Treating Suicidal Patients During COVID-19:
Best Practices and Telehealth
Education Development Center
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Treating Suicidal Patients During COVID-19: Best Practices and Telehealth..

>> Good morning, good afternoon. Welcome to today's webinar. I'm Julie Goldstein Grumet. You are attending the treating suicidal patients during COVID-19, best practices and telehealth webinar. We are thrilled to be able to present this today, and I see a lot of people already typing into the chat, so please go ahead and do so, if you haven't already, it's moving pretty quickly, but I see we have people from Idaho, Georgia, West Virginia, South Dakota, so thrilled, all different types of professions too. I've seen people in working directly in healthcare, in schools and counseling

centers, really a wonderful group of people joining us today, as well as presenters that we are really thrilled to be able to bring to you.

We will give people about one more minute, as you know, it was an extremely large response to this webinar, so we will give people one more minute, knowing that it may take another minute or so for people to log on. But again, we are just so appreciative of you taking time out of what we know is an incredibly busy time for you to join us. For those of you just joining, I want to make sure you are on the right place, welcome to treating suicidal patients during COVID-19 best practices and telehealth webinar. We will join, I'll give people about 20 or 30 seconds, because it can take a while for everybody to get in the room, and after that, we have an action packed webinar. I'll let people know while we are starting to please feel free, we will be able to monitor your chat throughout today's Webinar even though you may not see it publicly for everybody. That is in order so that we can get through the presentations and have time for Q and A at the end. Please don't worry about it. We see all of your questions coming through. We will make sure to get to each of them in turn. So given it's 1:01, we have a packed Webinar, I'm going to get started. My name is Julie Goldstein Grumet, I'm your

moderator today. I am the director of health and behavioral health initiatives for the Suicide Prevention Resource Center and the director of the Zero Suicide Institute.

I'm thrilled to be able to monitor, moderate today's Webinar. Before we start today's webinar, I'm going to turn it over for some tech tips. Chelsea?

>> Thank you, Julie. Thank you for joining us today. Audio is being provided over your computer speakers. If you cannot hear, please dial in to the number located at the lower left-hand side of your screen. All phone lines will be muted throughout today's entire webinar. If you have any questions, comments or run into tech issues, please type them into the chat box, located on the left side of your screen. Closed captioning is being provided at the bottom of your screen. The recording and slides will be made available and will be posted on our website after this call today. Thank you for listening. I'll pass it back to you, Julie.

>> JULIE GOLDSTEIN GRUMET: Great, thanks, Chelsea. Before we get started, I want to let people know they can tweet throughout today's webinar, we will be live tweeting, we are hoping to capture wonderful information throughout today's webinar, feel free to go to @ SPRC tweets, use that, you can also use hashtag zero suicide, a lot of what we are talking

about aligns with the zero suicide framework. I'll talk about that in a moment.

The Suicide Prevention Resource Center at EDC supported by a grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, SAMHSA, and the views, opinions and content don't necessarily reflect the views of SAMHSA that we express today by our presenters. I'm Julie Goldstein Grumet, the director of the Zero Suicide Institute here at EDC and the director of health and behavioral health initiatives, for the Suicide Prevention Resource Center. If you have never visited the Suicide Prevention Resource Center website, SPRC.org, please go ahead and take a look. We are federally funded to support suicide prevention across all settings, ages, populations across the life span. We take a public health approach to suicide prevention, however we also have many resources for clinical care including today's webinar. Everything that we discuss talks about how you don't do suicide prevention activities in isolation. The important ways to address suicide prevention in this country is through a comprehensive approach, and we have a very thorough comprehensive approach both for the community setting as well as for healthcare systems, the healthcare system comprehensive approach is what we call zero suicide.

Today's learning objectives, we want to 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 you on how to start using these practices and treatments, and provide resources that can be shared with individuals at risk for suicide immediately.

I want to give you a little information about today's webinar, to think about these as some of your take home points. They will be reiterated throughout the webinar but I want to set the stage. We hope that what you will get out of today's webinar is that providing suicide care during this time of COVID is possible, and your care can remain safe and effective even using telehealth and without the need for hospitalization. Our presenters will discuss suicide care practices that are evidence based, some of you may be familiar with these and this is a refresher and for some of you this may be all new. These evidence-based practices directly target patients thoughts of suicide. With social isolation in place and uncertainty everybody is facing across many different areas of our life, assessing thoughts of suicide among all of your patients is critical. Every patient, every visit. We stress this particularly those in behavioral health but at this time I'd say it should be for every patient even in medical care. This

is a time that you have to determine whether patients you are seeing are at risk for suicide and provide early intervention and care.

The care practices that will be discussed today are part of the zero suicide framework, which I'm not going to go in depth about today. But I do think understanding that this is part of a comprehensive approach that healthcare systems can employ is a helpful framing for today's webinar as well.

Zero suicide sets a bold goal of suicide as a never event in healthcare, it is something people strive towards, like we strive towards zero accidents and nuclear industry, zero airplane accidents, we should strive for zero suicides in healthcare. But zero suicide as a set of guiding practices, resources and tools to help you pursue that goal.

These utilized sustained best practices such as screening patients for suicide risk at every visit, providing interventions that directly target a patient's suicidal thoughts and behavior such as we will discuss today, ensuring all staff in the system are well trained to use these practices, and have the opportunity to practice what they are learning repeatedly, and conducting continuous quality improvements, that closely examines the impact of interventions and ensuring that you are doing what you say you are doing.

This bundle of practices has resulted in healthcare systems reducing suicide by as much as 65 to 75 percent among their patients. Zero suicide highlights the need for training of all who work in the system to ensure that they feel comfortable confident and skilled in delivering this care, and this intentional focus on preparation and the clinical work flows that go along with this type of care and manages the risk as well as training help to keep people out of the hospital, even during times of distress.

We know given the crisis that we are experiencing today, we need to avoid hospitalization when possible. We know that it is possible, even before COVID, part of the zero suicide framework was to think about how we can keep people out of the hospital and get good care without having to rely on hospitalization.

Sometimes hospitalization is necessary, but at this time we want to do what we can to teach the skills and interventions that we are teaching you today to help maintain patients' abilities to navigate emotional emergencies. There is a robust website, zero suicide.com, that is a free toolkit and a lot of resources to adopt and sustain these safer suicide care practices that we are talking about today, and the model that I briefly described, the archive of today's webinar as well as

many other resources about COVID-19, that address suicide and mental health and healthcare, are available on this website. We are thrilled to be able to bring you today's webinar. These are three world renowned speakers who are giving their time quickly, we put this webinar together in about ten, twelve days, they are, they have so much to offer. They are the developers of the interventions they will be talking about today. I'm privileged that I have the opportunity to work with them frequently.

Let me turn it over to them. Our first speaker, is Dr. Barbara Stanley, director of suicide prevention training implementation and evaluation programs at the New York state psychiatric institute, and Professor of medical psychology Colombia university. Barbara.

>> BARBARA STANLEY: Thank you, Julie. I want to echo my thanks for all of you joining today, what I know is probably a incredibly busy time for you, if your workload has changed like my workload has over this period, it's increased exponentially. Thank you all for joining. As the title of this was being presented, as working with suicidal patients during COVID-19, best practices, I thought that the title that is more appropriate is, working with suicidal patients during COVID-19 making it up as you go.

That is actually not a bad thing, because I think so much good is going is to come out of working with suicidal patients over this, during this crisis, where we really have had to improvise and that I hope will endure. I'd like to jump into it. We all know that what is happening now requires social distancing, and isolation. Because of this, telehealth has become a important vehicle for providing healthcare. This extends to providing mental health services. If we look at the recent past, while telehealth for psychotherapy has expanded, individuals who are suicidal are actually usually excluded from telehealth services. But current conditions demand finding ways to safely work with our suicidal patients during this crisis using telehealth.

Here is what I'd like to quickly cover today, some of the basic guidelines for initiating remote contact, some of the adaptations, I'm not going to go through how you do risk assessment or how you do safety planning. I'm going to describe simply what are the adaptations, with the idea that most of you know how to do this, and provide some resources at the end.

What are the adaptations in doing screening and risk assessment, what are the adaptations for clinical management and safety planning, and how to use ongoing check ins and

follow up and the importance of documentation and support for your own self.

One of the things that is really important when you initiate contact with somebody who you know to be suicidal is to get a sense of, get exactly where they are located, what their address is, at the start of the session, so in the event that you need to contact emergency services, you have that information right then and there. In addition, it would be great if you could have in advance contact information for who is their emergency contact, should you need it. And this is a little bit of a trick, because most of us are working at home, you need to develop a contact plan, should the call and video session be interrupted, and you need to develop a plan for how to stay on the phone, or in the video chat, while arranging for emergency rescue, if it's needed.

I'm saying that that is the ideal, it is actually not possible for all of us to do that. Some of us don't have two phones that we can use. I guess the underscoring of all of this is, you do the best that you can during this time. When we think about doing risk assessment, in addition to doing standard risk assessment.

(beeping).

One of the things of course that you want to ask about is

the emotional impact of the pandemic on your patient's suicide risk. These are some of the possible risk factors, these are pretty well-known social isolation, social contact and sheltering together, what are the particular financial concerns, worry about health or vulnerability in themselves or their others, decreased social support, increased anxiety and fear, and importantly what are the routines that have been disrupted.

Then we also want to inquire about increased access to lethal means. This is particularly true because people have now, because people have stockpiled medication, it makes sense that they have done that, but we want to inquire especially about Tylenol and other psychotropic medications because we know that Tylenol is quite lethal, and I'll come back to this in a little bit.

Given the strain our hospitals and E Ds, I'm from New York and I think our hospitals can't get more strained than they are right now, and the importance of remaining home, we want to try to identify ways with our patients of staying safe, short of going to the ED and this is even, this is always crucial as Julie mentioned and useful. But it's even more critical now. This comes from the group who I work with at New York state psychiatric institute, we put our heads together, and came up

with what are the things that we have used with our suicidal patients. We make provisions for increased contact even brief check-ins until the risk is diminished. It's important to remember that risk fluctuates over very brief periods of time, and so brief check-ins can be really helpful, and I'll talk a little about in a minute what those brief check-ins would look like, always provide crisis hot line and crisis text information to your clients. Then identify individuals in the client's current environment, who can help as monitors for the client's suicidal thoughts and behaviors. This can either be in person, or remotely. One of the things that would be very useful at this particular point is to seek permission to have direct contact with these individuals, and in fact follow through with that contact.

Develop a safety plan to help clients manage suicide risk on their own, and in addition, beyond the safety plan, collaborate with them to identify additional alternatives to manage risk, and people can come up with great ideas on their own about how, what can help them stay away from going to the hospital, should they become suicidal. However, in the case that risk becomes unmanageable, of course the person will have to go to the hospital. It's unfortunate, because we risk exposing them to becoming ill, but if risk becomes imminent and can't be managed

remotely, they need to go to the nearest emergency room, or as usual, call 911. It's really important to try to stay on the phone, or whatever mechanism you have, until the client is in the care of one of their support system who will take them to the hospital, or a professional, health professional.

This is in the event they have to go to the hospital but we can do a lot with safety planning to help, number one, reduce suicide risk overall, and two, help people to not go to the hospital. The remote safety planning process is quite similar to conducting it in person. You have to figure out how to make that work, and so that means who is going to have, how are you going to get a plan to the person, a written plan, are they going to write it down, are you going to write it down, are you going to take a picture of it, so the logistics of it you have to work out with the person, and that is a little different than doing it with them in person. If they haven't done a safety plan before, you tell them a little about what it is, how long it is going to take. If they have done a safety plan before, it's great to just say, let's take it out, take a look at it and see, given what is going on now in terms of social isolation, what needs to be changed on it. It's important at this moment to emphasize that having a safety plan is really important right now, to stay safe without going to the ED, or

to any other kind of medical facility. And just remind people that if they go to the ED, the resources are very limited at this point, and that it's really safer for them to stay home, if at all possible. As I just mentioned, we have to figure out a way to get the client a copy of the plan. It's going to differ, depending on what the client wants and what you feel comfortable doing.

So we came up with a few adaptations of safety planning for people. We want to first identify warning signs. For people who already have a safety plan, we want to revisit now that this is happening, what are their new kinds of warning signs, extreme fear of illness which I have heard, coping with illness, in self or others, like being ill and having to take care of others, feeling very lonely or socially isolated, or if you are not alone, family conflict, or roommate conflict.

We came up with the idea which is in a lot of different CPTs, form of CBT to have people think about an emotional thermometer, and to take their emotional temperature. This is a simple way of gauging where are you, where you are in terms of how distressed you are, and this can be used beyond being suicidal, but it can also be used for how angry, how anxious, how frustrated you are but here we use it particularly for people controlling their suicidality, and we all know that it's

easier to bring the temperature down when it's not high. We help people, you can spend time helping people identify when they start to enter that yellow zone, so that they don't ever enter the red zone, where for many people it's the point of no return.

Once they have the idea of, okay, these are the kind of clues that I have that things are getting out of control for me, so during the pandemic, it's important to identify things that they can do when they are alone, and so we want to, as we usually do, with safety planning, identify things that can be done to distract from suicidal thoughts and de-escalate the crisis. We want to, as always, to make sure that whatever we are helping them choose, it doesn't increase their suicide risk such as for some people, watching the news incessantly is going to make them much more upset. So we want to identify things that are going to bring the temperature down. These are some examples, taking a time out, using mindfulness apps, do activity that will change your physical state. I think Ursula will be talking about this later. Use distracting activities, I've heard many people go back to hobbies that they used to do, that they have the done in many years -- haven't done in many years. Do something nice for yourself, self soothing. Figure out if there is a way that you can contribute virtually. These

are all things that we can do now during this crisis that we can do on our own.

Then in terms of adaptations in terms of social context, one of the things that we like people to do is to identify social contacts that are not necessarily one on one social contacts, but like social contacts that put you in touch with other people without telling them that you are feeling suicidal. When people could go out socially, we would say, is there a coffee shop that you can go to, is there a park where there are people around that you can go to. We can't do that anymore. But there is lots of things on line, like virtual travel tours, virtual meetup programs, virtual hangouts with friends via Skype or FaceTime and there is also interactive on-line games or forums.

So, the Internet fills a lot of the gap here. In addition to focus on the current social environment, in other words, who the person is living with, and how they can utilize people in their social environments as distractions, here are some additional meeting spaces. I won't go through all of these. You will be able to see these later. Then we also want to identify for the person's social environment where they are, are there places that they can go outside, where social distancing is practiced, that are safe for them to go to, that

they can go to.

Okay. Then you need to figure out who in this environment now is it the same person and/or people who can help your patient, if they become suicidal and they need to say, hey, I'm in trouble, I'm feeling really suicidal, or I'm in crisis now, or is it a different person? The person that they may normally turn to might be emotionally very distressed right now, and so you know, you need to do a check in with your client about, so is the person that you usually turn to for support and help okay in this period of crisis, or do we need to think about who else might be better?

So, for all of these things, we want to be really specific, we want to help them identify one or two key people, and we want to encourage them to share the plan with these people to let them know that they would like to be able to use them in this way and check it out with them. As I mentioned, it's useful if you as the clinician can gain permission to have direct contact with the client's contacts or their supports.

If you are able to get direct contact with the supports, you can offer them in a brief call a couple tips on how to help your suicidal patient. Then finally, you need to identify emergency contacts, which can be different. A lot of the people who I work with, the psychiatrists who I work with are

really not available now. They have been deployed to ICUs and medical floors, and so they are not available to their patients in the way that they had been. We need to think about, who can they turn to now, and think about virtual meeting services, with healthcare professionals, or who are the stand ins for their professional. And of course using the hot line and text line.

So we just want to make sure for all of these steps that involve contacting other people, that the contact is virtual rather than in person, unless they are currently living with the person, and we just really want to underscore that with our clients. We want to let them know in advance, it's good to call it in advance, that it might seem a little different to have virtual contact as opposed to sitting with your support person. Some people hate talking over the telephone, or doing FaceTime. What you can do as a clinician is to kind of do a little bit of exposure with them, to help get them a little bit more comfortable with using virtual support in a crisis. Then providing them supports for doing it. In other words, having them do a little bit of exposure. Okay. This is really important. Reducing access to means, people have changed their circumstances, their living environment, some people have moved to other locations. Some people are in very packed

environment. And so we have to kind of talk with them very directly about increased access to lethal means.

And how to reduce that access, so with stockpiles of Tylenol or other medications, there might still be a way that somebody else can hold their medications or the extra amount of medications, even in this particular environment, can be left at somebody's door, can be put in their mailbox and it can be brought back so we have to get creative.

Then, finally, we have to make sure that firearms if present are stored safely or temporarily removed. Then a couple other things. If there is time, it's great to encourage and collaborate with your patient to develop a plan to maintain stability and to build mental reserves during this time. In other words, to help them not even get into that yellow zone on the emotional thermometer. These are really simple things, which you probably have seen on the Internet over and over by now. Develop a daily plan and follow it. This means what are you going to do each day, in addition within each day have a regular schedule, and try to keep to that. I know some people, day has turned night and night has turned day already. Try to go outdoors once daily in a safe manner. It is important to reconnect with the outside world, even if it's just standing outside your building for a little bit. Encourage acceptance

of the range of feelings. Then finally, build mastery or identify and encourage pleasurable activities. This is something that we typically don't have time to do many of us, and so you can encourage people to do this. The idea is building up the floor, building up the reserves as much as possible, in a time of great uncertainty and fear.

Then I want to talk a little bit about check ins and ongoing contact. If you have somebody who you have found out is currently suicidal and you are trying to help them stay out of the hospital, one of the simplest ways of doing this, and this definitely puts a burden on the clinician, is to conduct, is to have increased contact with that person, and to conduct a suicide screen at all contacts, and so you can use a standardized screening tool, like the CSSRS or another kind of tool, but we don't want you to do it in a way that now we are doing the CSSRS, you can do this in a conversational manner of course. So as you initiate the contact, you review any changes in risk or protective factors, is there change in their health, do they have new access to lethal means. Is interpersonal conflict increasing tremendously, is social isolation, feelings of loneliness increasing. What is actually changing in their lives. And are these having an impact on their feelings of suicidality. Then what we do in one of these contacts is

review and update the safety plan. We ask about whether they have used it. If they have used it, did it work? What didn't work? What helped? Then plan for the next contact. You determine with them based on the acuity of the risk, when that next contact should be. It could be in the next day, it could be later that day. Or it could be in three days, or if the person's risk has come down to pretty much very very minimal, you can say okay, let's have our next check-in at our next appointment. And which would be like say your weekly appointment. Now, I want to stress that this does put an increased burden on the clinician to do these kinds of increased check-ins. They should take about ten minutes, usually no more. They don't have to take. They could take up to 15 minutes. But we are talking about in the ten minute range, and I know from having worked with so many suicidal patients that I would rather do these kinds of check-ins, make sure my patient is safe, than worry about them. So if I have these kind of check ins, it increases the amount of work. So just a couple more things, I want to talk a little bit about documentation, and then support for yourself.

It's important just as you would normally do, to document all your interactions with your patients, and to document your clinical thinking about why you are doing what you are doing.

Friday to consult with your supervisor or peers, on challenging clinical decisions. We do this all the time. I've worked with hundreds of suicidal patients, and I'm constantly checking with my colleagues who also have this expertise, about okay, this is what I'm thinking of doing, what do you think, do you see other alternatives? During this time, when many clinicians are working remotely, it is also important to attend to your own sense of isolation. It's important for you as a clinician to get support. Working with suicidal clients, no doubt creates additional burden, in the time of great stress. So, clinicians self care activities are crucial. It is important for you, even though you are doing these kinds of brief check-s in, to arrange for periods of coverage, if possible, and allowing for yourself to have time off.

So what we do is we just let people know, our suicidal clients, or all of our clients, in advance of when time away will occur, and make alternative provisions to enhance their care and safety. Honestly clients respond typically very positively and respectfully, when clinicians explain that they will be available for a period of time, they recognize that we are people too.

I'd like to end here by pointing to some resources. This is my E-mail here. We have a website, suicide safety plan, there

is also an app that is called Stanley Brown safety plan in the app stores. Here are some of the references. I am open to questions later, and I will now turn it over to the next presenter. Thank you.

>> Barbara, thank you so much. This is Julie. What incredible information, useful, people can start using it immediately. I see that Adam pushed out in the chat where you can find the template that Barbara showed, so that you can pull that down and start using it immediately with clients. We want to give people a moment, we know that that was a lot of information. But what was one key take away from this presentation that's already starting to occur to you? I see a lot of people typing. I'm going to read a few things. These are great. People talk about self care of clinicians, a lot of that. People talking about how to adapt and reduce lethal means, people are really, it resonates to try to stay away from the E.R. and I don't know if this is new for some people, people, current events and how they have been disrupted and using that as risk factors, care that is changing during these times, and so I think Barbara's adaptations about accepting that some of the usual ways that we care for people and might suggest will change but accounting for that and give people space to talk about that and think through. Short check ins

resonates with people. Maybe they haven't done it frequently in the past. Letting people know when you are going to be away. There are many great comments here. I know people have a chance to see them as well, getting clients to remove lethal means. There are a few questions that came in. Please feel free to type those in now. We will pull them from the chat and save them for later. A couple people did ask about the webinar archive and access to the slides. All of that will be available probably within about two days or so. It takes us a little while to upload everything, and pull the technology out. But you will have access to this recording and access to the slides. I wanted to make sure people knew that. Barbara, thank you for an incredible presentation, with so much information that people can use immediately. I'm going to turn it over to our next presenter, Dr. David Jobes, professor of psychology at the Catholic university of America where he directs suicide prevention labs, past President of American association of suicidology and currently serves on the American foundation for suicide prevention, scientific council, public policy council, Board of Directors, he has been a great contributor to the zero suicide framework and to the SPRC as have all of our presenters and is a pleasure to welcome you. Dave.

>> DAVID JOBES: Thank you, Julie. I am thrilled to be able to present to you this afternoon on telehealth and use of interventions we are describing. What I'm going to do is give you a bit of a 10,000-foot perspective of a treatment, in telehealth reality, and how the process of converting the treatment into telehealth presentation is done and the considerations at hand. I have a couple of conflicts to disclose, grants for research, book royalties and founder of a training company that I'll describe as we go and talk about the army or V.A. I'm speaking for myself and not for the government.

COVID-19, SARS cov 2, World Health Organization's way of operationalizing this, is incredibly contagious, 1,000 times more contagious than SARS virus that has been turning our lives upside down. I have been struck as many people have by how this virus has changed the world and it's taxed our healthcare systems, and heroic work that we see in ICUs and mercy departments and sudden demands placed on health providers. I'm delighted to be in this presentation because Barbara is telling you practical in the weeds kind of thoughtful things that we need to attend to. Then I'm going to talk about the treatment, and then Ursula is going to talk about other pragmatic things that we can do that help us think about management issues, as

well as treatment as well. That is one way to organize what we are talking about today.

In any case, our training company in March was being inundated with calls about how do we now do CAMS or our intervention in telehealth reality. It seemed like it was overnight kind of thing, although it was coming for a while. What we did was immediately start moving to create a Web Page, on our website, and to offer a number of free resources at the website. We organized four different presentations that were given on Zoom, for free, we had a 300 person limit. Those filled up almost immediately. People from around the world, it was extraordinary, the level of interest that we saw. It speaks to the obvious needs that we have as health providers.

The initial part is what is telepsychology, Barbara gave a overview to that. Then specific to our intervention, protocol for converting use of CAMS to telehealth, for telepsychology. I found fascinating the Q and A. There were people that were very distressed about the idea that they wouldn't have a patient go to the emergency department or E.R., or hospitalize them, and for a lot of us, that is something that we are perhaps used to. In the CAMS model we are doing our best as Julie alluded to get everything we can to make hospitalization our last response, versus first response. In any event there

is a tremendous interest among hundreds of providers around the world, especially for the SPRC materials at last count over 1100 downloads of these materials as well.

If you are not familiar with the model, I'm not going to go into that. I'm going to say briefly that CAMS is a therapeutic framework that has a robust evidence base, we emphasize empathy, collaboration, honesty and the idea that a patient can articulate the problems that they think compel them to consider suicide which we call drivers. Treatment focuses on those drivers.

CAMS is guided by a multipurpose assessment and treatment planning tracking tool, where documentation is created in collaboration with the patient, in standard CAMS with permission taking a seat next to them and they are completing different assessment components, to develop a stabilization plan, variation of the safety plan concept. And develop a driver oriented treatment plan. Documentation is being completed in session with the patient. This becomes the medical record. After that initial session, there is additional documentation, the tracking update session, and there are criteria for accounting for different clinical outcomes, ideally a resolution.

We have this collaborative arrangement where the patient and

clinician work in this empathic and collaborative way.

Of course, with the pandemic, we want to think about using interventions that are proven to be effective, CAMS now has five randomized control trials showing it's demonstrated efficacy. Rapid reduction of ideation, and depression and hopelessness, promising data on self harm behaviors. All the things Barbara describing, Ursula will describe have a robust evidence base and support of what we encourage you to use and try.

There are three ongoing trials, one in Seattle where we are taking patients who have been hospitalized for a suicide attempt. Another in Germany for a inpatient version of this. A exciting RCT in San Diego, randomized control trial with veterans, who moved to telehealth before the pandemic started to ramp up. We have seen expansion of telehealth use of CAMS in this trial. Large multi site study looking at the comparison of cancer treatments as usual or longer term care CAMS versus behavior therapy, multi sites study done by NIH. Lots of clinical trial research going on. Eight correlational trials, lots of evidence to support CAMS in case you are not familiar with the model.

That said, what is telepsychology broadly based, 10,000-foot, any technology that can be used to

telecommunicate, we mean mobile devices and phones and videoconferencing like we are doing here. We are mindful of using these modalities as a means of connecting, where social distancing is now required, that can be synchronous, co-occurring or asynchronous where things get recorded and experienced at different times. You have probably been inundated with information about telehealth. These are very helpful. People are thrust into this feeling incompetent mode, where they haven't used telehealth or telepsychology, and they want to develop usual and customary practices around these kinds of care model. I can't emphasize the importance of consent and doing things upstream, anticipating possible outcomes. Prior informed consent, patients need to know the jurisdictional laws around clear and imminent danger, implications in terms of risk, Barbara described all those upstream considerations we need to have in place to safely engage in a telehealth modality with suicidal patients. Confidentiality is critical. You need to make sure the platform is HIPAA compliant. Not all platforms are. If you are doing psychological testing that is challenging in telehealth modalities and inner jurisdictional practice is a thorny issue that different orgs and jurisdictions are sorting through amidst the pandemic.

From the ATA this is off our website, you can get it from the A P.A. website, this wonderful checklist about thinking about resources and things upstream in terms of setting up scenario, technologies involved, how you have your office set up, different considerations presession, all the upstream consideration that is Barbara mentioned are so important if you are doing telepsychology in general, telehealth specifically to suicidal risk.

This is a template off our website that talks about informed consent and how you need that informed consent worked out carefully with these particular kinds of cases.

Specifically to CAMS, the three phases of our care, this is the protocol that is available off our website, the good news is that CAMS has been successfully used in telehealth, mostly with the army and some of the mountain rural regions of mountain west in the U.S., we have seen it applications or interest in applying it to correctional facilities. We are now using telehealth in the CAMS RCT in San Diego. Informed consent cannot be overemphasized. Like Barbara said with the safety plan, the way we think about using CAMS in telehealth is the parallel use of the CAMS, of the SSF and stabilization plan.

As we enter our first initial phase the patient will have

their copy of the SFF, the clinician has their copy. That becomes the roadmap that guides the intervention. That is critical because what we are trying to do in CAMS is ensure that the patient clearly gets that what they say matters, and the assessment and especially in the treatment plan. The patient's version that you have texted to them or that you have sent to them as a scan or as a .pdf or Fax'd or mailed, that is the patient's version of the tool for their assessment and treatment planning that they maintain. The clinician has their copy that they maintain that becomes the medical record. There are lots of opportunities to validate the patient's responses. I've been known to hold up the form and show it to the patient, there is a way of engaging and elaborating, you are taking down exactly what the patient means and intends and their responses.

With the interim process session after the first session, we are continuing to use the interim version of the SSF, and tracking their ongoing risk in the core assessment. We have suicide specific treatment plan with CAMS stabilization plan. The patient uses their forms for their reference and the clinician's completion of their form is the medical record. Lots of validation and verification by the clinician sees it just as the patient means it.

As we approach our clinical outcomes or ideally resolution,

we have a final set of SSF that is for outcome disposition, where we get one more assessment of their risk, and the clinician is orchestrating disposition and the patient has understanding of their disposition and their treatment and next steps.

The SSF will round out the record, the patient's copy for their own use and the clinician's for the medical record. It's the course of CAMS and telehealth is then concluded.

I want to share a great example in the real world that happened a few weeks ago. This is Dr. Melinda Moore, former student of mine, PhD Catholic university, associate professor at eastern Kentucky university. Melinda runs a clinic in her department where there is a I.D. program and they had 80 cases, 20 of which were CAMS cases, most of the clinicians in her clinic are graduate students. They are proponents of the intervention and have a successful clinic. When Melinda and her students went home for spring break, the COVID-19 pandemic was exponentially increasing. They were told to not come back to campus.

Melinda was faced with sudden reality that we have to adjust and they have 20 suicidal patients that they needed to keep track of and respond to. Melinda moved quickly to develop their version of telehealth platform, I use Zoom but you want

to make sure you get the HIPAA compliant version of Zoom. The clinicians started to observe things that maybe you yourself have seen if you moved into the space quickly, there are nonverbal cues and facial expressions that you don't necessarily pick up in a face-to-face in the room session. I notice as a Professor teaching 45 students, everybody is in the front row, and I have a intimacy with them that is different than I expected, in a lecture scenario. It's difficult to pick up other things and read everything. You are going to miss some things. Some clients prefer this, one client of hers in her clinic preferred it to going to the clinic. She could sit with her dog while she is in a therapeutic telehealth session.

Some of the cohort differences were clear but however there was a elder patient in their study or their clinic that took to this and enjoyed it more than she thought she would.

There are challenges for the client. A lot of this goes to privacy and a lot of the things the clinicians needs to do is ensure that the room is secure, and that you don't have noisy siblings or parents or spouses listening to the sessions. There is a number of things that in these checklists that involve verifying that things are secure and that these materials that you are getting to your client are only handled by them. You want to put a towel under the door, make sure

people are not eavesdropping on your sessions.

There are challenges on the clinic end. Do you have the facilities, the hardware, do you have a platform. These things are not free. There are legal implications and definitely insurance issues, as associate director of our training programs we know students are in these placements but our university, our insurance wouldn't cover them for telehealth. We had to modify the university policy to cover telehealth practices of our PhD students. There are these significant interjurisdictional issues. You need to check in with your local board and figure out what is available in terms of modifications during the pandemic.

We will continue to do our RCT data, there is meta an analysis being pursued. We are moving into a telehealth use of CAMS. Our training which has been partially on-line is being moved fully on-line. We are going to do Zoom based role play training with people across the country, and create separate rooms virtually in a Zoom platform, and conduct role play training which is a good way to change your practical clinical behaviors. We are going to study that as well, the impact of Zoom based training versus live training.

We are going to continue to provide resources and guidance off our training website. We are publishing two or three

papers on reaction to the telehealth crisis and the pandemic. That is important thing to be able to respond in realtime as we all know. There is a electronic version of SSF developed by the Microsoft Office group, that should be ready for prime time in the next year. I'll be working out the standard text for CAMS. What I want to emphasize is that we are here to try to help you move treatment on-line. There is this practical element that Barbara and Ursula are describing, and there is a treatment that is evidence-based with a robust evidence base that you can learn about or implement in a telehealth reality. There are other great resources, but the thing I would say is, we do not want a double tragedy. There are tragedies of people dying by this virus, every day. Our suicidal patients don't have to die as well. By heeding recommendations we are making and doing things we think are effective, doing what you need to do to get by, we are going to make a difference and help save lives. Thanks for listening.

>> JULIE GOLDSTEIN GRUMET: Thank you, so much. Such thoughtful, practical information that people can start using immediately, these interventions work. We have been having these conversations about safety planning in CAMS and DBT skills for years. So this is, the evidence base has been there for these programs for years, converting them to telehealth is

challenging, but it is doable.

It provides foundation to use these best practices in suicide care now, but also post this pandemic. Take a moment. What are the key take-aways from Dave's presentation, something that you feel like you might be able to start using immediately? Give people a moment. I see somebody already said informed consent. Both our presenters so far have homed in on that, and what does that mean and what are the dynamics under this circumstance, and we will post information too, Dave shared information from APA, Adam included the link. We will make sure it's on our website. Couple people commenting about the importance of planning upstream, with all of these policies and procedures, and again that is true both via telehealth and in person, when you go back to being able to work in person, having planning in place and policies and procedures, but some of the things the presenters talked today about give you tools to do that.

These checklists that we have are really going to be helpful and we will be sharing everything with you after today's presentation. It sound like many of our participants today are talking about how much this is helping, it seems like Dave's presentation narrowed it for the idea of confidentiality in telehealth and ways this can be achieved even at home. Thank

you, Dave, for highlighting that for our speakers and at this point I'm going to turn it over to Dr. Ursula Whiteside, our final speaker, after that we will have time for Q and A. Ursula is a clinical psychologist who describes herself as a intervention and training development researcher, she's extensive experience in behavior therapy, DBT and founder of now matters now.org which is a wonderful site that makes DBT skills more accessible. She will tell you a little about that. I'll turn it over to you, Ursula. You might be on mute, Ursula. Double checking if you are ready to go.

>> Let's try this. Hello COVID-19 warriors, I'm glad to be here. I have another affiliation, which is Ursula Whiteside LLC, I run a small company that does training and consultation, and that is where I make a income and I say that to make the point that now matters now.org is nonprofit that I run, but that I don't make a source of income for me and I've done that intentionally. My background and my training, largely centers around dial arctic Al behavior therapy which many of you are familiar with.DBT was COVID prepared in the '90s, but it was the type of treatment that you had to be flexible and adjustable, and therefore, some of the tools and techniques that I talk about today are ones that I've known forever. This is almost identical to the desk phone that I had in my office

in the research lab where I was a participant and therapist coordinator before I became a research therapist on a NIH funded trial in the research lab as well. That is what it used to look like, I did deliver caring messages that way and sometimes telehealth coaching and now it looks more like this. I've been using these types of platforms for several years. Some of us are lucky enough to have a type of platform where we can share our screen, where we can look at websites together, where we can also share links or chat. Some of us are lucky enough to have that. But if you don't, if you don't have that, that's okay. There are lots of other ways that we can share materials and information, even though we are not right in front of each other, even though we don't have a piece of paper to share.

My time with you today, I'm going to spend talking about the personal impact that this transitionary time is having on us. I'll talk about ways you can use a on-line resource to help support the work that you are doing, and on-line resource specifically to now matters now, I'll be doing a brief role play. After that I'll be, doing a role play with somebody as if they were in crisis in the moment, and then after that I'll be giving an example of how might teach that same intervention to somebody who wasn't in crisis.

I want to say now matters now.org website and nonprofit has been one of the most painful fun creative pieces of my life, not to mention frustrating and exciting. All of what has come out of that is stuff that I'll be sharing and talking with you about today.

Do no harm, one of our first and most important roles as care providers is to do no harm. What I want to do is take a moment to check in with ourselves and remind ourselves that when there is a lot of change, and when things are uncertain, that it's only natural to stiffen up, or to become afraid, or to cling to concerns that may not necessarily be applicable or that may be outdated.

Really, with the zero suicide approach, one of the key elements is that we take a less restrictive approach, that we take the approach that is the least restrictive. You might have already received a link in your chat box but what I'd like you to do right now, and this speaks to the personal impact, is to fill out this brief survey. It will take you about one minute. Either of those links should work for you. You will see there is a video at the very end. You do not need to watch that video, but you can copy and paste it later, if you would like the video. If you have any trouble, try the other link. Capitalization matters, so the S and the E matter. If you

can't get it, that is okay. We can make sure to send out a link for folks as well.

You can always do it later. This questionnaire asks, what for you is true, personally, in your own life, and in your role as a provider, how have you been impacted by suicide? Over 500 people I interviewed, provided responses and worked in settings such as emergency rooms, specialty mental health, primary care, and across settings, what we found was that the vast majority or the majority, 65 percent supported a family member or friend who had been suicidal. Of those over 500 care providers, who completed the survey, about 50 percent have had, endorsed having had suicidal thoughts in their lifetime. Every time I do a training, I ask people to fill this out, the data is completely anonymous. It doesn't collect any IP addresses, if you are familiar with that type of thing. But I find these results quite striking, almost 40 percent of those surveyed had a patient who died by suicide. I think this means in the same way that COVID means is that the distance between us and them is becoming like a smaller distance. When I meet with my patients on-line, we are doing our video session, I think about the way that it's maybe more intimate and less intimate. But the ways in which it is intimate in which they would never have seen me before, they are seeing more of me in some ways. I

think that is very interesting as we are transitioning. Also when you look at the data, to see how very similar we are to those that we work with, and I think that is important, when it gets to the idea of the least restrictive care, and the idea that folks prefer to have their care delivered outside of a inpatient hospital. We may find after all this has passed, God willing, that a lot of people prefer in general to have more of their care delivered the way that we are delivering it already.

Think in terms of stress and confusion, we can come back to the fundamentals, the things that we know that work, suicide being one of those and with their suicide's emphasis on treatment that specifically targets suicidal behavior and that engages folks in safety planning and lethal means assessment, we can come back to that and say, I don't know how I'm going to do it but I'm going to figure out a way to get that done, because that is the foundation, that is the fundamental. Suicide approach, leadership, create the recommended standard care guideline, if you are not familiar, in this document, you can Google recommended standard care for people with suicide risk, and the page 7 is assembly of the recommendations across health settings. One of the recommendations for intervention across care settings, they tell you the short story, which is that the recommended standard care across health systems and

settings is three things. One is that we identify who is at risk, two, is that once they are identified, we provide safety planning, including addressing access to lethal means. Third, provide follow-up care and contact. You have the opportunity while you are doing these virtual sessions to do all three of those. One of those are not doable during this time.

I think it's only natural, and especially in this setting for us to feel powerless in the face of people who are really struggling. I want to say this is true across the board for attending this webinar, you are experts, but sometimes I would say for myself, I feel powerless. But what I come back to also another touch stone is that people that I've worked with and the people who inform the work that I do have said simple things can be quite powerful. I think that is backed up by the power of caring context. We are going to take a trip back in time to 1999, I was working at a hospital, harbor view hospital with talented clinicians and social workers, and one of the things we struggled with despite being in Washington, in Seattle, the home of the treatment dialectical behavior therapy was to get people into treatment, people who had recently attempted suicide and were struggling to get the care they needed. One of the resources we send people to is DBT self-help. This is a free website that was put together by a

consumer. It still exists, DBT self-help.org, it is a valuable resource.

In the research, including the trial I was a therapist in, we found that DBT skills plus support can also be effective. We know DBT is a big treatment but DBT plus support can be effective. That is all to say that maybe a website like DBT self-help we can use that to support our own work. We got funding from the NIH, American foundation for suicide prevention, to create this resource for you, called nowmattersnow.org. It includes videos of people with lived experience talking about how they got through using strategies from dialectical behavior therapy. It's a video based resource. I'd ask that you open it now on your phone, to start to get familiar with it, now matters now.org. We published research that shows that visitors who came to our website and filled out a survey that was prompted, they noticed significant reductions in their suicidal thoughts. One third of our visitors just by visiting the website reported less intense suicidal thoughts in under ten minutes. Never before have we known that sending someone to a resource could potentially help reduce their suicidality. Of course we hoped, but we know there is good data that suggest visiting this website, it could help reduce people's suicidal thoughts in the short term. The

interesting thing is, when we looked at different demographics, we found that this was true for middle-aged men, for teenagers, for young adults, and also for suicide attempt survivors. We want to know why if it was working, what about it was working. On publish what we are beginning to discover is that particularly among suicide attempt survivors, they said they felt less alone. After that, they said I learned something. This is really interesting way that people are using the website. In your phone and video were a few tips. You want to administer PHQ and GAD assessments at the very beginning and come back to them throughout. If you start to veer off, you can say we were talking when you filled out your assessment questionnaire about how difficult sleep had been. I want to come back to that as we talk about suicide. Very practical things are important. It takes bravery to say can you get a pen and paper. Ask if they are still with you. These things take bravery to do. I ask you to be in this COVID world more assertive than you would otherwise be.

Additional techniques, we are trying to assess whether somebody is learning something, it's easier in some ways to do so in the room. But you can also bump up your learning in the virtual world by people telling you back what you said. For example, I know I taught you this skill, I would love to hear

how you thought, what you thought I was trying to say, for example. There are tips like summarizing at the end of the call, asking them to record some part of the call, completing a work sheet. Basically, anything that you can do to get them practice what you have talked about more deeply. There is a risk that we will just end up talking at people, and they won't have had opportunity to practice the information more deeply. Sarah is 23-year-old college student, who experienced date rape, and recently, had her treatment halted, her exposure therapy halted, and I'm learning from our usual session, I can tell by looking at her, her distress is really high. The first thing I say instead of throw out the PHQs, I say where would you say you are at on the zero to 10 scale, go back to that green, yellow, red we were talking about. She is at a 9 or 9 and a half, she says.

What I'm going to do now is jump into a role play, and I'm going to be very directive because right now her cognitive processes is very low, okay, Sarah, I'd like you to take me with you, let's walk into the kitchen, bring the laptop into the kitchen. Set it on the counter. Open the door to the freezer. Do you have any ice in there? You don't have any ice. What about any frozen peas or corn. You do have frozen peas and corn. Great. Let's take that out, let's take both

peas and the corn, great. Let's go back to the kitchen table, grab a couple towels on the way. Now what I'd like you to do is put that cold ice, icy corn on the back of your neck, and with me in front of you, you are doing good, take the peas and put those on your forehead. I'd like us to count together, we are going to do two minutes of paced breathing. It's going to get a little cold. If it gets too cold, you can pull back, taking a deep breath. You notice in the role play, I immediately jumped into having Sarah do the tool right away, rather than pushing what I had already done. If somebody is in super crisis, I walk them through a skill and the most common one I use is the cold water, which is, or ice water, so it's what you can do for when you are on fire emotionally.

If he was teaching someone this, I would ask them, do you know what to do in an emotional emergency or how to survive a full on crisis. Say this is a person who I'm doing phone sessions with and I have yet to work directly within a crisis. I would talk to them about how using cold water or substitute of frozen peas can help us tolerate painful events, and things that might not be able to get better, right, because they reduce emotions fast. They do this by acting on our vagus nerve, the nerve that innervates a number of our organs. I'll tell you more about this later. But I want to give you an

overview for now.

This is something called the mammalian dive response that cold water does. To put it briefly, it's like shutting down a computer that is on the Fritz, when we get up to that 9 or 10, in terms of our emotional intensity, we are like a computer that needs to be restarted, and this is one way to do that.

I want you to find the video on the now matters now website to help walk you through this. I'd like you to try that between now and the next time we get on a call. So if you go to the crisis line tab on now matters now, you see at the top there is steps for what to do in a crisis and a video. I'd like you to watch that video and we can talk next time about what that was like for you.

All right. So I gave two examples there of role plays, one was, with someone in crisis, one giving someone a intro orientation to cold water. There is a resource tab on the page including free on-line training related to the content I've been talking about. At the end of the day, the people that lived this experience say we should do these three things, not panic, be present and offer hope. I think that that definitely rings true in the COVID time.

>> JULIE GOLDSTEIN GRUMET: Ursula, thank you so much for an incredible presentation, with just a abundance of skills

teaching people what to do, how to do it, that it can be easily replicated. She demonstrated it here. People have access to this afterwards. But it doesn't have to feel so scary to try out these tools now that you had a chance to watch her walk through it. One key take away from Ursula's presentation, before we open it up to a general Q and A. I see a lot of responses about how much people loved it, excellence and loved it, trying to scroll through. Demonstrating the skills, generally your presentation, Ursula, a chance to see what it would be like, seems like using the cold water is resonating with people. I've seen, encourage you now matters [inaudible] Ursula demonstrates putting her face in icy cold water. So it's definitely worth watching and trying these things out with your patients.

I'm going to move us on to Q and A. I've already seen many questions come in. I'll start turning them over to our presenters. As I said when we started, it's a packed house with such great appreciation for all the work that our presenters did preparing for today, and joining us. I thank all of you for joining us during this incredibly difficult challenging time taking you away from patient care, your families, really appreciate everybody being able to join us today. I want to thank the SPRC staff for putting this

incredible webinar together, that we encourage you to watch again, share, disseminate with your peers. We know a lot of people weren't able to join today because we had to turn it down because of the size of the room.

Please go ahead and start typing your questions. I will start some of our questions. I saw a few people ask about screening and safety planning with unique populations like youth, or elderly. Barbara, I'm going to start with you. What types of plans, how do you modified safety plan in any way, if people are youth or adolescents?

>> BARBARA STANLEY: That is a good question. I think it depend how young the youth is. We just used the standard safety plan, for youth that are 12 and above. One of my postdocs, LEA is developing a safety plan for 12 and unders, but that is not ready for prime time yet.

But I would say the adaptation that there were a few adaptations on, number one, we let the adolescent youth know that we would be sharing the safety plan with a trusted adult, usually it would be one of their parents. I do that right up front so they know to not put on the safety plan anything that we wouldn't want to share with their parents.

The other, so we do share it with the parents, we explain just as we do with the youth, what the safety plan is, why they

have it, and how to use it. The other thing that is important with youth is that we don't have other youth as people they turn to on the safety plan. Those are just about the two adaptations that we do with youth.

The issue about the elderly, I know that a few people asked about older patients who are not tech savvy, so that is actually a much bigger challenge. I would say that for older adults, they probably are most comfortable doing and having a intervention over the phone, as opposed to trying to do something through a platform, although I have to say many older adults, especially those with grandchildren, are very knowledgeable about how to do FaceTime.

So, I suppose they should be able to learn how to use your secure platform. That I think is, I would say figuring out what is the right technology for the population that you are working with is important. One other thing, I know somebody mentioned something about having limited minutes, and limited amount of time. This is really an issue. I think that a lot of companies are now removing limits on data during this time, which is really great. But this is an issue. Some of the people that we worked with in Washington Heights in New York don't have a phone at all. So this can't be for everybody. So this is just, this is for, if somebody does have the resources,

and they have access to the technology, this is how you can use it. Unfortunately, not everybody does.

>> JULIE GOLDSTEIN GRUMET: Thanks, Barbara. Dave, do you have anything to add about youth or adults, elderly adults?

>> DAVID JOBES: Sure. CAMS SSF has been standardized with teenagers and we are moving into clinical trials with teenagers and even using a version of the intervention with children under the age of 12. We are trying to get into clinical trials with that. The only thing I would add is the need for upstream clarification about who is in this person's life, this child, minor child, is the parents need to be looped in, or a elderly person that might have people in their life. My only observation would be, I think there is a lot being surprised by technology, we are all in this together, as you keep hearing on TV and so forth. I think people are going the extra mile to try to connect, and I've had a number of people say to me that they have switched over to telehealth, our intervention, and surprised how well it goes and patients are surprised how well it goes. Maybe that is one of the weird silver linings of this pandemic, is that people are being surprised by going outside their comfort zone and actually connecting in a way they didn't expect to do and are finding it helpful.

>> JULIE GOLDSTEIN GRUMET: Thanks. Ursula, or really

anybody, what are some of your thoughts about how teachers or school staff, checking in with students, when they notice they are depressed or having suicidal ideation, what would you recommend? I'll start with you, Ursula, about using any of these skills.

>> URSULA WHITESIDE: That is a good question, I think a lot of times we tend to say if you don't have clinical training, within your licensure to do X, Y and Z but I think a lot of that is changing partly out of necessity, partly because it's not true. We know with Columbia that just about anybody can deliver a Columbia tool. I guess I don't have a great answer on that, except for that there are trainings that exist for teachers on how to spot people, I think on your website, Julie, how to spot students who are struggling and what to do next.

>> JULIE GOLDSTEIN GRUMET: Thanks. Another question for you is, some of the things that you have described in your intervention are geared towards getting that hot emotion under control. People are looking for people though, what do they do with people that are hyper controlled, rigid, may not recognize that they are in that state of red hot.

>> URSULA WHITESIDE: Yeah, sometimes we describe it as so hot you are cold, like the switch has flipped over. I do believe for some people who die by suicide, that is where they

are at, they are at a 80, 90, a hundred out of a hundred, and it flips and they become cold and there is this idea of screw it, I don't care anymore. One of the interventions, one of the thoughts that are happening when somebody is cold, what are the thoughts, to check those facts and to look at, is this really true that you want to die right now, or that everything is hopeless? Or is this a type of thinking that you have in situations where you shut off your emotions. If it's the second, let's make a plan for that, let's address that. The other skill might be opposite action because there is still a strong urge there which is to stay rigid, so what would be the opposite of that emotional urge, would be interesting to explore with that type of person.

>> JULIE GOLDSTEIN GRUMET: You guys have done a lot of work thinking about how to tell when somebody is at higher risk versus more moderate risk, what advice do you have for the clinicians in the webinar today about differentiating some of those differences at this point.

>> DAVID JOBES: For my part it's being dialed into the patient and being candid about this topic and asking the patient directly. Both Ursula and Barbara and I emphasize the idea of putting things on a scale, with 10 point scale or five point scale, it operationalizes where people are. The other

thing I'd like to add, there are incredible resources that are on-line, like what Ursula offers, (indecipherable) crisis survival skills on YouTube. These resources are available and hopefully people get the idea that this information is out there and can be used readily, on-line platforms.

>> BARBARA STANLEY: This is Barbara. A couple points. One, I think the point about that some people may not be hot, they may be the opposite, is really important. I find that with people who are in that position, I try to work with them on trying to get a hook into a reasons for living, and to try to hook into a little bit of their sense of hopefulness, like why stick around. That actually with a person like that, seems to be helpful. In terms of risk, in evaluating risk, the unfortunate part of that is that it really comes from knowing your patient, really well, and from having a sense of trust that the two of you have developed together. One of the things that I have told patients when I work with them is that I tolerate a tremendous amount of risk in my patients who I'm working with as outpatients, as long as I can and will help keep you out of the hospital which people do not want to go to generally, as long as I can trust you, as long as I can trust what you are saying.

So we try, so they will tell me how suicidal they are, if

you kind of develop this kind of openness in the relationship. The way that I think about it is today's moderate risk is tomorrow's high risk, and that you are not necessarily going to be with the person when they slip from moderate to high risk, which is usually we think about somebody who has suicidal ideation with intent and plan, but what you want to do is proactively have them figure out what, where are they entering that danger zone and what to do when they are in that danger zone, so because you are not with them all the time.

One thing I wanted to mention also is, I think Adam is going to put up a quawlt length for a brief survey we want to do about your experience in working with suicidal clients during this period of time. Is it here anywhere?

>> JULIE GOLDSTEIN GRUMET: Adam is going to push that out over the Q and A right now.

>> BARBARA STANLEY: Great. If you can take a minute, it's a few brief questions and answer it, it will help us get some sense. We can push it out to the results to anybody who was on this call.

>> JULIE GOLDSTEIN GRUMET: I'm mindful of the time. I want to invite, there is so much information here, we really just kind of had you drink from the fire hose, but I think that it was, every word was so hopeful for the hard work that you are

all doing. We have such honor and respect for all the participants joining in today's call, and feel so privileged to work with these three incredible speakers.

I would invite anybody who had additional questions that we may not have gotten to, please go ahead and type them in the Q and A. Our intention is to try to see if there are some themes that we didn't get a chance to address and put out an FAQ or some other resources to address that. I'm sorry if we didn't get to every question today. Obviously, we have to come to an end.

But please go ahead, type in the Q and A, if there are a couple questions that you feel are really burning that you hope that we might be able to address in the future. I want to thank everybody for joining us. Thank our presenters, fill out Barbara's survey. We have the zero suicide listserv. You can access that on the zero suicide.com website. It is another treasure chest of people willing to share their thoughts and information and resources, it's a free listserv with a few thousand participants. You may want to sign up for that listserv to share your questions with your peers. Thank you again for joining us. Good luck. Stay safe and healthy at this time. Thank you again to everybody.

>> The meeting is now over. All the participants have been

disconnected.

(end of webinar at 1:35 p.m. CST)

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