



SUICIDE RISK ASSESSMENT & MANAGEMENT IN THE AGE OF TELEHEALTH

December 16, 2020

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- Slides and a recording will be made available.
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Suicide Risk Assessment and Management in the Age of Telehealth



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BLUF: Pros of Choosing In-Person vs. Telehealth with Suicidal Patients

In-Person

1. Physical access to the patient if they need to be transported to higher level of care
2. Potentially greater engagement
3. Increased behavioral activation in coming to the office
4. Privacy easier to achieve
5. Crisis Response Planning more straightforward

Telehealth

1. Less chance of spreading COVID-19
2. Observe the patients' living situation
3. Opportunity for visual inspection for lethal means counseling
4. Facilitate engagement with patients' family
5. Increase attendance in treatment and ability to reschedule

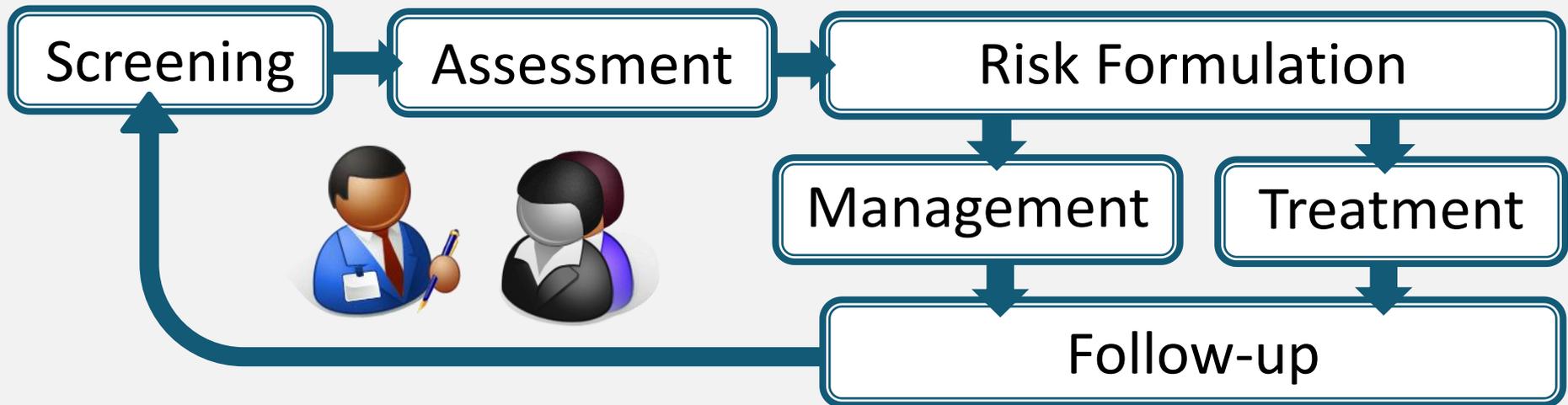
Overview

- Suicide risk screening
- Suicide risk assessment
- Management vs. Treatment
- Management by Telehealth
 - Technology supports
 - Discussion

Want to acknowledge Jeff Sung, MD, with whom I developed many of these perspectives and slides

Overview of Clinical Interventions for Suicide Risk

Suicide Care in Systems Framework



Standardized Screening

COLUMBIA-SUICIDE SEVERITY RATING SCALE Screen with Triage Points for Emergency Department

Ask questions that are bolded and underlined.	Past month	
Ask Questions 1 and 2	YES	NO
1) <u>Have you wished you were dead or wished you could go to sleep and not wake up?</u>		
2) <u>Have you actually had any thoughts of killing yourself?</u>		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) <u>Have you been thinking about how you might do this?</u> E.g. "I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."		
4) <u>Have you had these thoughts and had some intention of acting on them?</u> As opposed to "I have the thoughts but I definitely will not do anything about them."		
5) <u>Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?</u>		
6) <u>Have you ever done anything, started to do anything, or prepared to do anything to end your life?</u> Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. If YES, ask: <u>Was this within the past three months?</u>	Lifetime	
		Past 3 Months

If yes—follow listed recommendation:
 Item 1 Behavioral Health Referral at Discharge
 Item 2 Behavioral Health Referral at Discharge
 Item 3 Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
 Item 4 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
 Item 5 Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions
 Item 6 Over 3 months ago: Behavioral Health Consult (Psychiatric Nurse/Social Worker) and consider Patient Safety Precautions
 Item 6 3 months ago or less: Immediate Notification of Physician and/or Behavioral Health and Patient Safety Precautions



Suicide Risk Assessment – ED to Inpatient

Continuous Readiness for Patient Safety – September 2019

Starting the second week of October 2019, the Emergency Department (ED) will begin using a different, validated screening tool to screen patients for suicide risk. They will be using the *Columbia – Suicide Severity Rating Scale (C-SSRS)*, which will help identify patients who are at Low, Moderate and High risk for suicidal ideation (SI). Here are instructions for inpatient staff:

- Confirm risk level when getting report from the ED
 - HIGH risk – patient should have a 1:1 patient monitor, and staff should follow the Suicide Prevention Protocol.
 - Moderate or Low risk – no immediate actions are required. Interventions should be initiated in ED before the patient transfers to inpatient status.
- Information from the ED assessment will display on the Suicide Risk Assessment page of the Inpatient Admission History PowerForm:

If the C-SSRS risk assessment was done in the ED: a. Select C-SSRS previously completed in ED b. Do NOT complete the 4 question screening	If the C-SSRS risk assessment was NOT done in the ED: a. Complete the 4 question screening
--	--

Admission Hx (Adult) - INPATIENT - ctest, steve20

Performed on: 09/20/2019 11:32 By: Moody RN, Charles H

Suicide Risk Assessment

To be done on patients 12 years and older.

UWMC 7N Staff. Use form UH2794 to complete assessment.

We are required to ask all patients questions about suicide. It is our goal to keep our patients safe. These questions may or may not apply to you.

Columbia Suicide Severity Rating Scale
 C-SSRS Suicide Severity Rating: HIGH SUICIDE RISK (09/05/19 13:27:00)
 Suicide Risk Screening: Start "C-SSRS" (09/05/19 13:27:00)

1. Was there a time in your life when you attempted suicide?

Yes
 No
 Patient declines to answer question
 Unable to access

If the C-SSRS was completed in the ED, 1. Mark YES here, and Stop. There is no need to repeat the assessment on admission.

Questions?
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UW Medicine
HARBORVIEW MEDICAL CENTER

Assessment: Standardized Assessments

Standard Measures

- Columbia Suicide Severity Rating Scale (full interview)
- Suicide and Self-Injury Interview
- Self-Harm Behavior Questionnaire
- Suicide Status Form (from CAMS)
- Reasons for Living Scale

Assessment: Standardized Assessments

TABLE 3. Response patterns for all suicide attempt measures

Pattern	Self-Report Measures			Clinician Interview Measures		n	%
	BSS	SBQ-R	MSRC CDEs	C-SSRS	SHBQ		
1						439	44.6%
2						197	20.0%
3						77	7.8%
4						48	4.9%
5						39	4.0%
6						35	3.6%
7						26	2.6%
8						20	2.0%
9						12	1.2%
10						12	1.2%
11						11	1.1%
12						9	0.9%
13						8	0.8%
14						8	0.8%
15						7	0.7%
16						7	0.7%
17						7	0.7%
18						5	0.5%
19						4	0.4%
20						4	0.4%
21						3	0.3%
22						3	0.3%
23						2	0.2%
24						1	0.1%
25						1	0.1%
26						1	0.1%
27						1	0.1%
n (%) reported SA	371 (37.7%)	306 (31.1%)	487 (49.5%)	394 (40.0%)	430 (43.7%)		

Note. Black tile: reported a suicide attempt; BSS: Beck Scale for Suicide Ideation; C-SSRS: Columbia-Suicide Severity Rating Scale; MSRC CDEs: Military Suicide Research Consortium Common Data Elements; SA: suicide attempt; SBQ-R: Suicidal Behaviors Questionnaire-Revised; SHBQ: Self-Harm Behavior Questionnaire (SHBQ); White tile: denied a suicide attempt.

994 active duty service members referred as being at some suicide risk:

- 45% denied any suicide attempt across all measures
- 20% reported a suicide attempt across all measures
- 35% responded inconsistently

Assessment: Risk Assessment

UNCERTAINTIES

Can we usefully stratify patients according to suicide risk?

Matthew Michael Large *conjoint professor*¹, Christopher James Ryan *clinical associate professor*², Gregory Carter *conjoint professor*³, Nav Kapur *professor*⁴

¹School of Psychiatry, University of New South Wales, NSW, Australia; ²Discipline of Psychiatry, Westmead Clinical School and Sydney Health Ethics, University of Sydney, Australia; ³Centre for Brain and Mental Health, Faculty of Health and Medicine, University of Newcastle,; ⁴Centre for Suicide Prevention, Manchester Academic Health. Science Centre, University of Manchester, & Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK

What you need to know

- Despite the ubiquity of advice to use suicide risk assessment in clinical practice, there is no evidence that these assessments can usefully guide decision making
- All patients presenting with a mental health problem require a thorough and sympathetic assessment with the aim of negotiating an individualised treatment plan
- All patients with suicidal thoughts or behaviours should be offered evidence based therapies for the treatable problems associated with suicide, such as substance misuse disorder and depression
- The overwhelming majority of people who might be viewed as at high risk of suicide will not die by suicide, and about half of all suicides will occur among people who would be viewed as low risk

Assessment: Risk Assessments

Box 2: How to approach a patient who you think might be suicidal

- Conduct a respectful, thorough, and sympathetic assessment using active listening
- Keep a focus on the content and nature of the doctor-patient interaction
- Try to understand and address the individual circumstances that are distressing the patient
- Identify the patient's current treatment needs, including common modifiable social and clinical factors for suicide
- Do not attempt to stratify patients into high and low risk categories
- Do not simply rely on the patient's expression or non-expression of suicide plans and ideas
- Never dismiss any patient who raises your concern about suicide as low risk
- Talk with the patient's family or friends
- Ask about firearms and other lethal methods of methods of suicide
- Involuntary hospitalisation should be used sparingly and with great care
- Negotiate a management plan with every patient
- Document your assessment, reasoning, and treatment plan

Assessment: Culturally Based Assessment

Cultural Assessment of Risk for Suicide (CARS) Scale

Family conflict

- There is conflict between myself and members of my family

Social support

- I am accepted and valued by others†
- I feel connected to, like I am a part of, a community†

Sexual minority stress

- The decision to hide or reveal my sexual or gender orientation to others causes me significant distress
- Because of my sexual or gender orientation, no one understands my pain or distress

Acculturative stress

- Adjusting to America has been difficult for me

Assessment: Culturally Based Assessment

Cultural Assessment of Risk for Suicide (CARS) Scale (continued)

Non-specific minority stress

- People treat me unfairly because of my ethnicity, sexual, or gender identity

Idioms of distress (emotional/somatic)

- When I get angry at something or someone, it takes me a long time to get over it
- Sometimes I feel so tired I do not want to get up/wake up
- There is something in my life I feel ashamed about

Idioms of distress (suicidal actions)

- I have access to a method of suicide other than a gun that I have previously thought to use (like a weapon, a rope, poison, or medication overdose)
- I have, without anyone's knowledge, thought of suicide in the past

Cultural sanctions

- Suicide would bring shame to my family†
- I consider suicide to be morally wrong†

† indicates scored in reverse

Assessment: Culturally Based Assessment

Reason for Life – A Strengths Based Assessment of Protective Factors

Efficacy Over Life Problems

1. I believed I can help others fix their problems.
2. I believed I can make things work out for the best even when life gets difficult.
7. I believed I can fix my problems.
11. I had the courage to face life's hardest moments.

Cultural and Spiritual Beliefs

4. No matter how hard things got, I believed God wanted me to live.
6. My Yup'ik Elders taught me that my life is valuable.
8. I believed I must live to be an Elder.
9. My religion taught me that my life is valuable.

Others Assessment

3. People saw me do good things to help others.
5. People saw that I am strong and care about others.
10. People saw I live my life in a good way.



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Rocky Mountain MIRECC for Suicide Prevention



Updated: 13 February 2019

Therapeutic Risk Management of the Suicidal Patient

[About TRM](#) [Risk Tool](#) [Presentations](#) [Resources](#) [Join](#)

About TRM

The Rocky Mountain MIRECC model of Therapeutic Risk Management of the Suicidal Patient is a clinically and medicolegally informed model for the assessment and management of suicide risk. It involves three main components:

- Augmentation of clinical risk assessment with structured instruments
- Risk stratification with respect to both severity and temporality
- Collaborative development of a safety plan

The model and its components are fully described in a series of four articles published in the Journal of Psychiatric Practice (see below under resources).

Rocky Mountain MIRECC

- Home
- Research
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 - VA Suicide Risk Management Consultation Program
 - Resources for Clinicians
 - SDV Nomenclature
 - Assessment Tools
 - Therapeutic Risk Management
 - Lethal Means Safety
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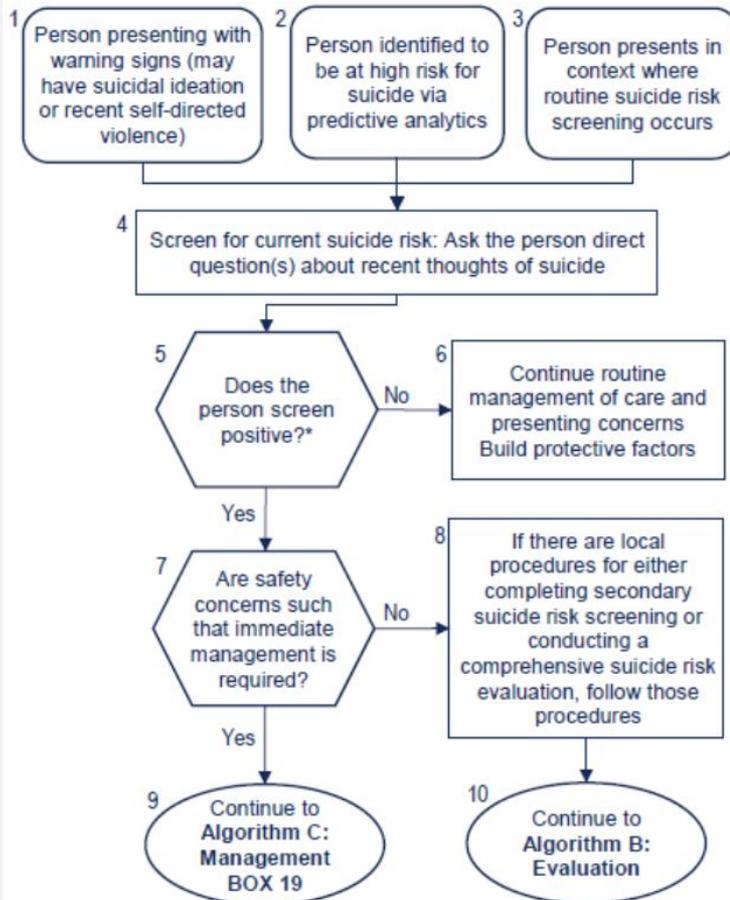
Order Educational

VA/DoD CLINICAL PRACTICE GUIDELINES

The Assessment and Management of Patients at Risk for Suicide



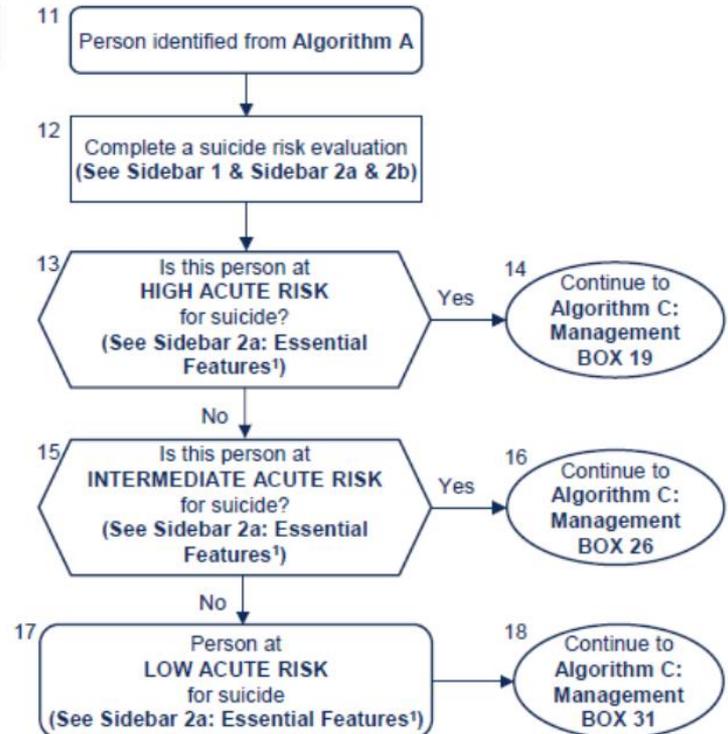
ALGORITHM A: IDENTIFICATION OF RISK FOR SUICIDE



*Note: Follow to Box 7 if screen is negative but additional evidence (e.g., collateral) suggests the need for continued screening and/or evaluation

Access to full guideline and toolkit: <https://www.healthquality.va.gov/guidelines/mh/srb/index.asp>

ALGORITHM B: EVALUATION BY PROVIDER



Sidebar 1. Risk Factors for Suicide**

- Any prior suicide attempt
- Current suicidal ideation
- Recent psychosocial stressors
- Availability of firearms
- Prior psychiatric hospitalization
- Psychiatric conditions (e.g., mood disorders, substance use disorders) or symptoms (e.g., hopelessness, insomnia, agitation)

**Necessary as part of a comprehensive assessment of suicide risk, but not sufficient

(See Recommendation 3)

**VA/DoD
Clinical
Practice
Guidelines**

VA/DoD Clinical Practice Guidelines

Sidebar 2a. Essential Features from Risk Stratification Table – Acute Risk ¹		
Level of Risk	Essential Features	Action
High Acute Risk	<ul style="list-style-type: none"> - Suicidal ideation with intent to die by suicide - Inability to maintain safety, independent of external support/help <p>Common warning signs:</p> <ul style="list-style-type: none"> - A plan for suicide - Recent attempt and/or ongoing preparatory behaviors - Acute major mental illness (e.g., major depressive episode, acute mania, acute psychosis, recent/current drug relapse) - Exacerbation of personality disorder (e.g., increased borderline symptomatology) 	<ul style="list-style-type: none"> - Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors - These individuals may need to be directly observed until they are transferred to a secure unit and kept in an environment with limited access to lethal means (e.g., keep away from sharps, cords or tubing, toxic substances) - During hospitalization co-occurring conditions should also be addressed
Intermediate Acute Risk	<ul style="list-style-type: none"> - Suicidal ideation to die by suicide - Ability to maintain safety, independent of external support/help <p>These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g., children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.</p>	<ul style="list-style-type: none"> - Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g., acute psychosis) - Outpatient management of suicidal thoughts and/or behaviors should be intensive and include: frequent contact, regular re-assessment of risk, and a well-articulated safety plan - Mental health treatment should also address co-occurring conditions
Low Acute Risk	<ul style="list-style-type: none"> - No current suicidal intent AND - No specific and current suicidal plan AND - No recent preparatory behaviors AND - Collective high confidence (e.g., patient, care provider, family member) in the ability of the person to independently maintain safety <p>Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.</p>	<ul style="list-style-type: none"> - Can be managed in primary care - Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and co-occurring conditions exist

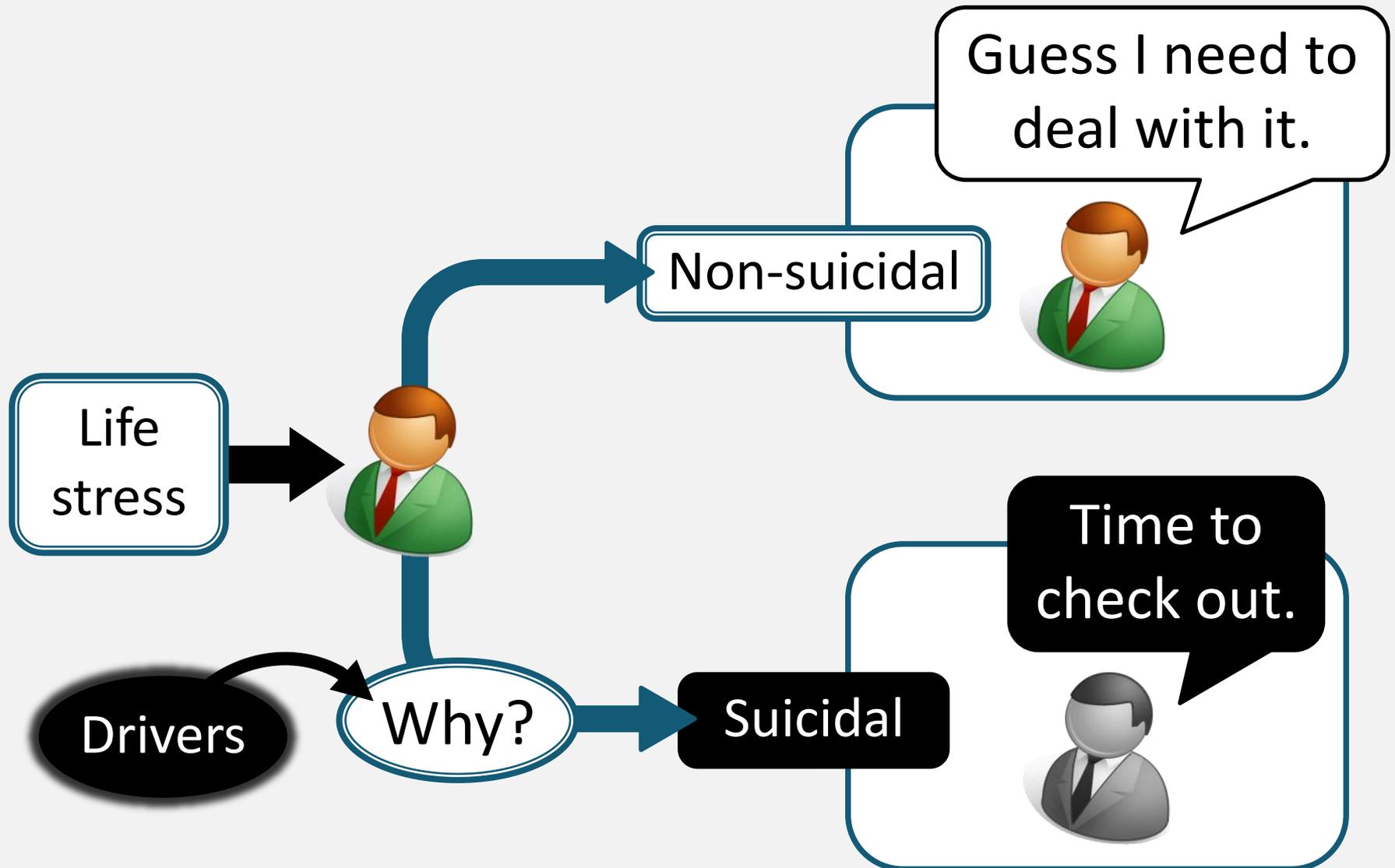
VA/DoD Clinical Practice Guidelines

Sidebar 2b. Essential Features from Risk Stratification Table – Chronic Risk¹

Level of Risk	Essential Features	Action
High Chronic Risk	<p>Common warning sign:</p> <ul style="list-style-type: none"> - Chronic suicidal ideation <p>Common risk factors:</p> <ul style="list-style-type: none"> - Chronic major mental illness and/or personality disorder - History of prior suicide attempt(s) - History of substance use disorders - Chronic pain - Chronic medical condition - Limited coping skills - Unstable or turbulent psychosocial status (e.g., unstable housing, erratic relationships, marginal employment) - Limited ability to identify reasons for living 	<p>These individuals are considered to be at chronic risk for becoming acutely suicidal, often in the context of unpredictable situational contingencies (e.g., job loss, loss of relationships, relapse on drugs).</p> <p>These individuals typically require:</p> <ul style="list-style-type: none"> - Routine mental health follow-up - A well-articulated safety plan, including lethal means safety (e.g., no access to guns, limited medication supply) - Routine suicide risk screening - Coping skills building - Management of co-occurring conditions
Intermediate Chronic Risk	<ul style="list-style-type: none"> - These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance use, medical and pain disorders - Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without engaging in self-directed violence 	<p>These individuals typically require:</p> <ul style="list-style-type: none"> - Routine mental health care to optimize psychiatric conditions and maintain/enhance coping skills and protective factors - A well-articulated safety plan, including lethal means safety (e.g., safe storage of lethal means, medication disposal, blister packaging) - Management of co-occurring conditions
Low Chronic Risk	<ul style="list-style-type: none"> - These individuals may range from persons with no or little in the way of mental health or substance use problems, to persons with significant mental illness that is associated with relatively abundant strengths/ resources - Stressors historically have typically been endured absent suicidal ideation - The following factors will generally be missing: <ul style="list-style-type: none"> - History of self-directed violence - Chronic suicidal ideation - Tendency towards being highly impulsive - Risky behaviors - Marginal psychosocial functioning 	<ul style="list-style-type: none"> - Appropriate for mental health care on an as needed basis, some may be managed in primary care settings - Others may require mental health follow-up to continue successful treatments

The Experience of Suicidality

What are the drivers of suicide?



There are many stressors, including psychiatric diagnosis, experienced by suicidal and non-suicidal individuals alike.

“Indirect drivers” of suicidality



Financial problems



Depression



Homelessness



Relationship problems

The most effective treatments focus on the *unique problems of suicidal people* that prevent them from solving secondary drivers.

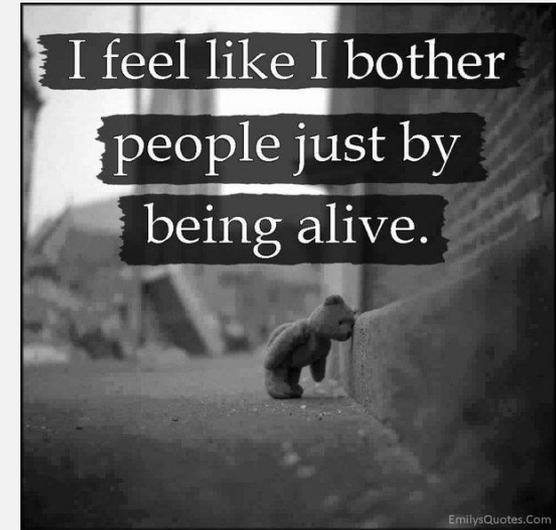
“Direct drivers” of suicidality



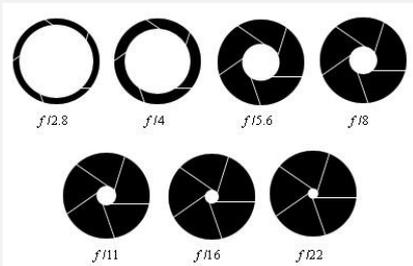
Stress & Agitation



Intense emotion dysregulation or pain



Burdensomeness

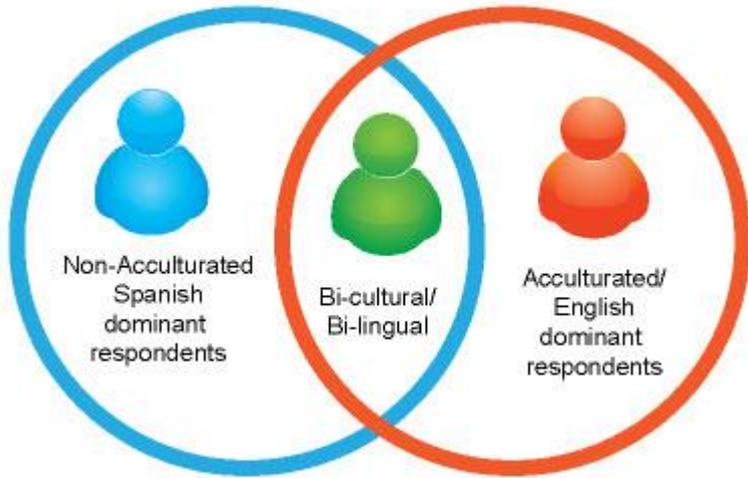


Attentional fixation on suicide



Lack of social connection

Minority and Cultural Drivers to Consider



MICROAGGRESSIONS

Wow, you're really articulate.

Where are you really from?

You're a much better driver than I expected.

Acculturation



Historical Trauma



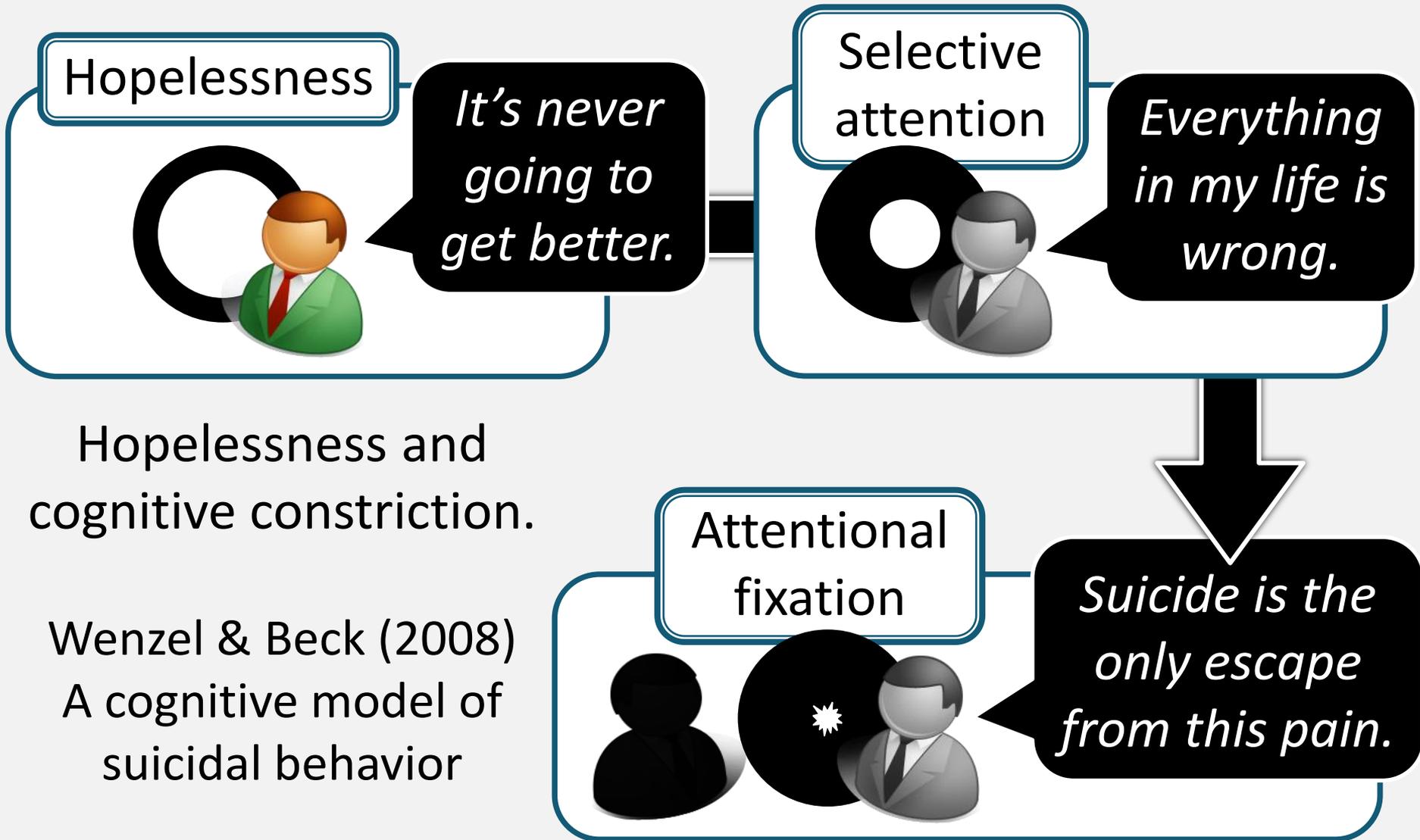
Familism



Religiosity

Wenzel & Beck's Cognitive Model of Suicidal Behavior

Hopelessness, Selective Attention, Attentional Fixation



Assessment: Narrative Interviewing

Narrative Interviewing

Please *tell* me the *story* of what led to the suicidal crisis. Just let me listen to you.

Aeschi group



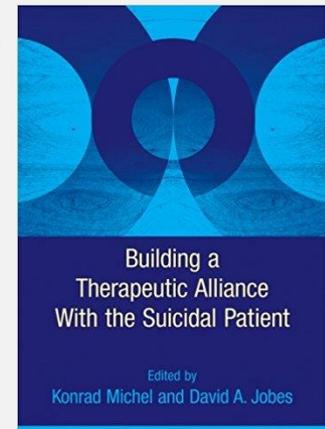
Themes

Self-esteem
Separation and Loss
Rejection
Restrained or Dependent

Narrative interviewing: An effort find a story so that actions make sense. “*Tell*” and “*story*” correlated with alliance (Michel et al., 2004).

Aeschi Model – Collaboration and the Suicidal Narrative

1. The clinician's task is to reach, together with the patient, a shared understanding of the patient's suicidality.
2. The clinician should be aware that most suicidal patients suffer from a state of mental pain or anguish and a total loss of self-respect.
3. The interviewer's attitude should be non-judgmental and supportive.
4. The interview should start with the patient's narrative.
5. The ultimate goal must be to engage the patient in a therapeutic relationship.



Management vs. Treatment



Client

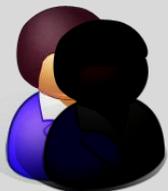
Nothing is working. I should just kill myself.

1

What do you think about a short hospitalization?



Therapist



Client

Nothing is working. I should just kill myself.

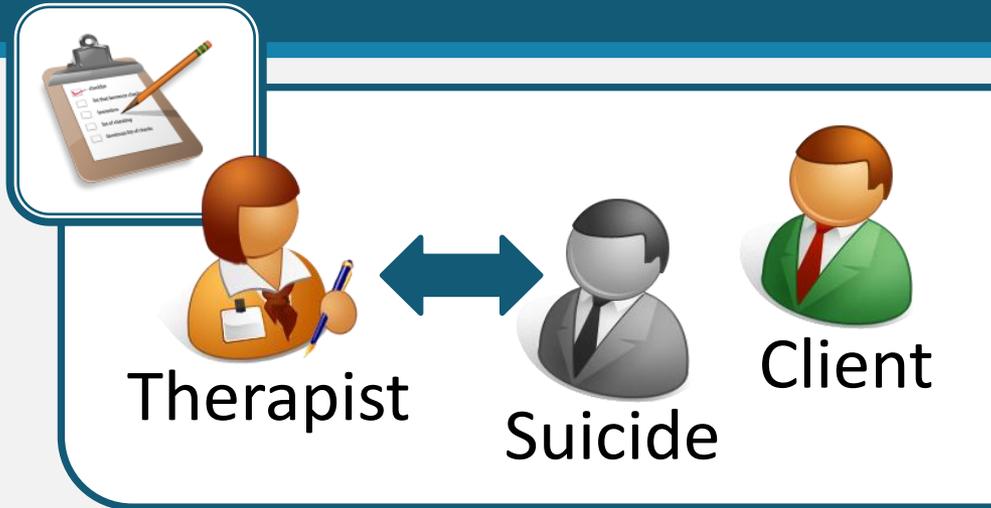
2

Can we take a closer at that way of thinking?



Therapist

Management of Suicide Risk

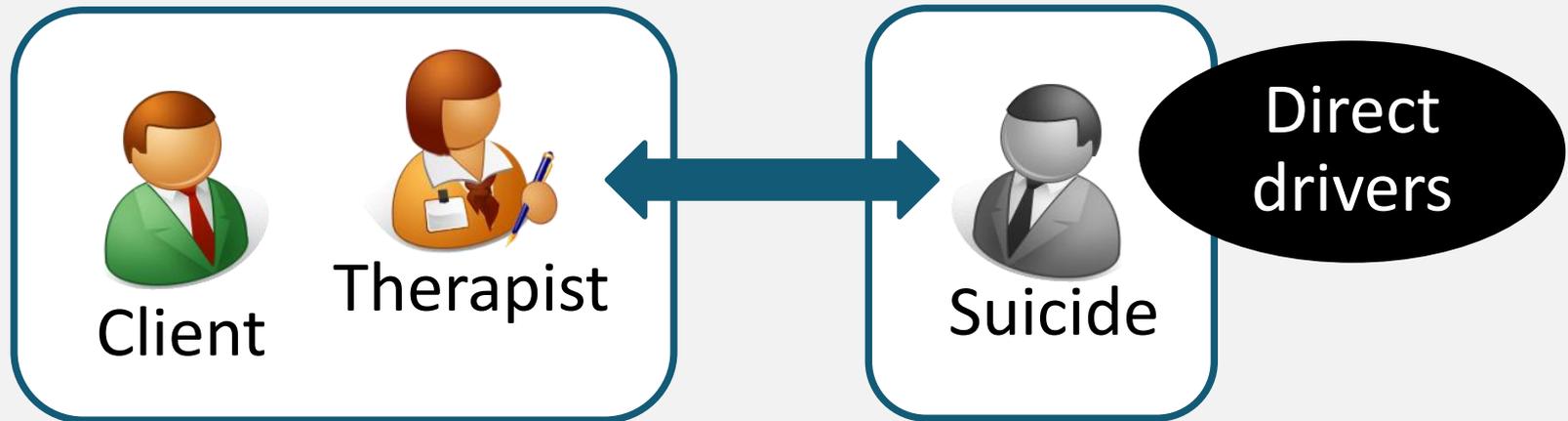


Continuity of care
(managing transitions,
discharge & referral)
Psychiatric treatment
Safety planning,
including means safety

Management

Therapist engages in interventions that seek to *reduce risk* by modifying risk factors related to suicide. Management is *optimally*, but *not necessarily*, collaborative.

Treatment of Suicide Risk



Treatment

Therapist and client engage in a *collaborative relationship to resolve risk* by targeting internal factors that are unique/intrinsic to suicide risk.

Treatment is *necessarily* collaborative.

Treatment of Suicide Risk

Consultative &
Collaborative



Therapist



Client



Suicide

Self-Management

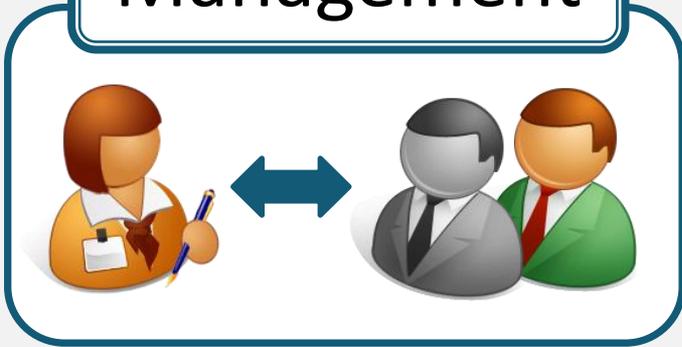
Treatment to Promote Self-Management

Over time, the patient grows in confidence and responsibility in self-management of suicide risk.

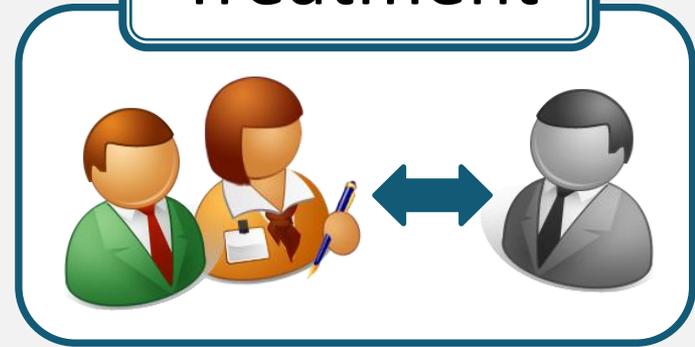
Ellis. (2004). *Collaboration and a self-help orientation in therapy with suicidal clients.*

Treatment for Suicidality

Management



Treatment



	Collaboration	Goal	Target
Management	Optimal when collaborative	Reduce risk	External factors related to suicide risk
Treatment	Necessarily collaborative	Resolve risk	Internal factors intrinsic to suicide risk

Goal of Psychotherapy is the Resolution of Suicidality

Suicidal



Non-suicidal



Interpersonal Theory of Suicide

Thwarted belongingness

Connection and belonging

Perceived burdensomeness

Value, purpose and self-worth

Hopelessness, helplessness

Hope, agency

Cognitive Theory of Suicide

Selective attention, attn. fixation

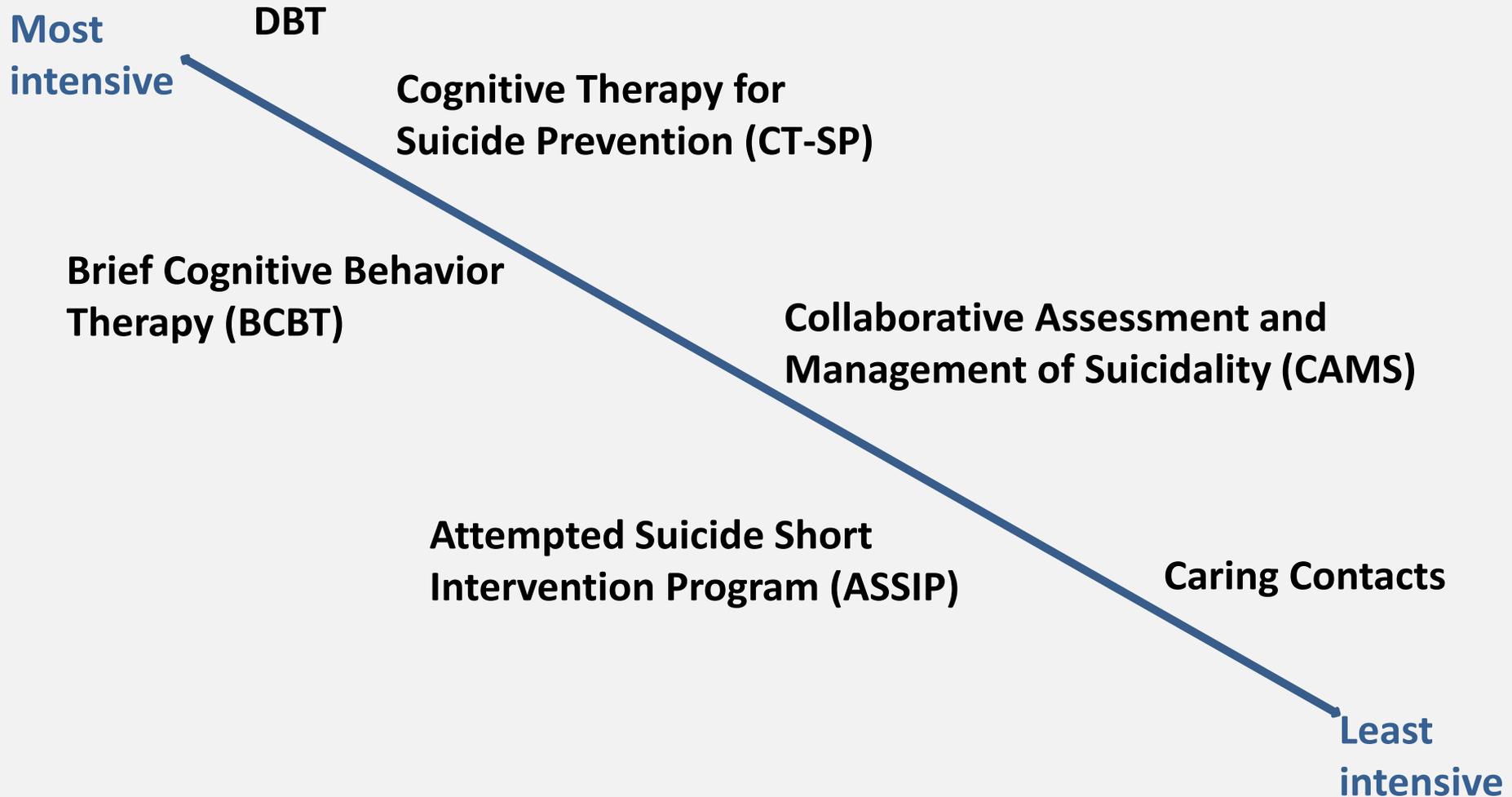
Mindfulness and perspective

Emotion Dysregulation

Emotion dysregulation and skills deficits in emotion-regulation, problem-solving, communication

Mindfulness, distress tolerance, emotion regulation, interpersonal effectiveness, problem-solving

Evidence Based Treatments for Suicidality: A Story for Another Day



Telehealth Practice/Agency Plans

Lead Telehealth Sessions with Contact Information

- Where is the person located for your call/session?
- At what phone number can you reach them?
- If you are going to have an ongoing relationship with the patient, establish who their emergency contact is and explain you will reach out to that person *if*
 - You are concerned they are at imminent risk and
 - What? (conditions where you would act against the patient's confidentiality and autonomy)

REMEMBER – you cannot control their behavior and are responsible for your behavior not theirs

Telehealth Practice/Agency Plans

Agree on Policy and Procedures

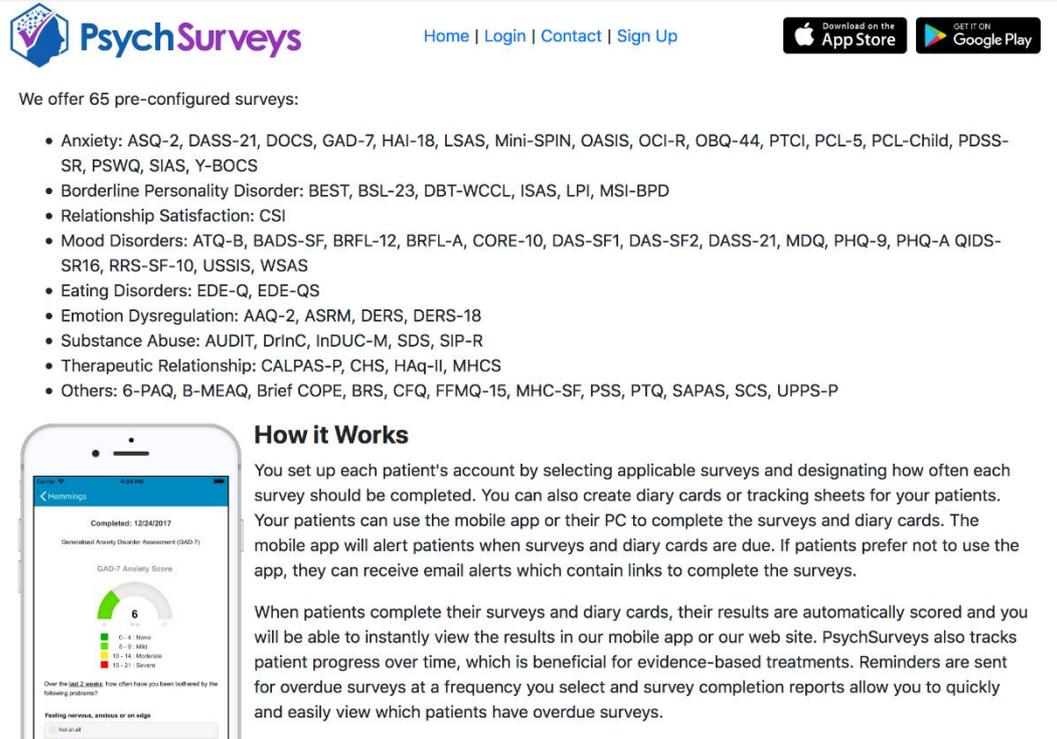
- Up front, when no one patient is at risk, decide on how you want to approach high risk situations on telehealth
- Include the right players from clinicians up through leadership and risk management (or a colleague, attorney, or ethics consult with your professional organization, if solo practice)
- Have written P&P ready to share with any attorney or reviewer who request records after a bad outcome
- Adapt informed consent documents, as needed

REMEMBER – you cannot control patient's behavior and are responsible for your behavior not theirs

Telehealth Options for Risk Assessment

Online Surveys

- PHQ-9 in EPIC can be conducted online ahead of session
- PsychSurveys



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We offer 65 pre-configured surveys:

- Anxiety: ASQ-2, DASS-21, DOCS, GAD-7, HAI-18, LSAS, Mini-SPIN, OASIS, OCI-R, OBQ-44, PTCI, PCL-5, PCL-Child, PDSS-SR, PSWQ, SIAS, Y-BOCS
- Borderline Personality Disorder: BEST, BSL-23, DBT-WCCL, ISAS, LPI, MSI-BPD
- Relationship Satisfaction: CSI
- Mood Disorders: ATQ-B, BADS-SF, BRFL-12, BRFL-A, CORE-10, DAS-SF1, DAS-SF2, DASS-21, MDQ, PHQ-9, PHQ-A QIDS-SR16, RRS-SF-10, USSIS, WSAS
- Eating Disorders: EDE-Q, EDE-QS
- Emotion Dysregulation: AAQ-2, ASRM, DERS, DERS-18
- Substance Abuse: AUDIT, DrInC, InDUC-M, SDS, SIP-R
- Therapeutic Relationship: CALPAS-P, CHS, HAQ-II, MHCS
- Others: 6-PAQ, B-MEAQ, Brief COPE, BRS, CFQ, FFMQ-15, MHC-SF, PSS, PTQ, SAPAS, SCS, UPPS-P

How it Works

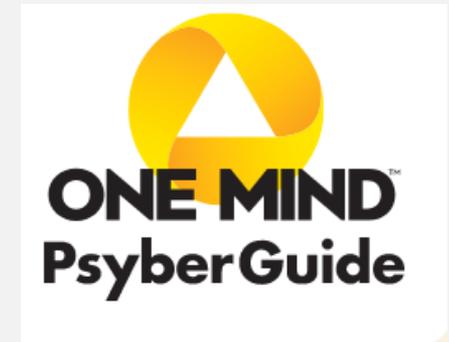
You set up each patient's account by selecting applicable surveys and designating how often each survey should be completed. You can also create diary cards or tracking sheets for your patients. Your patients can use the mobile app or their PC to complete the surveys and diary cards. The mobile app will alert patients when surveys and diary cards are due. If patients prefer not to use the app, they can receive email alerts which contain links to complete the surveys.

When patients complete their surveys and diary cards, their results are automatically scored and you will be able to instantly view the results in our mobile app or our web site. PsychSurveys also tracks patient progress over time, which is beneficial for evidence-based treatments. Reminders are sent for overdue surveys at a frequency you select and survey completion reports allow you to quickly and easily view which patients have overdue surveys.



Completed: 12/24/2017
Generalized Anxiety Disorder Assessment (GAD-7)
GAD-7 Anxiety Score
6
0-4: None
5-6: Mild
7-9: Moderate
10-14: Moderate to Severe
Over the last 2 weeks, how often have you been bothered by the following problems?
Feeling nervous, anxious or on edge
Not at all
Several times

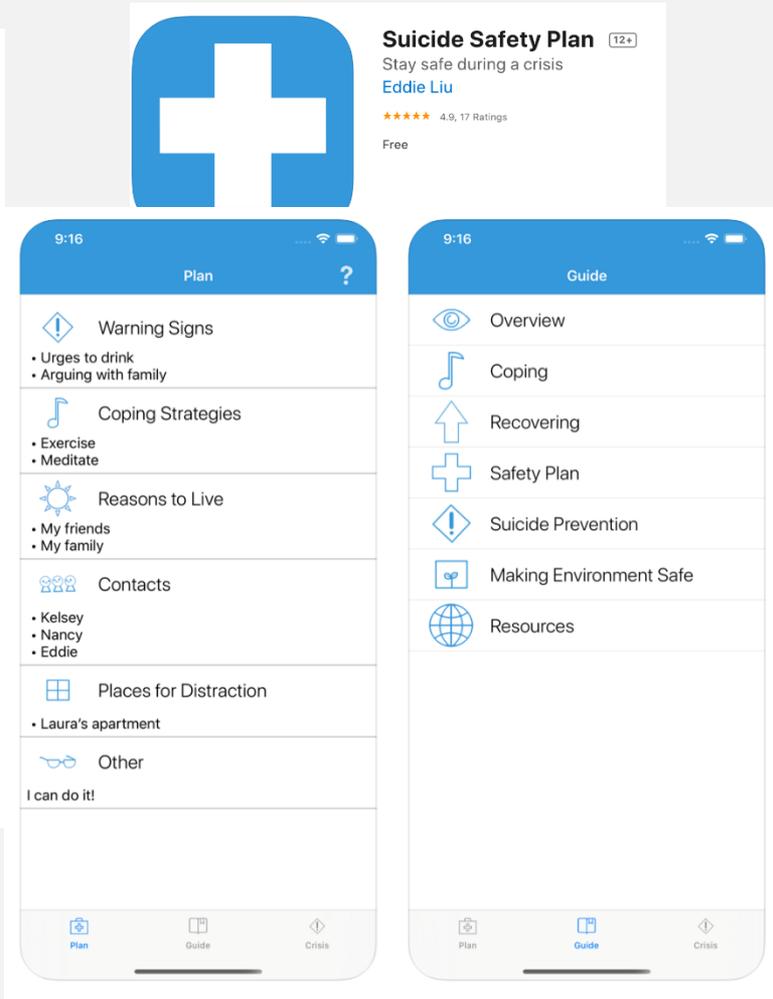
- Other self-monitoring apps



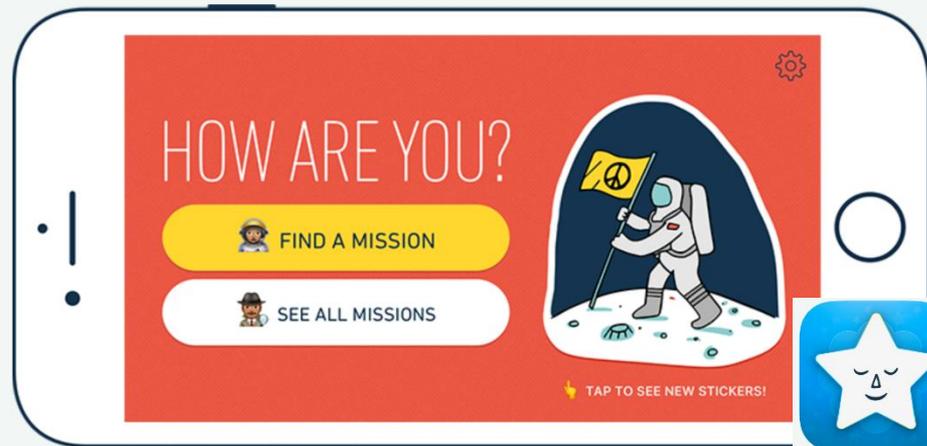
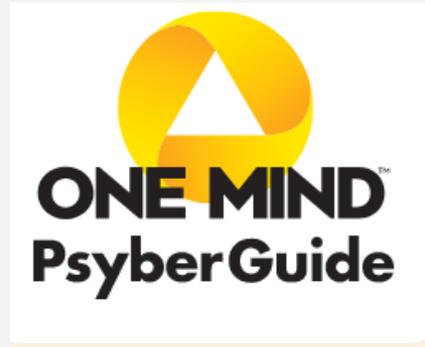
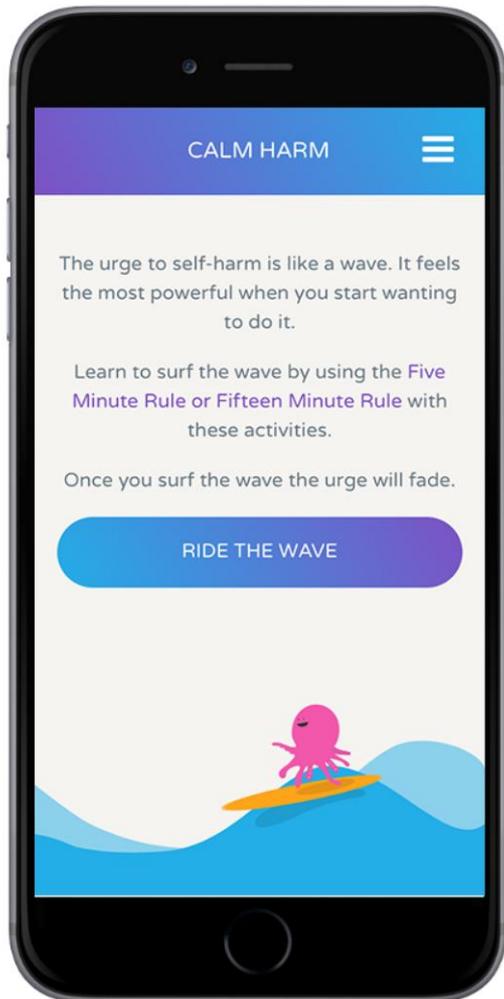
Non-profit company that rates apps for safety, data privacy and user ratings

Telehealth Options for Risk Management

Safety Plan and Crisis Management Apps

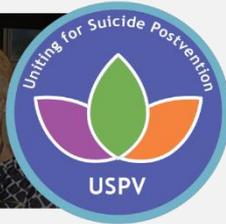


Telehealth Options for Coping Skills



STOP, BREATHE & THINK KIDS

VA Free Telehealth and Suicide Resources



**SUICIDE RISK MANAGEMENT
Consultation Program**
FOR PROVIDERS WHO SERVE VETERANS



itabase

Self-Help

These apps provide support and guidance in living with PTSD.



PTSD Coach



PTSD Family Coach



Mindfulness Coach



VetChange

Treatment Companions

These apps offer additional help for PTSD treatments.



CPT Coach



PE Coach



CBT-i Coach



ACT Coach

Related

These apps help with related issues affecting people with PTSD.



COVID Coach



Insomnia Coach



Mood Coach



Concussion Coach

Let's come back now with a discussion: In-Person vs. Telehealth with Suicidal Patients

In-Person

1. Physical access to the patient if they need to be transported to higher level of care
2. Potentially greater engagement
3. Increased behavioral activation in coming to the office
4. Privacy easier to achieve
5. Crisis Response Planning more straightforward

Telehealth

1. Less chance of spreading COVID-19
2. Observe the patients' living situation
3. Opportunity for visual inspection for lethal means counseling
4. Facilitate engagement with patients' family
5. Increase attendance in treatment and ability to reschedule

Questions? Thoughts? Concerns?

I still don't see how...

Well, what about when...

I had a patient once who...

I'm not sure this would work with...

This would help so much with...

So are you saying that...

How would this work with...



Thank you!

Please complete our short evaluation.

Hannah Stanfield
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WASHINGTON COUNCIL
FOR BEHAVIORAL HEALTH



Washington
Association for
Community Health