BEHAVIORAL HEALTH SERVICES
Suicide Prevention, Intervention and Postvention Team
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Telehealth Tips: Clients With Suicide Risk

COVID-19 Crisis – Supporting clients who have suicide thoughts or behaviors

This document includes recommendations from the Suicide Prevention, Intervention and Postvention (S-PIP) Team. The Oregon Health Authority (OHA) convened S-PIP to address needed interventions across the lifespan during the COVID-19 crisis.

Basic guidelines for beginning contact when your client may be experiencing suicidal thoughts or behaviors.

- Verify the person's location (e.g., address, apartment number) at the start of the session in case you need to contact emergency services.
- Get a verbal consent to use a telehealth platform. If the platform you are using is not HIPAA compliant, the client must verbally consent to that as well. The provider should document verbal consent in the client's notes and follow up with written consent. Consider mailing the form to the client with a self-addressed stamped envelope.
- Ask for or make sure you have emergency contact information with verbal consent to contact should the need arise.
- Secure the client's privacy during the telehealth session as much as possible. If you live with others, use headphones and a white noise machine; keep doors closed.
- Make sure you have a backup plan in case the technology does not work, such as having the best number to reach your client.
- Before contact, develop a plan for how to stay on the phone with the client while arranging emergency rescue if needed. Essentially, how are you going to call 911 or a crisis outreach team while staying connected with your client?

Adaptations for conducting a comprehensive suicide risk assessment

- Considering the current stressful circumstances, a broader assessment of suicide risk is indicated. Express concern and ask directly about recent suicidal ideation or behavior using a tool such as the Columbia Suicide Severity Rating Scale (C-SSRS) or a risk assessment tool such as SAMHSA's SAFE-T. Some clinicians use the Patient Health Questionnaire (PHQ-9) or the ASQ (Ask Suicide-Screening Questions) as a preliminary screening. Then follow up with one of the above suicide risk-specific scales when indicated.

- As well as using a standard risk assessment, assess for the emotional impact of COVID-19 and if there is an increased suicide risk. Examples that can escalate risk include:
    - Increased social isolation
    - Social conflict for those sheltering together
    - Increased financial concerns or worry about health or vulnerability in self, friends and family
    - Decreased social support
    - Increased anxiety and fear
    - Disruption of routines and support.
- Identify protective factors to emphasize: Reasons for living (family, hope for the future, children); deterrents (fear of injury, religious beliefs). Attend to protective factors that may have diminished recently.
- Inquire about increased access to lethal means (medications, drugs, firearms, etc.). If you have not already done so, OHA recommends you take the web-based Counseling on Access to Lethal Means (CALM) training. For those in rural settings, Oregon has developed a research brief and short training videos to talk with a rural firearm owner that may be thinking about suicide.

Adaptations for working with clients who are experiencing suicidal thoughts or behaviors

- Identify ways to increase safety in place if you do not deem it necessary to send the client to the emergency department (ED). The emergency room should be used only if the provider assesses the client's risk as needing in-patient care when suicide seems imminent or is in progress.
- Develop a safety plan that will help clients manage their suicide risk by involving them in the agreed-upon safety plan and one that involves others in the community.
- Make provisions for increased clinical contact (even brief check-ins) until risk de-escalates.
- Provide the crisis hotline (1-800-273-8255) or the Crisis Text Line (Text HOME to 741741). For youth, provide the YouthLine at 877-968-8491 or Teen2Teen text 839863 (peers available from 4-10 p.m. daily).
- Identify individuals in the client's current environment to help monitor the client's suicidal thoughts and behaviors in-person or remotely; seek written consent to have direct contact with those individuals.
- If the risk becomes imminent and cannot be managed remotely, make a three-way call to the nearest mental health crisis center to determine how the center can support the client and make a warm handoff. The local crisis centers will determine terms of sending out the crisis response team or call for emergency services. Research how operating

procedures may be different due to COVID-19 so you are providing accurate information to your client.

- However, if suicide is in progress (the client has already acted) call 911 and stay on the phone with the client
- If the risk is imminent, stay on the phone with the client until other care is present. Although you cannot be with them physically, you can support them emotionally until other care is present.

Adaptations for safety planning

- Safety planning works mostly the same as when done in-person. Use the Stanley Brown Safety Planning Intervention form (download form and training manual for free here). Let the client know that you want to develop a safety plan with them to help maintain their safety and that it will take approximately 30 minutes to do.
- Emphasize: Having a Safety Plan is particularly important now as a way to stay safe without going to the ED or a medical facility.
- Arrange a way for the client to get a copy of the plan. Clients can write it down as you go, or the clinician can write it down, take a picture or scan and email or text to the client.
- There are several free Android and Apple phone apps that also can serve to build a safe plan. Also, youth and young adults are more likely to use apps. Search for "suicide safety plan" in your app store. The My3 app incorporates the Stanley Brown Safety Plan and allows the user to share the plan with anyone including their therapist. Become familiar with how these tools operate before using them as tools to work with clients

Steps in developing a safety plan

Step 1: Identify warning signs that a suicide crisis is developing. The safety plan needs to be used to make sure the client can maintain safety. Communicate that you care.

Step 2: Identify internal coping skills that can distract from suicidal thoughts and de-escalate crises, considering limited access to resources during COVID-19.

Step 3: Identify social contacts that can help distract from a suicidal crisis. Many social distraction options are limited by physical distancing. Focus on virtual activities. Some examples are:

- Virtual travel tours, opera, theater performances or concerts, museums or zoos
- “Meet-up” programs, such as online painting, cooking or karaoke
- Virtual hang-outs with friends via Skype, FaceTime and Zoom to watch movies or play board games
- Online support groups or forums or virtual Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings.

Also, focus on the current social environment (i.e., who the client is living with).

Step 4: Identify social supports that can help handle a suicidal crisis. Determine who is currently available to help the client manage the suicidal crisis. If the client is living with others, determine with the client:

- Who is the best source of support
- Who the client feels comfortable turning to.

Seek written consent to contact and initiate contact with one or two key people who will provide support to make sure they are willing to do so. Also, have some tips on how to help the client. This takes time initially, but it will help the caregiver and preserve clinician time later.

Step 5: Identify professional emergency contacts that are currently available. Provide the National Suicide Prevention Lifeline **800-273-8255**. For youth, provide the YouthLine at 877-968-8491 or text 839863 (peers available 4-10 p.m. PST daily).

Step 6: Plan for reducing access to lethal means and review or revise any existing plan that might need updating in the current situation. Discuss increased access to lethal means (particularly stockpiles of Tylenol or other medications) and if there is someone with whom the client is living who can help secure lethal means. Ensure firearms, if present, are stored safely or removed temporarily.

- Be specific when listing adaptive options (talking to a good friend privately vs. exposure to more general social media, which may be upsetting).
- Virtual contact may "feel" different or mean different things to your client. Discuss types of remote contact that best suit your client's emotional needs. For example, some prefer phone calls or texts for disclosure of distress but video chats for distraction, etc.
- Review and revise existing safety plans to make sure social contact information on steps 3-5 is electronic rather than in person. If in person, make sure they are currently living with the client. Remember: Contact information can include telephone numbers, video chat, social media, game consoles, internet forums, etc.

Ongoing follow-up and monitoring

- Conduct a suicide screen at every contact for those at elevated risk. Use a standardized screen such as the C-SSRS. The screening takes <2 minutes and should be done conversationally.
- Review any changes in risk or protective factors. Examples are:
  - Changes in physical health in the client or a loved one
  - New access to lethal means
  - Interpersonal conflict in close quarters
  - Social isolation and feelings of loneliness
  - Mistrust of the intentions of others.
- Review and update the safety plan as needed.
- Get permission to continue providing follow-up phone contact. Schedule the next contact while you are on the phone, if possible.

Documentation and supervision or support for yourself

- Document all interactions and your clinical thinking or rationale. Consult with supervisors and peers on challenging clinical decisions and document the consultations.
- During this time when many clinicians are working remotely, it is especially important to attend to our own isolation and mental health. Peer consultation groups with other professionals using a secure platform such as Zoom can help clinicians brainstorm ideas for challenging cases and provide support.
- Working with clients who have suicidal thoughts or behaviors creates an additional burden for clinicians in a time of great stress. It is important to plan periods of coverage, if possible, to allow for time off.
- Clinician self-care activities are crucial, as is time off. Clients often respond positively and respectfully when clinicians explain they will be unavailable for a while, especially when:
    - Told in advance when time away will occur
    - Alternate provision is in place.

Resource list

Telephone and online resources

- Lines for Life is operating all lines, which include:
    - The National Suicide Prevention Lifeline
    - YouthLine
    - Senior Loneliness Line.
- OPAL-K and OPAL-A (open 9 a.m. to 5 p.m. at 855-966-7255) lines operate for primary care physicians as a clinical resource.

  These lines are answered by physicians with expertise in behavioral health. Services are available for discussing the needs of individuals, assisting primary care providers in delivering care in their offices, conducting suicide assessments, and other behavioral health-related activities including prescribing. OPAL A serves 18 and older, and OPAL K serves ages 17 and under.

- ReachOut Oregon is a statewide telephone and chat service that provides support for parents and caregivers of children with behavioral health needs. Parents and caregivers can call or chat online about their children who experience emotional, behavioral, or physical health, intellectual or developmental disabilities, or educational issues.
    - **833-REACHOR** (833-732-2467) is the parent "warmline" for support by phone.
    - ReachOut Oregon website is for chat, email and Facebook messaging.
        - Hours for immediate assistance are 12 noon to 7 p.m. Tuesday through Thursday.

  Messages can be left at any time to be returned during regular business hours.

The service is staffed by certified family support specialists who have the training and personal experience in parenting children with emotional, developmental or physical health concerns. The website and family support specialists provide information about accessing local resources, including support groups and local family support specialists. Parents and caregivers can:

- Get help with navigating the complex and complicated system of services
- Day-to-day practical tools for parenting children with challenging behaviors or issues
- Just plain support and understanding from someone who “has been there.”

The service is a resource:

- After a crisis
- When parents and caregivers need practical ideas about handling stress and frustration
- For how to talk to siblings and other adults about the needs of their child
- For how to adapt their communication and parenting style to advocate for their family's needs.

- Now Matters Now has resources for clinicians and patients that teach dialectical behavior therapy (DBT) skills such as mindfulness, mindfulness of current emotion, opposite action and paced-breathing. It offers videos and stories to provide skills and support for coping with suicidal thoughts.

Telephone and online resources

- Oregon Health Authority is offering free Collaborative Assessment and Management of Suicidology (CAMS) training online to any provider in Oregon. Contact mpos@aocmhp.org for details.
- Treating Suicidal Risk Using Telepsychology on-demand recorded presentation
- The PESI® training (use the code TELEFREE at checkout)
- The American Psychological Association (APA) telepsychology best practices training series
- C-SSRS website and access to training videos
- CALM: Counseling on Access to Lethal Means: Reducing access to lethal means, such as firearms and medication, can determine whether a person at risk for suicide lives or dies. This free online course focuses on how to reduce access to the methods people use to kill themselves.
- American Psychiatric Association: Telepsychiatry Toolkit

Oregon resources and guidance

- For the latest on Oregon's COVID-19 response, please go here.
- For the latest on Oregon's COVID-19 temporary Oregon Admirative Rule (OAR) changes, please go here.
- On the Oregon Suicide Prevention website, go to health care and mental health professionals and Zero Suicide section.

Other resources

- Seager van Dyk I, Kroll JL, Martinez R, Donoghue Emerson N. (2020). COVID-19 tips: Building rapport with youth via telehealth: 10.13140/RG.2.2.23293.10727.
- McGinn MM, Roussev MS, Shearer EM, McCann RA, Rojas SM, Felker BL. (2019). Recommendations for using clinical video telehealth with patients at high risk for suicide. *Psychiatric Clinics, 42*(4), 587-595.

Clinician self-care resources

- Provider Burnout
- Resources for Responders and Behavioral Healthcare Providers
- The American Psychological Association is also a resource. The APA is curating free access articles on COVID-19 and a list of self-care tips for providers

Accessibility: Everyone has a right to know about and use Oregon Health Authority (OHA) programs and services. OHA provides free help. Some examples of the free help OHA can provide are sign language and spoken language interpreters, written materials in other languages, Braille, large print, audio and other formats. If you need help or have questions, please contact Mavel Morales at 1-844-882-7889, 711 TTY, OHA.ADAModifications@dhsoha.state.or.us.

This document was adapted for Oregon with permission from *Teleheath Tips: Managing Suicidal Clients During the COVID-19 Pandemic,* produced by the Center for Practice Innovations at Columbia Psychiatry.