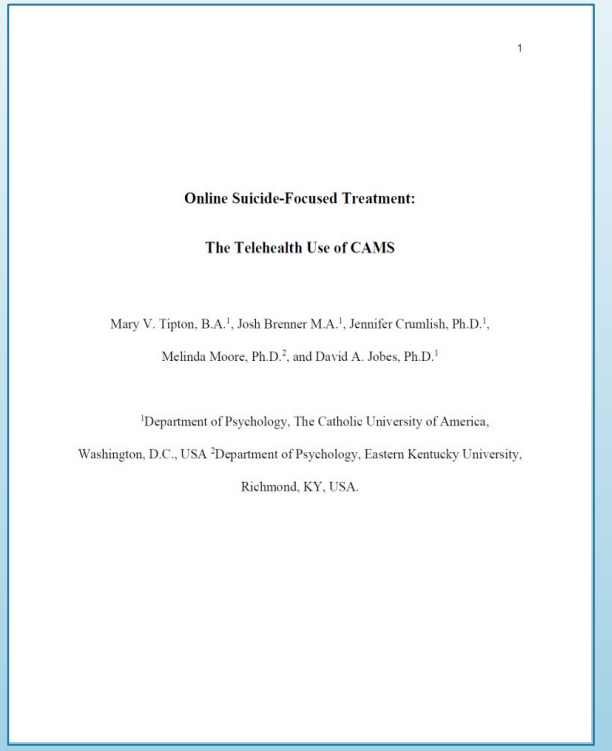

1

**Online Suicide-Focused Treatment:**

**The Telehealth Use of CAMS**

Mary V. Tipton, B.A.[1], Josh Brenner M.A.[1], Jennifer Crumlish, Ph.D.[1], Melinda Moore, Ph.D.[2], and David A. Jobes, Ph.D.[1]

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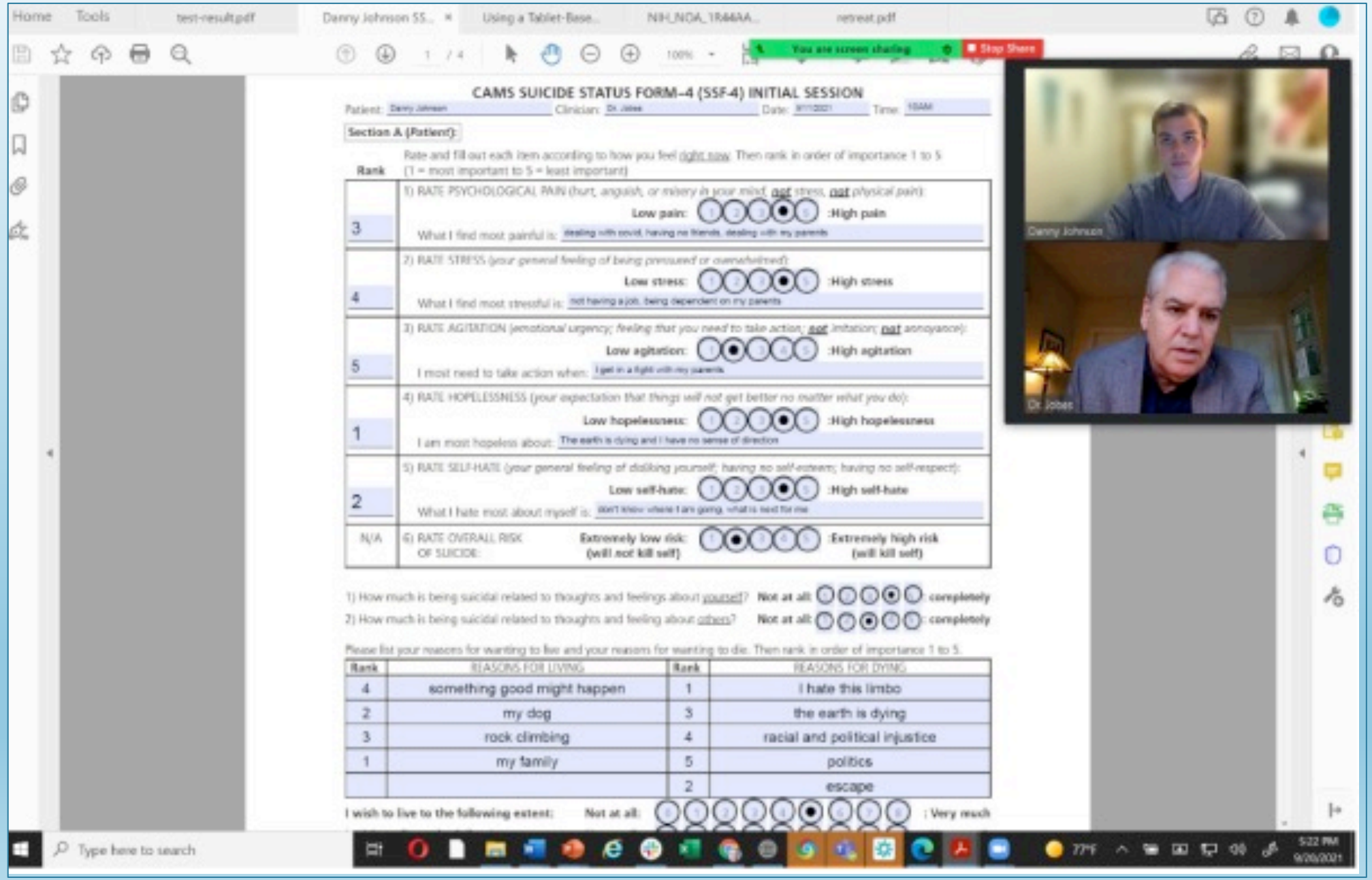
*Free* online webinars are a corona virus pandemic silver lining!

The form-fillable PDF of the Suicide Status Form is available, and it works well!

# Form-fillable PDF of the SSF for telehealth sessions



CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient: Danny Johnson  Clinician: Dr. Jones  Date: 9/11/2021  Time: 10AM

Section A (Patient):

Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)

| Rank | |
|---|---|
| 3 | 1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind; not stress, not physical pain): Low pain: 1 2 3 ● 5 :High pain. What I find most painful is: dealing with covid, having no friends, dealing with my parents |
| 4 | 2) RATE STRESS (your general feeling of being pressured or overwhelmed): Low stress: 1 2 3 ● 5 :High stress. What I find most stressful is: not having a job, being dependent on my parents |
| 5 | 3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance): Low agitation: 1 ● 3 4 5 :High agitation. I most need to take action when: I get in a fight with my parents |
| 1 | 4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do): Low hopelessness: 1 2 3 ● 5 :High hopelessness. I am most hopeless about: The earth is dying and I have no sense of direction |
| 2 | 5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect): Low self-hate: 1 2 3 ● 5 :High self-hate. What I hate most about myself is: don't know where I am going, what is next for me |
| N/A | 6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 ● 3 4 5 :Extremely high risk (will kill self) |

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 ● 5 :completely

2) How much is being suicidal related to thoughts and feeling about others? Not at all: 1 2 ● 4 5 :completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

| Rank | REASONS FOR LIVING | Rank | REASONS FOR DYING |
|---|---|---|---|
| 4 | something good might happen | 1 | I hate this limbo |
| 2 | my dog | 3 | the earth is dying |
| 3 | rock climbing | 4 | racial and political injustice |
| 1 | my family | 5 | politics |
| | | 2 | escape |

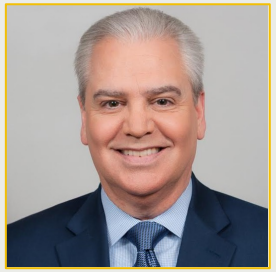
I wish to live to the following extent: Not at all: 0 1 2 3 4 ● 6 7 8 9 10 :Very much

Suicide Prevention Resource Center

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

April 14, 2020






@SPRCTweets

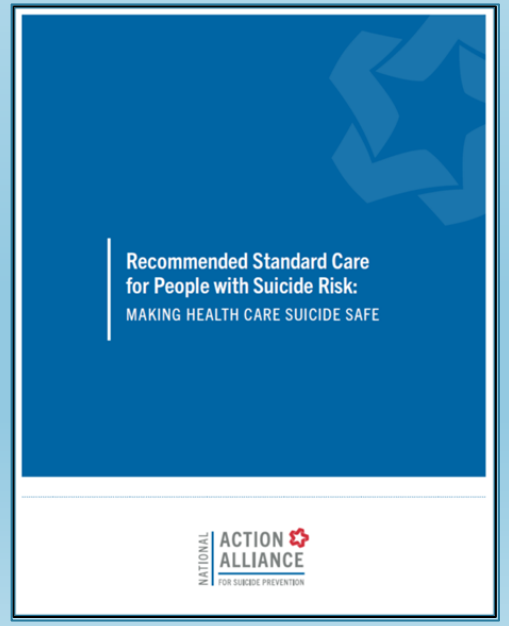
EDC Education Development Center

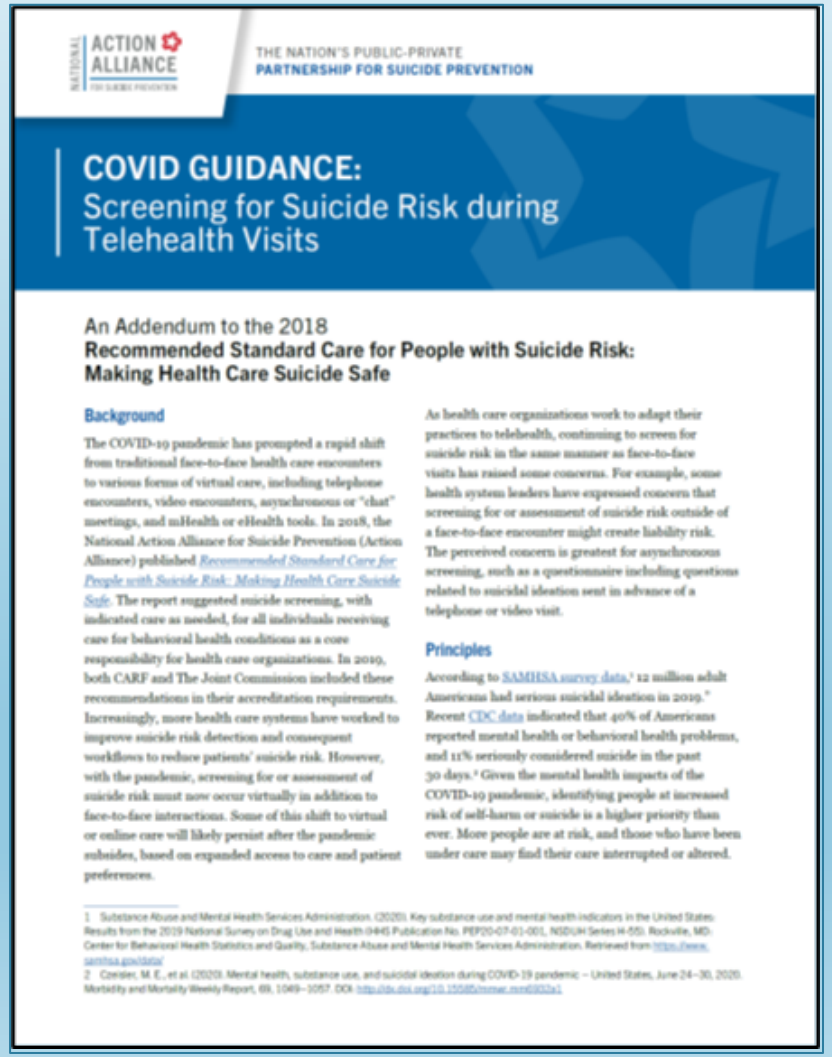
SAMHSA

# Suspending the screening of suicidal risk?

- Dr. Simon noted to members of our Task Force in the fall of 2020 that large healthcare systems were suspending suicide screenings due to remote access online telehealth.
- So…don't ask, don't tell?
- Is this anyway to save lives from suicide?

Gregory E. Simon, MD, MPH



NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

THE NATION'S PUBLIC-PRIVATE PARTNERSHIP FOR SUICIDE PREVENTION

**COVID GUIDANCE:**
Screening for Suicide Risk during Telehealth Visits

An Addendum to the 2018
**Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe**

**Background**

The COVID-19 pandemic has prompted a rapid shift from traditional face-to-face health care encounters to various forms of virtual care, including telephone encounters, video encounters, asynchronous or "chat" meetings, and mHealth or eHealth tools. In 2018, the National Action Alliance for Suicide Prevention (Action Alliance) published *Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe*. The report suggested suicide screening, with indicated care as needed, for all individuals receiving care for behavioral health conditions as a core responsibility for health care organizations. In 2019, both CARF and The Joint Commission included these recommendations in their accreditation requirements. Increasingly, more health care systems have worked to improve suicide risk detection and consequent workflows to reduce patients' suicide risk. However, with the pandemic, screening for or assessment of suicide risk must now occur virtually in addition to face-to-face interactions. Some of this shift to virtual or online care will likely persist after the pandemic subsides, based on expanded access to care and patient preferences.

As health care organizations work to adapt their practices to telehealth, continuing to screen for suicide risk in the same manner as face-to-face visits has raised some concerns. For example, some health system leaders have expressed concern that screening for or assessment of suicide risk outside of a face-to-face encounter might create liability risk. The perceived concern is greatest for asynchronous screening, such as a questionnaire including questions related to suicidal ideation sent in advance of a telephone or video visit.

**Principles**

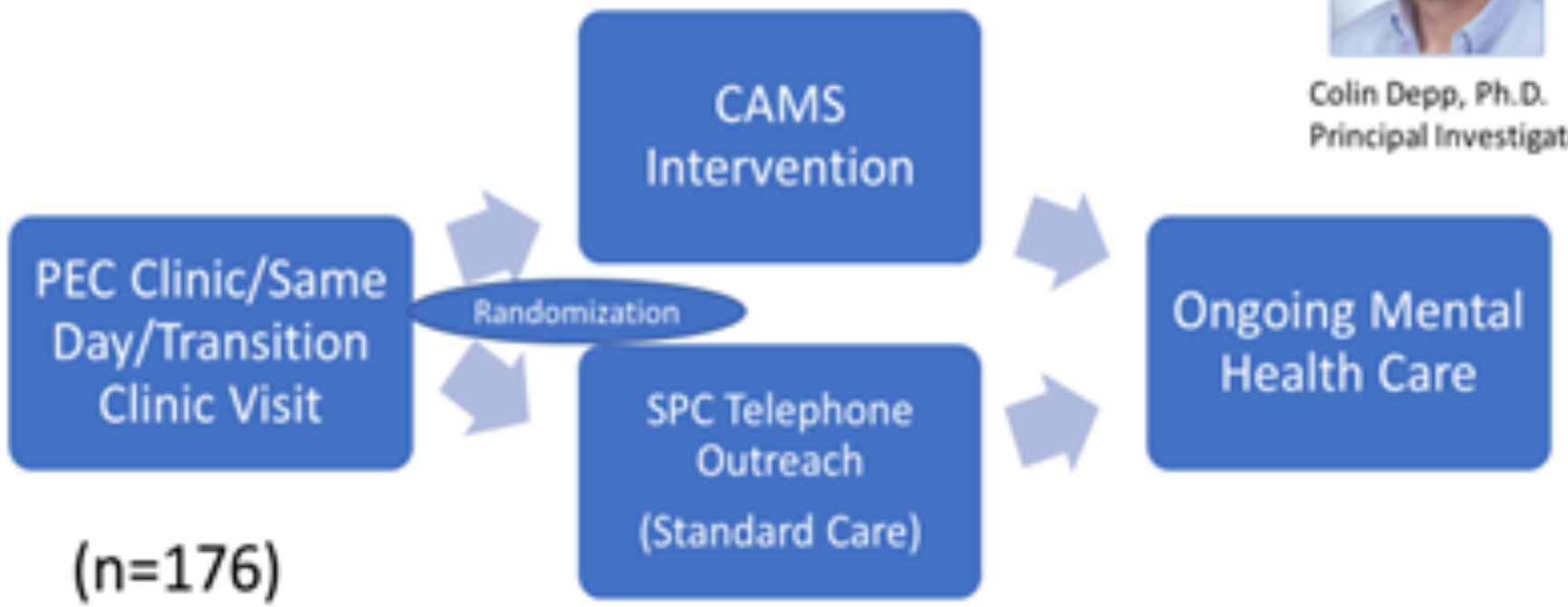
According to SAMHSA survey data,[1] 12 million adult Americans had serious suicidal ideation in 2019.[2] Recent CDC data indicated that 40% of Americans reported mental health or behavioral health problems, and 11% seriously considered suicide in the past 30 days.[2] Given the mental health impacts of the COVID-19 pandemic, identifying people at increased risk of self-harm or suicide is a higher priority than ever. More people are at risk, and those who have been under care may find their care interrupted or altered.

1. Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/
2. Czeisler, M. É., et al. (2020). Mental health, substance use, and suicidal ideation during COVID-19 pandemic — United States, June 24–30, 2020. Morbidity and Mortality Weekly Report, 69, 1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1

# On-going CAMS RCT's flipped to telehealth

## San Diego VA randomized controlled trial: "Rapid Referral Study"

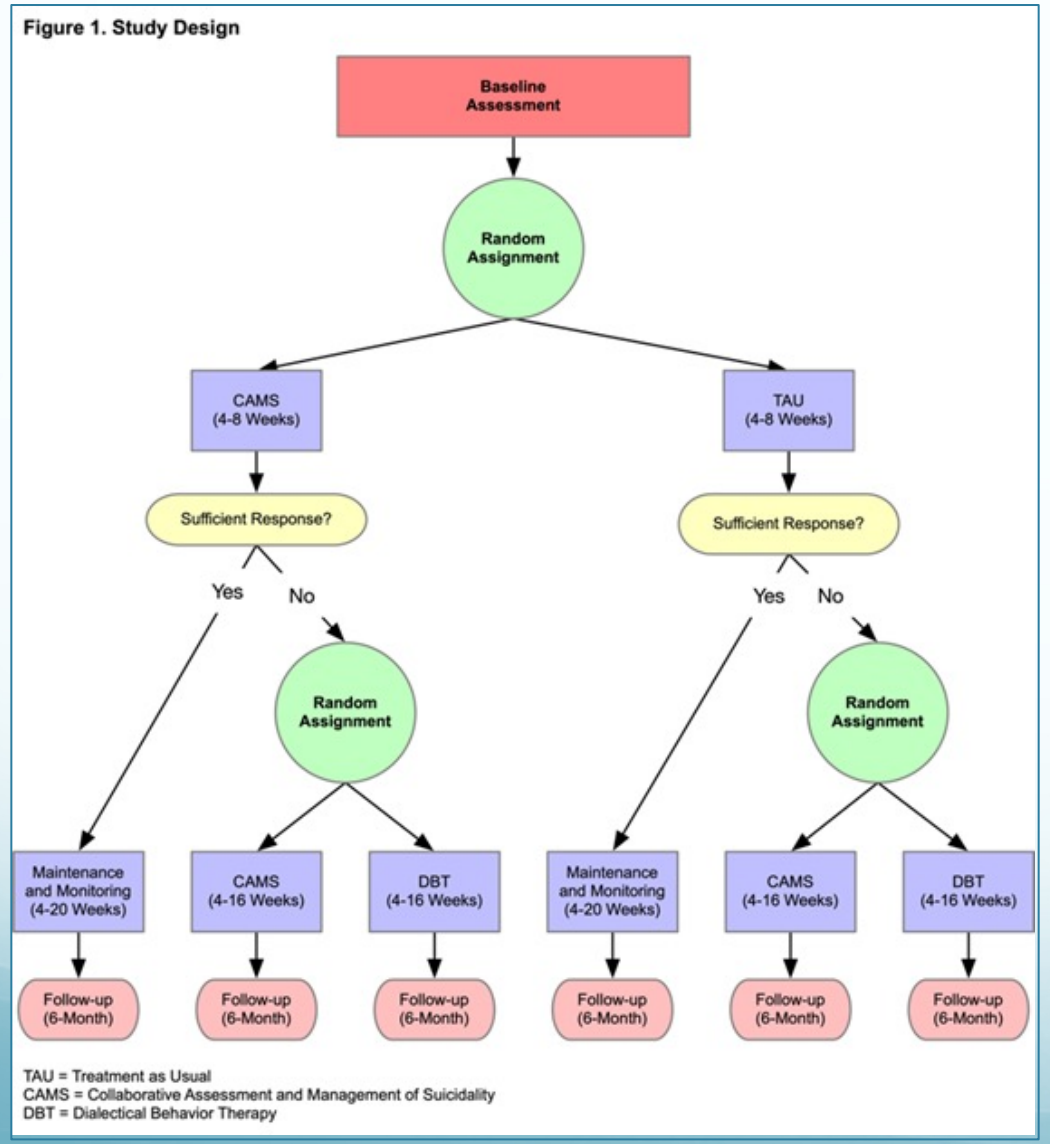
Colin Depp, Ph.D.
Principal Investigator




(n=176)

VA Health Services Research and Development (HSRD) Merit Grant;
VA IRB H180055

# Comprehensive Adaptive Multisite Prevention of University student Suicide



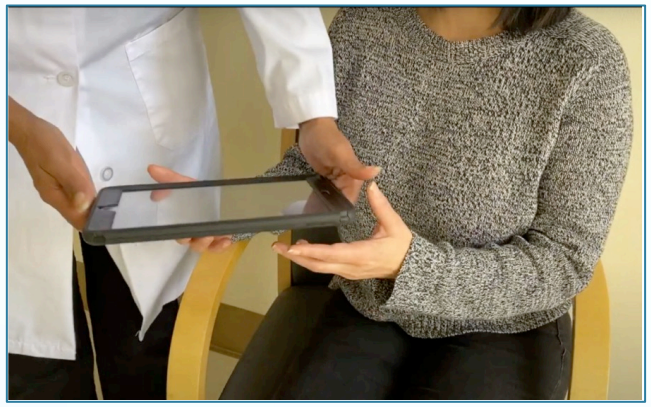

## The CAMPUS Study

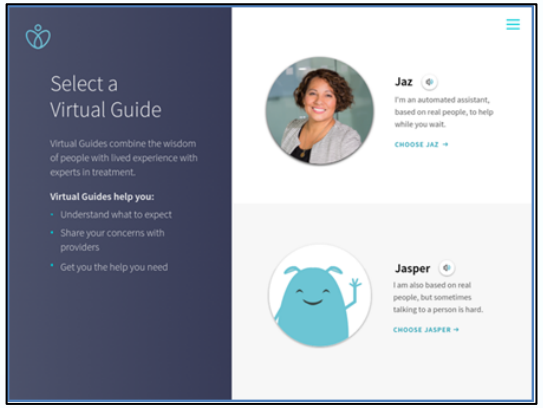
NIMH-funded ($11M) multisite SMART of n=700 suicidal college students at four universities (University of Oregon, University of Nevada-Reno, Duke University, and Rutgers University).

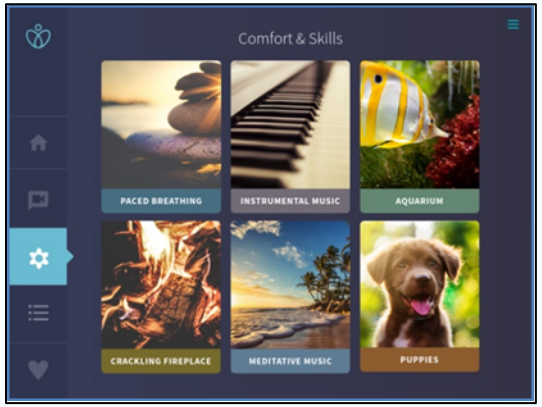
*Authorized to do a feasibility trial for academic years 2020-2021 to study online training and online treatment.*

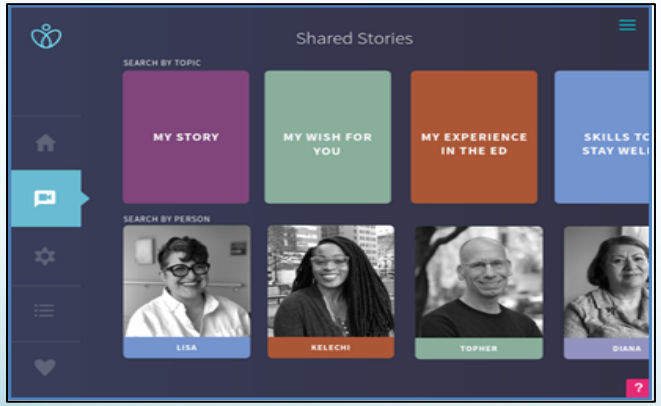
*Intent-to-treat main trial starts in 2022!*

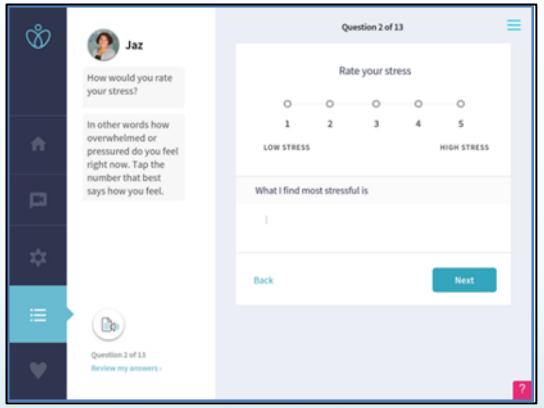
# Developing and Studying “Jaspr Health”

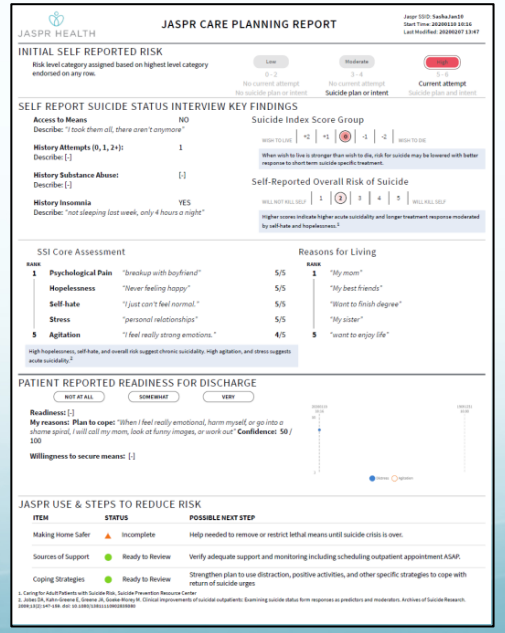


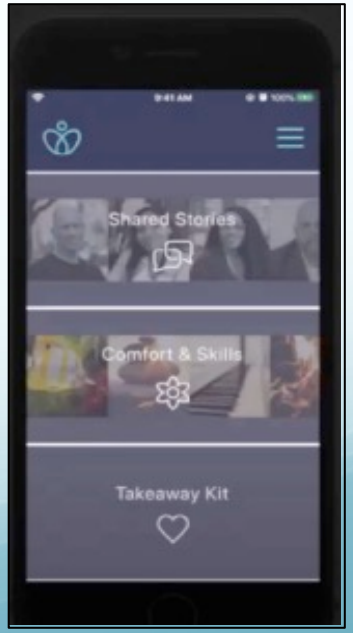



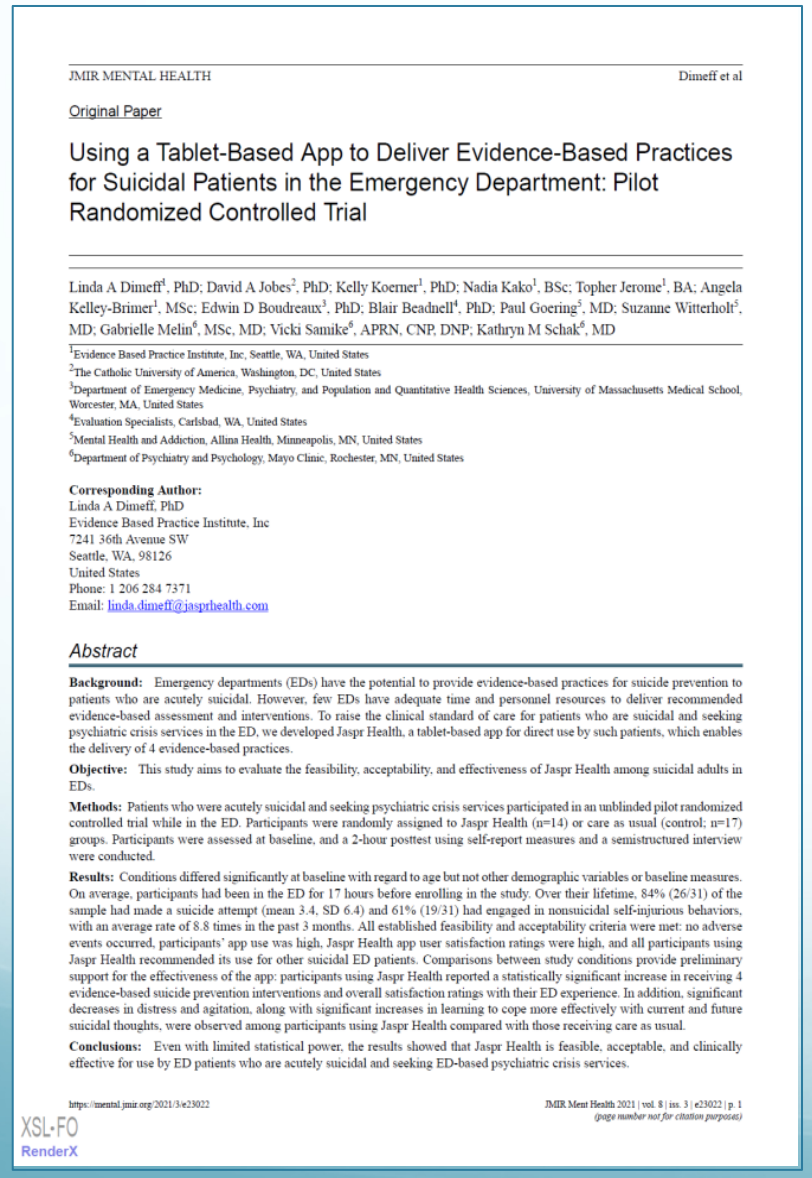




Covid compelled us to expand the use of Jaspr Health to primary care and outpatient settings…

# Jaspr Health RCT findings and next steps...



JMIR MENTAL HEALTH Dimeff et al

Original Paper

## Using a Tablet-Based App to Deliver Evidence-Based Practices for Suicidal Patients in the Emergency Department: Pilot Randomized Controlled Trial


Linda A Dimeff[1], PhD; David A Jobes[2], PhD; Kelly Koerner[1], PhD; Nadia Kako[1], BSc; Topher Jerome[1], BA; Angela Kelley-Brimer[1], MSc; Edwin D Boudreaux[3], PhD; Blair Beadnell[4], PhD; Paul Goering[5], MD; Suzanne Witterholt[5], MD; Gabrielle Melin[6], MSc, MD; Vicki Samike[6], APRN, CNP, DNP; Kathryn M Schak[6], MD

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*Abstract*

**Background:** Emergency departments (EDs) have the potential to provide evidence-based practices for suicide prevention to patients who are acutely suicidal. However, few EDs have adequate time and personnel resources to deliver recommended evidence-based assessment and interventions. To raise the clinical standard of care for patients who are suicidal and seeking psychiatric crisis services in the ED, we developed Jaspr Health, a tablet-based app for direct use by such patients, which enables the delivery of 4 evidence-based practices.

**Objective:** This study aims to evaluate the feasibility, acceptability, and effectiveness of Jaspr Health among suicidal adults in EDs.

**Methods:** Patients who were acutely suicidal and seeking psychiatric crisis services participated in an unblinded pilot randomized controlled trial while in the ED. Participants were randomly assigned to Jaspr Health (n=14) or care as usual (control; n=17) groups. Participants were assessed at baseline, and a 2-hour posttest using self-report measures and a semistructured interview were conducted.

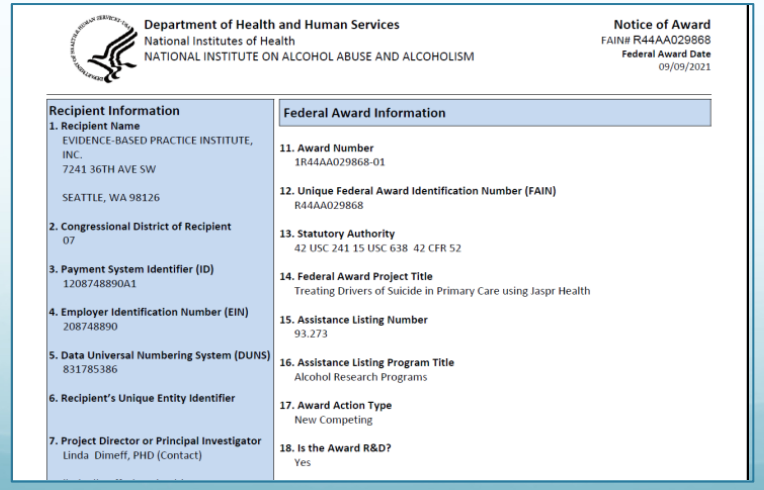
**Results:** Conditions differed significantly at baseline with regard to age but not other demographic variables or baseline measures. On average, participants had been in the ED for 17 hours before enrolling in the study. Over their lifetime, 84% (26/31) of the sample had made a suicide attempt (mean 3.4, SD 6.4) and 61% (19/31) had engaged in nonsuicidal self-injurious behaviors, with an average rate of 8.8 times in the past 3 months. All established feasibility and acceptability criteria were met: no adverse events occurred, participants' app use was high, Jaspr Health app user satisfaction ratings were high, and all participants using Jaspr Health recommended its use for other suicidal ED patients. Comparisons between study conditions provide preliminary support for the effectiveness of the app: participants using Jaspr Health reported a statistically significant increase in receiving 4 evidence-based suicide prevention interventions and overall satisfaction ratings with their ED experience. In addition, significant decreases in distress and agitation, along with significant increases in learning to cope more effectively with current and future suicidal thoughts, were observed among participants using Jaspr Health compared with those receiving care as usual.

**Conclusions:** Even with limited statistical power, the results showed that Jaspr Health is feasible, acceptable, and clinically effective for use by ED patients who are acutely suicidal and seeking ED-based psychiatric crisis services.






- RCT of n=31 emergency department patients
- Jaspr patients effectively received four evidence-based suicide-focused interventions
- Significant between-group decreases in distress and agitation compared to treatment as usual (TAU)
- Significant between-group increases in coping with current and future suicidal thoughts compared to TAU
- 100% of patients recommended use of Jaspr for others



Department of Health and Human Services
National Institutes of Health
NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

Notice of Award
FAIN# R44AA029868
Federal Award Date
09/09/2021

| Recipient Information | Federal Award Information |
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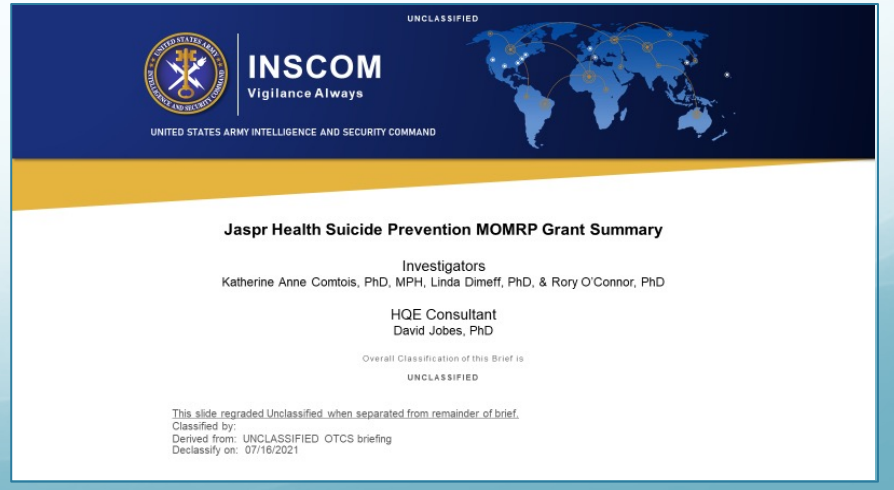
| 1. Recipient Name<br>EVIDENCE-BASED PRACTICE INSTITUTE, INC.<br>7241 36TH AVE SW<br><br>SEATTLE, WA 98126 | 11. Award Number<br>1R44AA029868-01 |
| 2. Congressional District of Recipient<br>07 | 12. Unique Federal Award Identification Number (FAIN)<br>R44AA029868 |
| 3. Payment System Identifier (ID)<br>1208748890A1 | 13. Statutory Authority<br>42 USC 241 15 USC 638 42 CFR 52 |
| 4. Employer Identification Number (EIN)<br>208748890 | 14. Federal Award Project Title<br>Treating Drivers of Suicide in Primary Care using Jaspr Health |
| 5. Data Universal Numbering System (DUNS)<br>831785386 | 15. Assistance Listing Number<br>93.273 |
| 6. Recipient's Unique Entity Identifier | 16. Assistance Listing Program Title<br>Alcohol Research Programs |
| 7. Project Director or Principal Investigator<br>Linda Dimeff, PHD (Contact) | 17. Award Action Type<br>New Competing |
| | 18. Is the Award R&D?<br>Yes |



UNCLASSIFIED

INSCOM
Vigilance Always
UNITED STATES ARMY INTELLIGENCE AND SECURITY COMMAND

**Jaspr Health Suicide Prevention MOMRP Grant Summary**

Investigators
Katherine Anne Comtois, PhD, MPH, Linda Dimeff, PhD, & Rory O'Connor, PhD

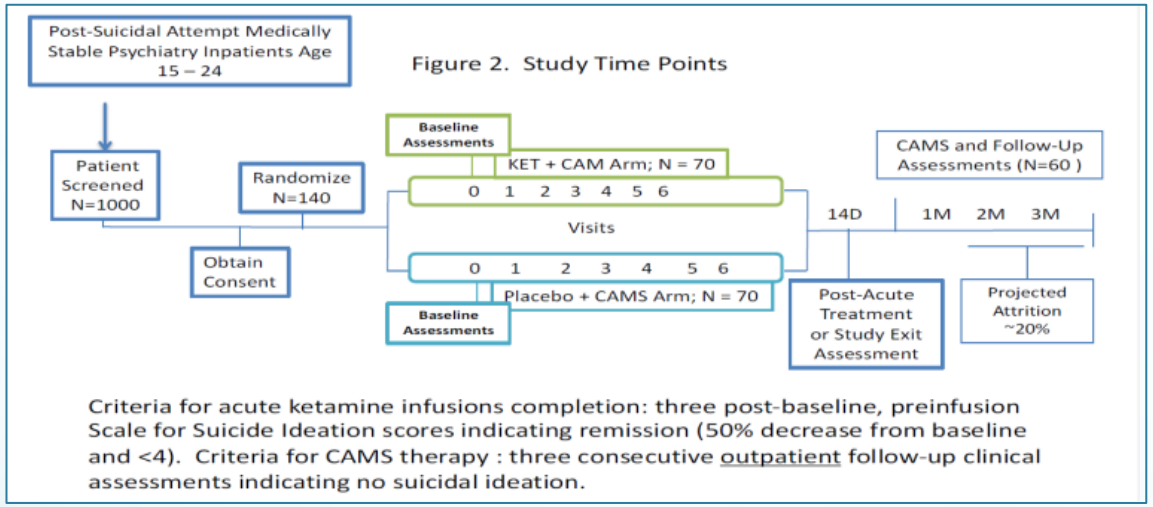
HQE Consultant
David Jobes, PhD

Overall Classification of this Brief is
UNCLASSIFIED

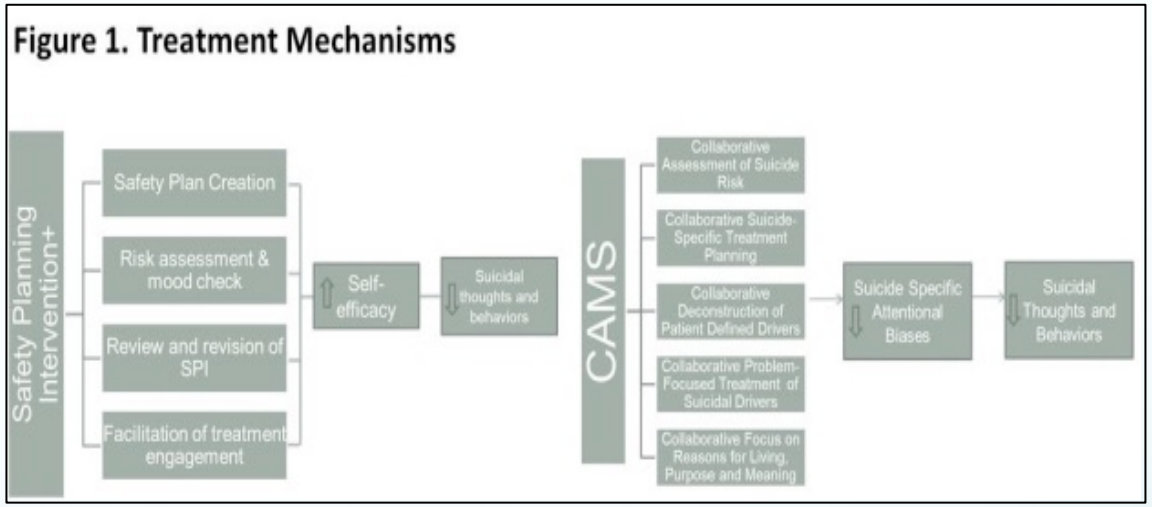
This slide regraded Unclassified when separated from remainder of brief.
Classified by:
Derived from: UNCLASSIFIED OTCS briefing
Declassify on: 07/16/2021

# Two new NIMH-funded R01 CAMS-related RCT's!

## CAMS & Ketamine RCT
## Mass General & Cleveland Clinic
## (PI's: Amit Anand & Tatiana Falcone)




## CAMS-4Teens vs. SPI+
## Seattle Children's & Nationwide
## (PI's: Molly Adrian & Jeff Bridge)




# Swift et al's (2021) meta-analysis of nine CAMS clinical trials: CAMS is a "well supported" intervention for suicidal ideation as per CDC criteria

ORIGINAL ARTICLE

The effectiveness of the Collaborative Assessment and Management of Suicidality (CAMS) compared to alternative treatment conditions: A meta-analysis

Joshua K. Swift PhD, Associate Professor | Wilson T. Trusty MS, Doctoral Candidate | Elizabeth A. Penix MS, Doctoral Candidate

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Funding information
CAMS-care, LLC

Abstract

**Introduction:** This meta-analysis aimed to test the efficacy of the Collaborative Assessment and Management of Suicidality (CAMS) intervention against other commonly used interventions for the treatment of suicide ideation and other suicide-related variables.

**Method:** Database, expert, and root and branch searches identified nine empirical studies that directly compared CAMS to other active interventions. A random effects model was used to calculate the effect size differences between the interventions; additionally, moderators of the effect sizes were tested for suicidal ideation.

**Results:** In comparison to alternative interventions, CAMS resulted in significantly lower suicidal ideation ($d = 0.25$) and general distress ($d = 0.29$), significantly higher treatment acceptability ($d = 0.42$), and significantly higher hope/lower hopelessness ($d = 0.88$). No significant differences for suicide attempts, self-harm, other suicide-related correlates, or cost effectiveness were observed. The effect size differences for suicidal ideation were consistent across study types and quality, timing of outcome measurement, and the age and ethnicity of participants; however, the effect sizes favoring CAMS were significantly smaller with active duty military/veteran samples and with male participants.

**Conclusions:** The existing research supports CAMS as a *Well Supported* intervention for suicidal ideation per Center of Disease Control and Prevention criteria. Limitations and future directions are discussed.

INTRODUCTION

Globally, approximately 800,000 individuals die by suicide each year (World Health Organization [WHO], 2019). The frequency of suicide-related deaths is also a major concern in the United States (U.S.), where annually 47,511 die by suicide, over 1.4 million adults attempt suicide, and 12 million have serious suicidal thoughts (Substance Abuse & Mental Health Service Administration [SAMHSA], 2020; WHO, 2019). Given the pervasive nature of this leading cause of death, studies have tested interventions addressing suicide-related deaths, attempts, self-harm, and ideation. A recent meta-analysis of this research (Fox et al., 2020) that included data from 591 articles found that interventions for addressing suicidal thoughts and behaviors are effective overall; however, the effects tend to be small and have not improved over time. Although the results from Fox and colleague's (2020) meta-analysis provide an overall picture of the research, the



*Figure 2.* Forest plot of effect sizes for suicidal ideation, general distress, suicide attempts, and self-harm.

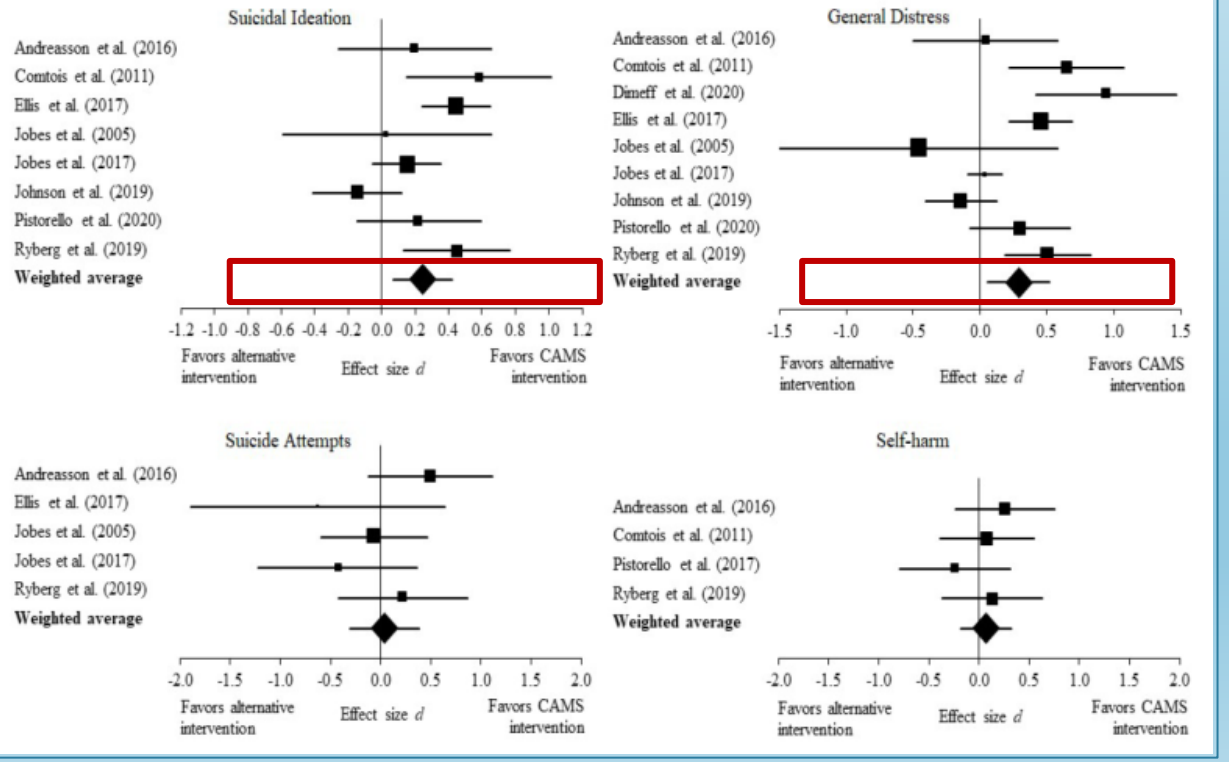
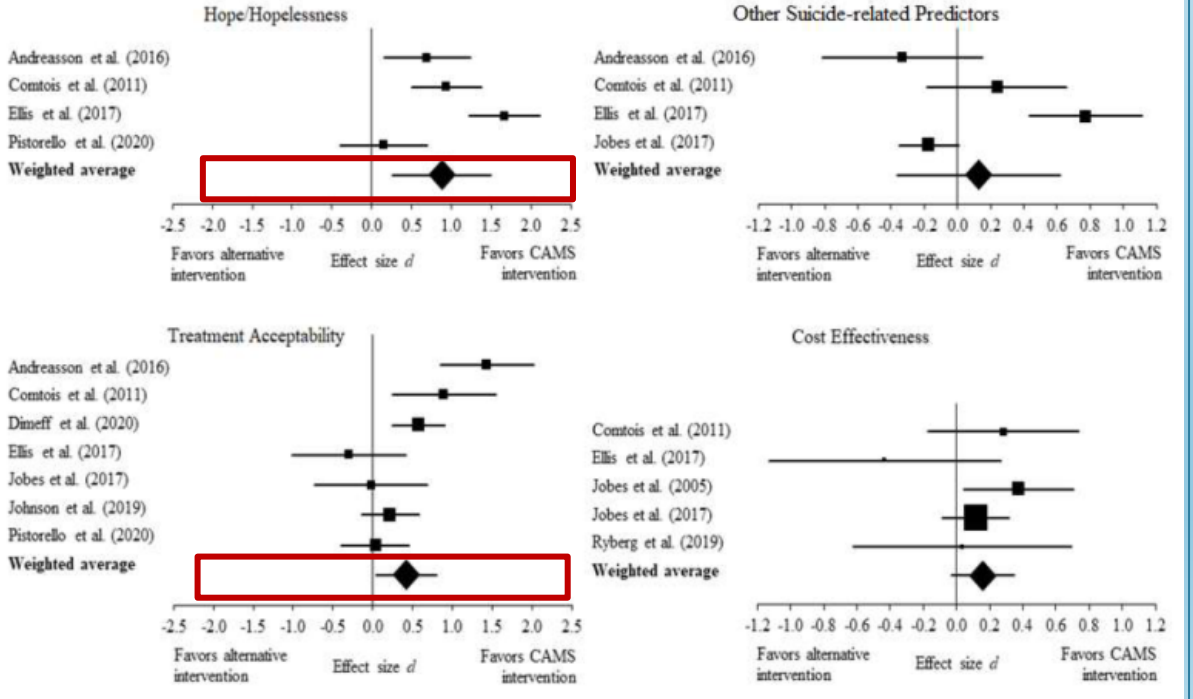
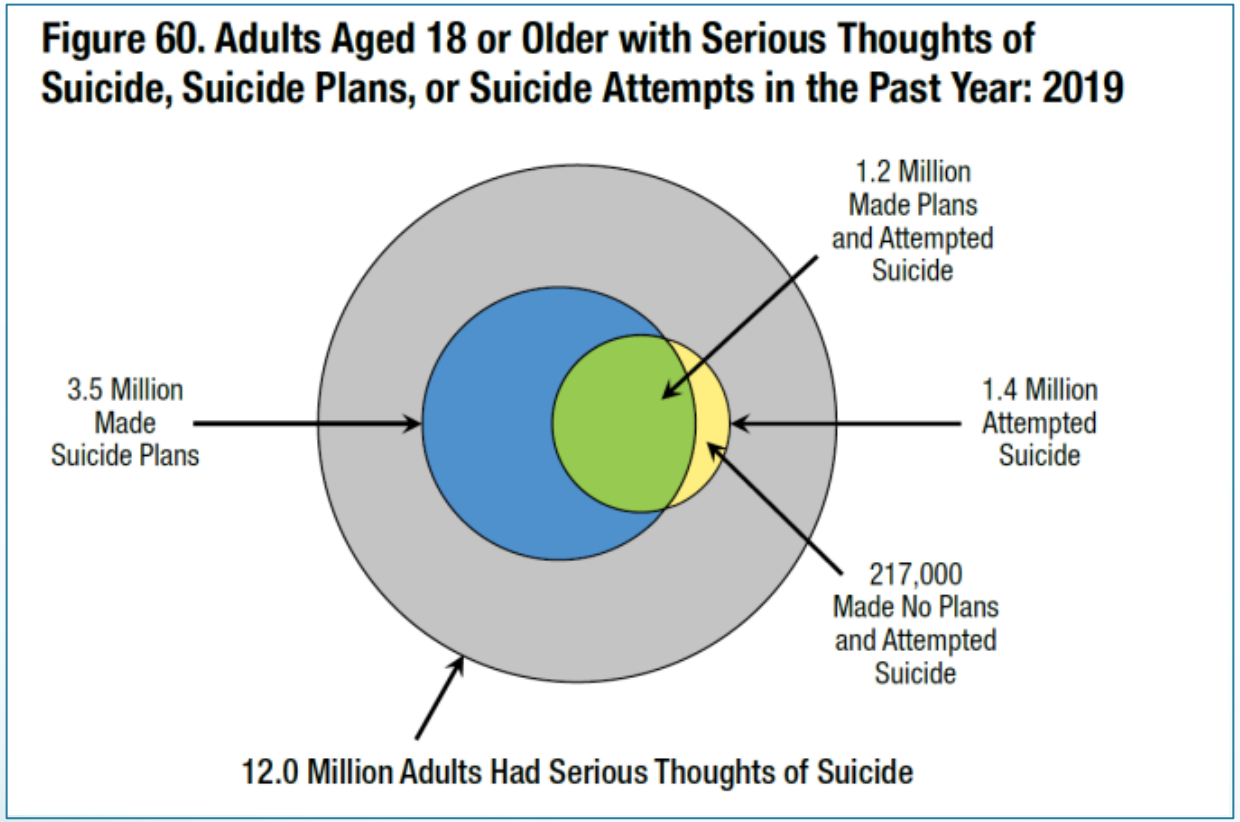



*Figure 3.* Forest plot of effect sizes for hope/hopelessness, other suicide-related predictors, treatment acceptability, and cost effectiveness.



# The Importance of Suicidal Ideation




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.

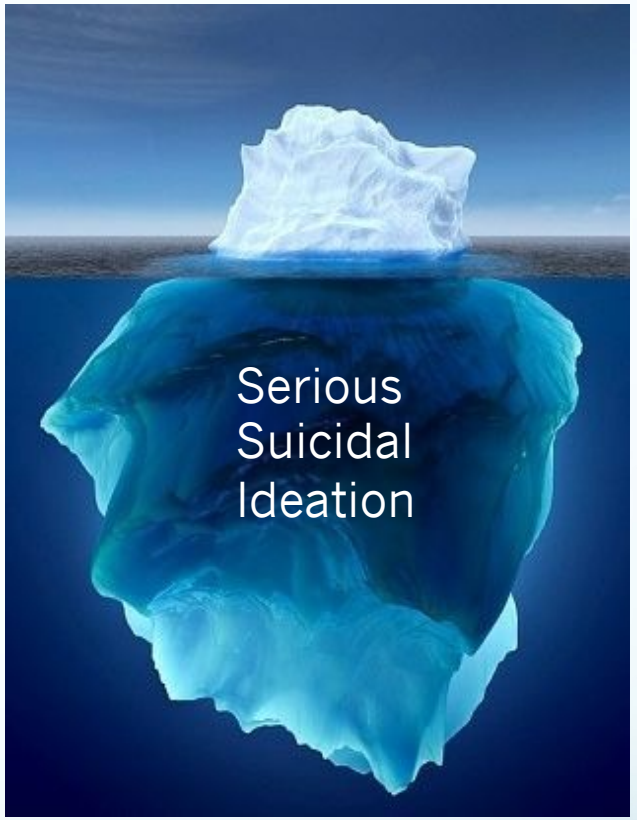
As suicide prevention researchers, we understand the appeal of observable suicidal *behaviors* with implications for morbidity and mortality. However, the morbidity of suicidal ideation should not be underestimated. As a focus of research, suicidal ideation tends to be a more elusive, ephemeral, and 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




We are understandably preoccupied with attempts and deaths.
But why do we not appreciate the largest population of suicidal people of all—those with *serious thoughts of suicide* in the past 30 days?

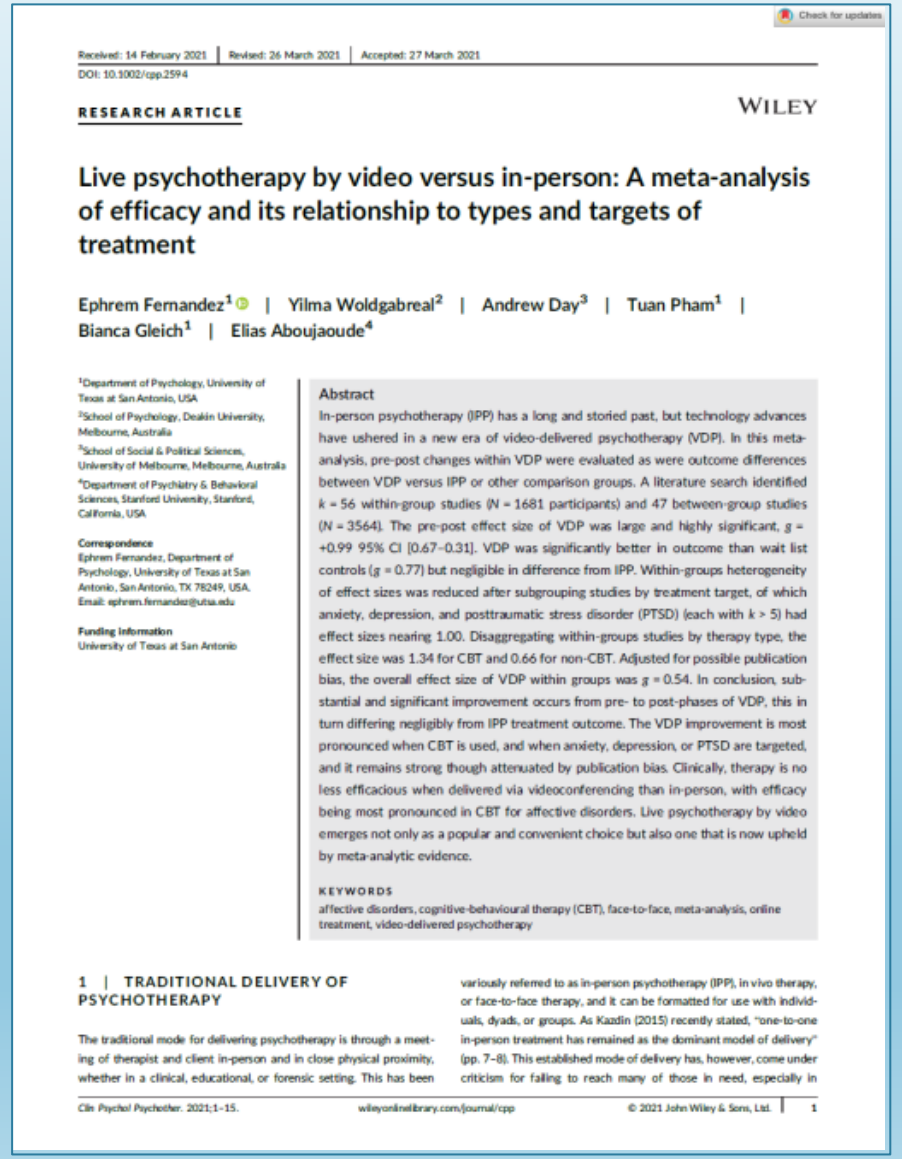
**15,000,000 total Americans with serious suicidal thoughts**

2019 CDC YRBS data adds another 3,000,000 adolescents with serious thoughts of suicide

# Key Ideas: Telehealth with Suicidal Risk

- Informed consent has never been more critical—use telehealth-specific consent
- Make arrangements for any imminent risk—3rd party involvement critical!
- Develop plan for contact—cell, text, email, phones numbers for key people
- Anticipating technology challenges (Wi-Fi failures) update software/platforms
- Use secure HIPAA-complaint platforms, be clear about recording sessions
- Verifying private space for the session—patients should use headphones
- Provide back up resources—National Lifeline/Textline, access to clinician?
- Consider increased follow-up and check-ins (e.g., phone, email, text)
- Ensure your competence with using technology—get trained or consult!

# Getting back to “normal” post-pandemic?



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RESEARCH ARTICLE

WILEY

## Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment

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**Abstract**

In-person psychotherapy (IPP) has a long and storied past, but technology advances have ushered in a new era of video-delivered psychotherapy (VDP). In this meta-analysis, pre-post changes within VDP were evaluated as were outcome differences between VDP versus IPP or other comparison groups. A literature search identified $k = 56$ within-group studies ($N = 1681$ participants) and 47 between-group studies ($N = 3564$). The pre-post effect size of VDP was large and highly significant, $g = +0.99$ 95% CI [0.67–0.31]. VDP was significantly better in outcome than wait list controls ($g = 0.77$) but negligible in difference from IPP. Within-groups heterogeneity of effect sizes was reduced after subgrouping studies by treatment target, of which anxiety, depression, and posttraumatic stress disorder (PTSD) (each with $k > 5$) had effect sizes nearing 1.00. Disaggregating within-groups studies by therapy type, the effect size was 1.34 for CBT and 0.66 for non-CBT. Adjusted for possible publication bias, the overall effect size of VDP within groups was $g = 0.54$. In conclusion, substantial and significant improvement occurs from pre- to post-phases of VDP, this in turn differing negligibly from IPP treatment outcome. The VDP improvement is most pronounced when CBT is used, and when anxiety, depression, or PTSD are targeted, and it remains strong though attenuated by publication bias. Clinically, therapy is no less efficacious when delivered via videoconferencing than in-person, with efficacy being most pronounced in CBT for affective disorders. Live psychotherapy by video emerges not only as a popular and convenient choice but also one that is now upheld by meta-analytic evidence.

**KEYWORDS**
affective disorders, cognitive-behavioural therapy (CBT), face-to-face, meta-analysis, online treatment, video-delivered psychotherapy

### 1 | TRADITIONAL DELIVERY OF PSYCHOTHERAPY

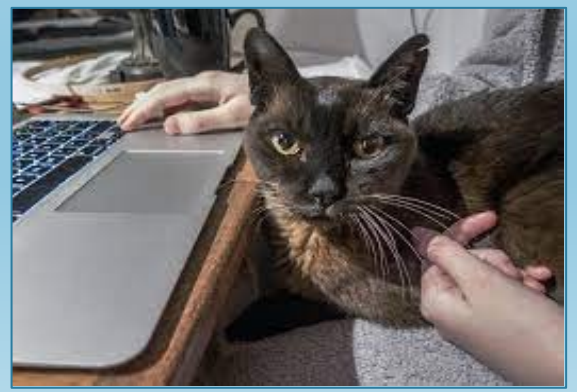
The traditional mode for delivering psychotherapy is through a meeting of therapist and client in-person and in close physical proximity, whether in a clinical, educational, or forensic setting. This has been variously referred to as in-person psychotherapy (IPP), in vivo therapy, or face-to-face therapy, and it can be formatted for use with individuals, dyads, or groups. As Kazdin (2015) recently stated, “one-to-one in-person treatment has remained as the dominant model of delivery” (pp. 7–8). This established mode of delivery has, however, come under criticism for failing to reach many of those in need, especially in

- 56 within-group studies (*N*=1,681)
- 47 between-group studies (*N*=3,564)
- Psychotherapy is no less efficacious when delivered via telehealth than in-person/face-to-face therapy
- Effects are most pronounced for CBT with affective disorders
- “Live psychotherapy by video emerges as not only a popular and convenient choice but also one that is now upheld by meta-analytic evidence.”

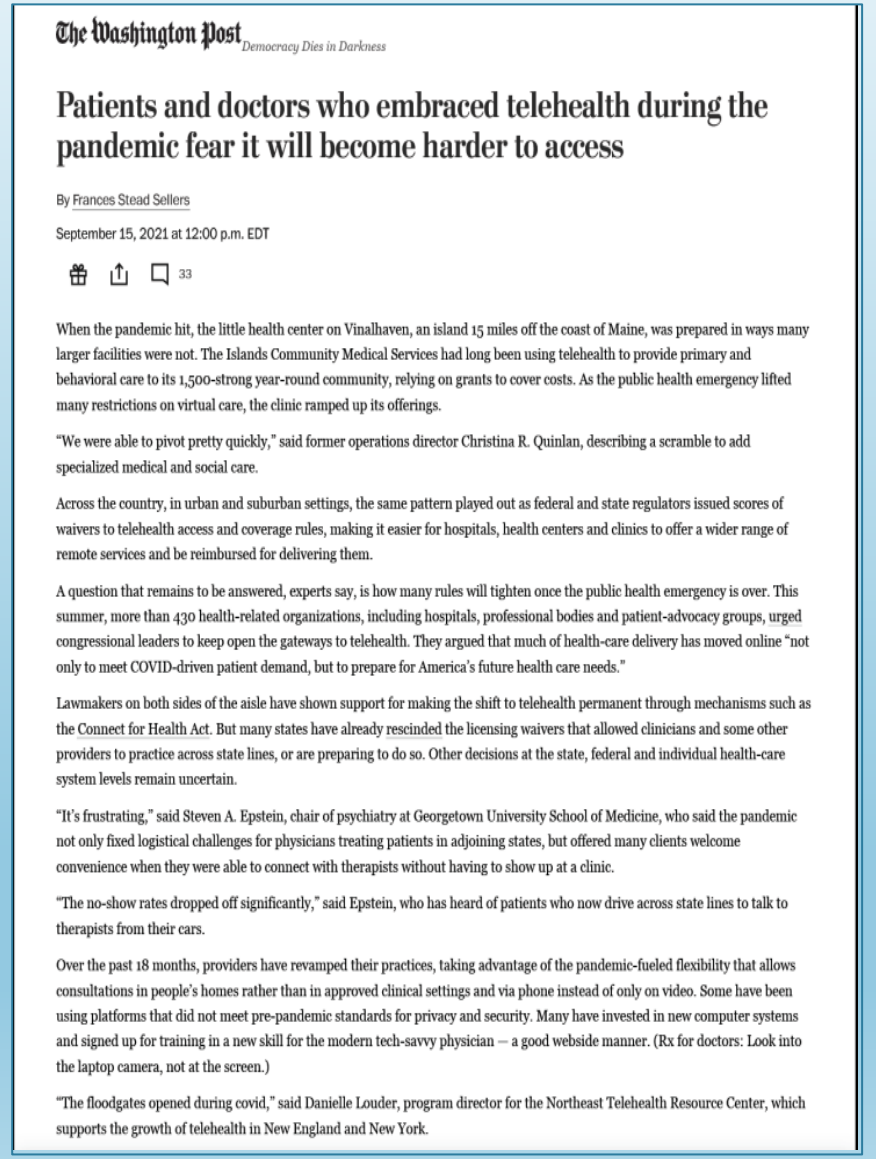
# The great democratization of mental health?

- With proper infrastructure and secure internet access, telehealth may potentially extend the reach of mental health care making it much more accessible to:
  - Rural populations
  - Frontier populations
  - Underserved and marginalized populations
  - Not seen walking into clinics—avoiding stigma
  - Not fighting traffic
  - Pets can join telehealth psychotherapy
  - Retention to care is better with fewer missed sessions
  - Lethal means safety can be done remotely—securing lethal means
  - PSYCHPACT—more provider options across state lines (for psychologists)

# Limitations of Telehealth with Suicidal Risk

- Basic issue: access to hardware and the internet
- Privacy—patients in a closet or next to co-workers!
- A distinct loss of intimacy and missing nuance
- Signing documents and sharing materials
- Seeing a teen at home in crisis and parents are gone (not as previously negotiated and expected)
- Patients may have challenges using technology
- Cell phone telehealth sessions can be problematic
- Technology routinely fails
  - Poor Wi-Fi connectivity—freezing or getting dropped
  - External hacks—"Zoombombing"



The Washington Post *Democracy Dies in Darkness*

**Patients and doctors who embraced telehealth during the pandemic fear it will become harder to access**

By Frances Stead Sellers

September 15, 2021 at 12:00 p.m. EDT

33

When the pandemic hit, the little health center on Vinalhaven, an island 15 miles off the coast of Maine, was prepared in ways many larger facilities were not. The Islands Community Medical Services had long been using telehealth to provide primary and behavioral care to its 1,500-strong year-round community, relying on grants to cover costs. As the public health emergency lifted many restrictions on virtual care, the clinic ramped up its offerings.

"We were able to pivot pretty quickly," said former operations director Christina R. Quinlan, describing a scramble to add specialized medical and social care.

Across the country, in urban and suburban settings, the same pattern played out as federal and state regulators issued scores of waivers to telehealth access and coverage rules, making it easier for hospitals, health centers and clinics to offer a wider range of remote services and be reimbursed for delivering them.

A question that remains to be answered, experts say, is how many rules will tighten once the public health emergency is over. This summer, more than 430 health-related organizations, including hospitals, professional bodies and patient-advocacy groups, urged congressional leaders to keep open the gateways to telehealth. They argued that much of health-care delivery has moved online "not only to meet COVID-driven patient demand, but to prepare for America's future health care needs."

Lawmakers on both sides of the aisle have shown support for making the shift to telehealth permanent through mechanisms such as the Connect for Health Act. But many states have already rescinded the licensing waivers that allowed clinicians and some other providers to practice across state lines, or are preparing to do so. Other decisions at the state, federal and individual health-care system levels remain uncertain.

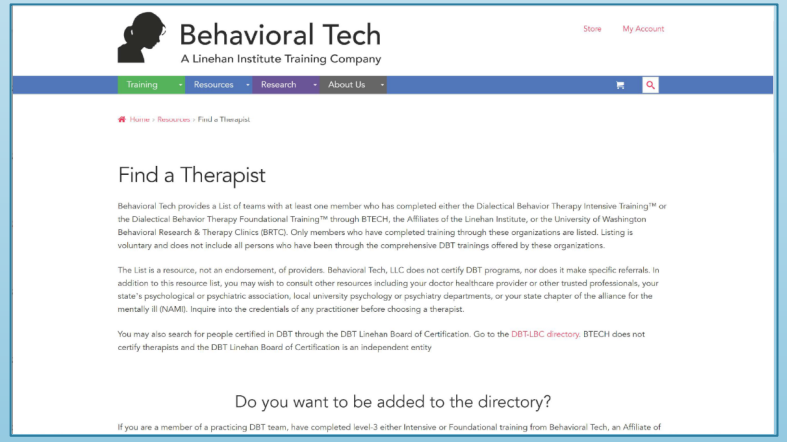
"It's frustrating," said Steven A. Epstein, chair of psychiatry at Georgetown University School of Medicine, who said the pandemic not only fixed logistical challenges for physicians treating patients in adjoining states, but offered many clients welcome convenience when they were able to connect with therapists without having to show up at a clinic.

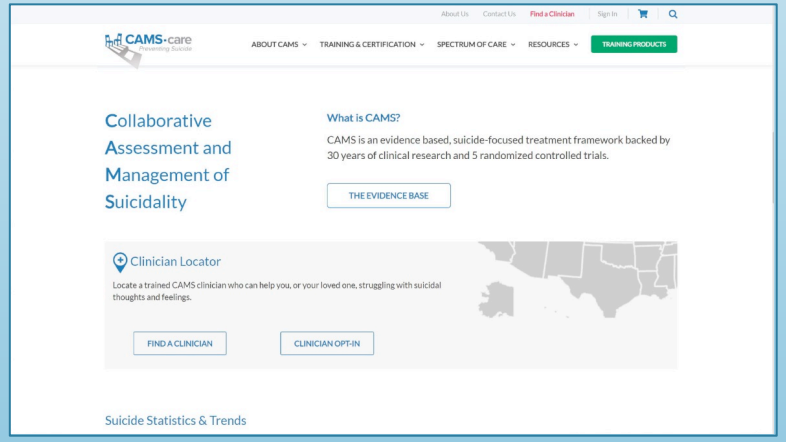
"The no-show rates dropped off significantly," said Epstein, who has heard of patients who now drive across state lines to talk to therapists from their cars.

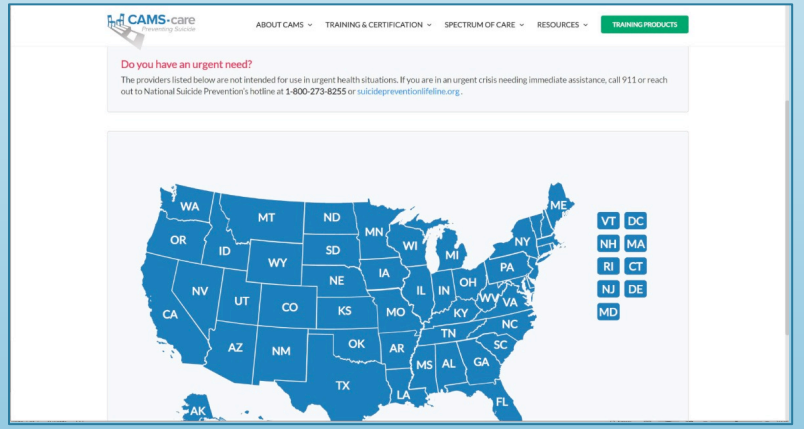
Over the past 18 months, providers have revamped their practices, taking advantage of the pandemic-fueled flexibility that allows consultations in people's homes rather than in approved clinical settings and via phone instead of only on video. Some have been using platforms that did not meet pre-pandemic standards for privacy and security. Many have invested in new computer systems and signed up for training in a new skill for the modern tech-savvy physician — a good webside manner. (Rx for doctors: Look into the laptop camera, not at the screen.)

"The floodgates opened during covid," said Danielle Louder, program director for the Northeast Telehealth Resource Center, which supports the growth of telehealth in New England and New York.

# Creating More Access to Evidence-Based Care



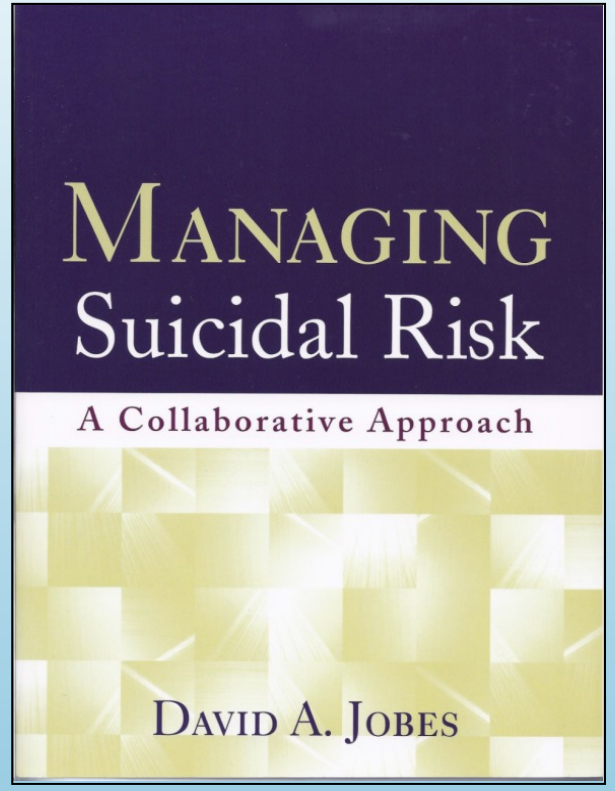




To help save more lives clinically, proven effective suicide-focused treatments need business models to help scale-up professional training and adherent use of effective care...

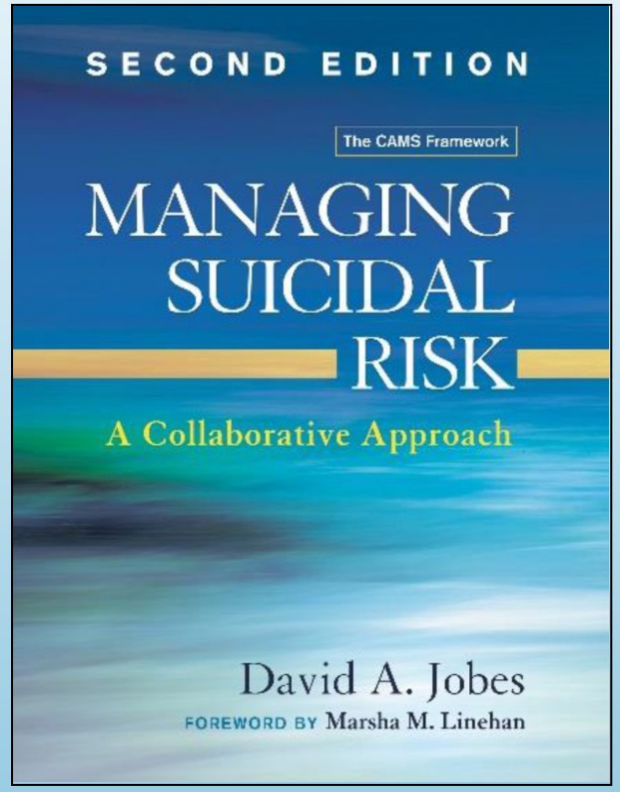
CAMS TRAINED CAMS

CAMS CERTIFIED CAMS

# The twenty-year evolution of CAMS




Assessment




Treatment

3rd Edition

Sabbatical
2021-2022

Outcomes

- The final edition of the Guilford Press book on CAMS is now underway (to be published 2022 or 2023)
- And we are launching a line of qualitative research with people who have lived experience of suicide, exploring notions of ***what makes life worth living*** and their thoughts about a ***post-suicidal life***…

# A Stepped Care Model for Suicide Care

**Stabilization Planning + Lethal Means Safety + caring follow-up used throughout the model**

## Suicide-specific Care at Each Step

From Least to Most Restrictive Intervention

**Suicide-focused care that is:**

- **evidence-based**
- **least-restrictive**
- **cost-effective**


**NEWS FLASH: 988 is coming!**

**Mental Health Service Corp—paraprofessionals (and people with lived experience) creating the necessary work force**

# 988 Lifeline creates a unique opportunity

NATIONAL SUICIDE PREVENTION LIFELINE™

1-800-273-TALK

www.suicidepreventionlifeline.org

Logo of the National Suicide Prevention Lifeline

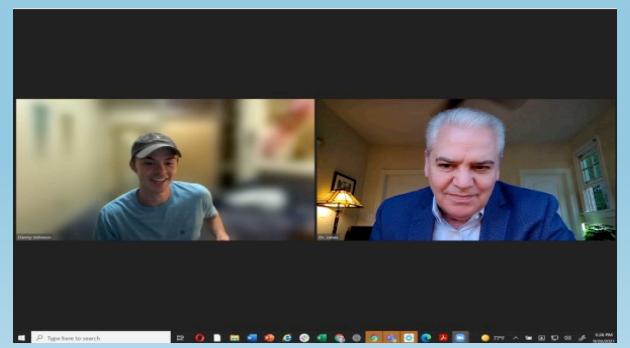
| | |
|---|---|
| **Formation** | December 6, 2004[1][2] |
| **Purpose** | Suicide prevention |
| **Headquarters** | 50 Broadway, New York City, New York, U.S. 10004 |
| **Region** | Nationwide |
| **Official language** | English |
| **Key people** | Dr. John Draper |
| **Volunteers** (2014) | 150 |
| **Website** | suicidepreventionlifeline.org (https://suicidepreventionlifeline.org/) |

- The creation of a 3-digit number for Lifeline is an extraordinary and historic achievement!
- But there are many challenges as we already have capacity issues.
- How do we reach marginalized populations?
- Many issues related “active rescue” or “safety checks” (particularly for people of color)?
- Mental health as the first touch versus law enforcement?
- Can we imagine whole new approaches to crisis response?

The Retreat Model

# In 2021 Suicidology is Exploding!

- Suicide research is growing exponentially and is more rigorous
- Suicide-related policy, advocacy, and legislation is expanding
- American Foundation for Suicide Prevention “Project 2025”
- 988 Lifeline number—potential for new models of crisis response
- Proven suicide-focused clinical treatments are gaining ground
- Zero Suicide policy movement is gaining traction in US and abroad
- Recommended standards of clinical care for different settings
- More focus on inclusion, diversity, and marginalized populations
- The lived experience movement is making huge contributions
- And telehealth can be a valuable tool for working with suicidal risk!



# Appreciation and Thanks!