2020 NRTRC TAO VIRTUAL CONFERENCE

Northwest Regional Telehealth Resource Center and the Telehealth Alliance of Oregon

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VIRTUAL SESSION INSTRUCTIONS

- Audio and video are muted for all participants
- Use the Q&A feature to ask questions 
- Moderator will read questions to the speaker
- Presentation slides are posted at https://nrtrc.org/sessions. Recordings will be posted after the conference.

Utilization of Telemental Health for Suicide Prevention

- Moderator: Matt McCullough
- Presenters:
  - Erika Shearer, Clinical Psychologist, VA Puget Sound, Seattle Division
  - Jean Kim, Clinical Psychologist, VA Puget Sound, Seattle Division
  - Marilyn Piccirillo, Psychology Intern, VA Puget Sound, Seattle Division
  - Sasha Rojas, Telehealth and Rural Outreach Fellow, VA Puget Sound, Seattle Division

Utilization of Telemental Health for Suicide Prevention

Sasha Rojas, Ph.D., Marilyn Piccirillo, M.A., Erika Shearer, Ph.D., & Jean Kim, Ph.D.

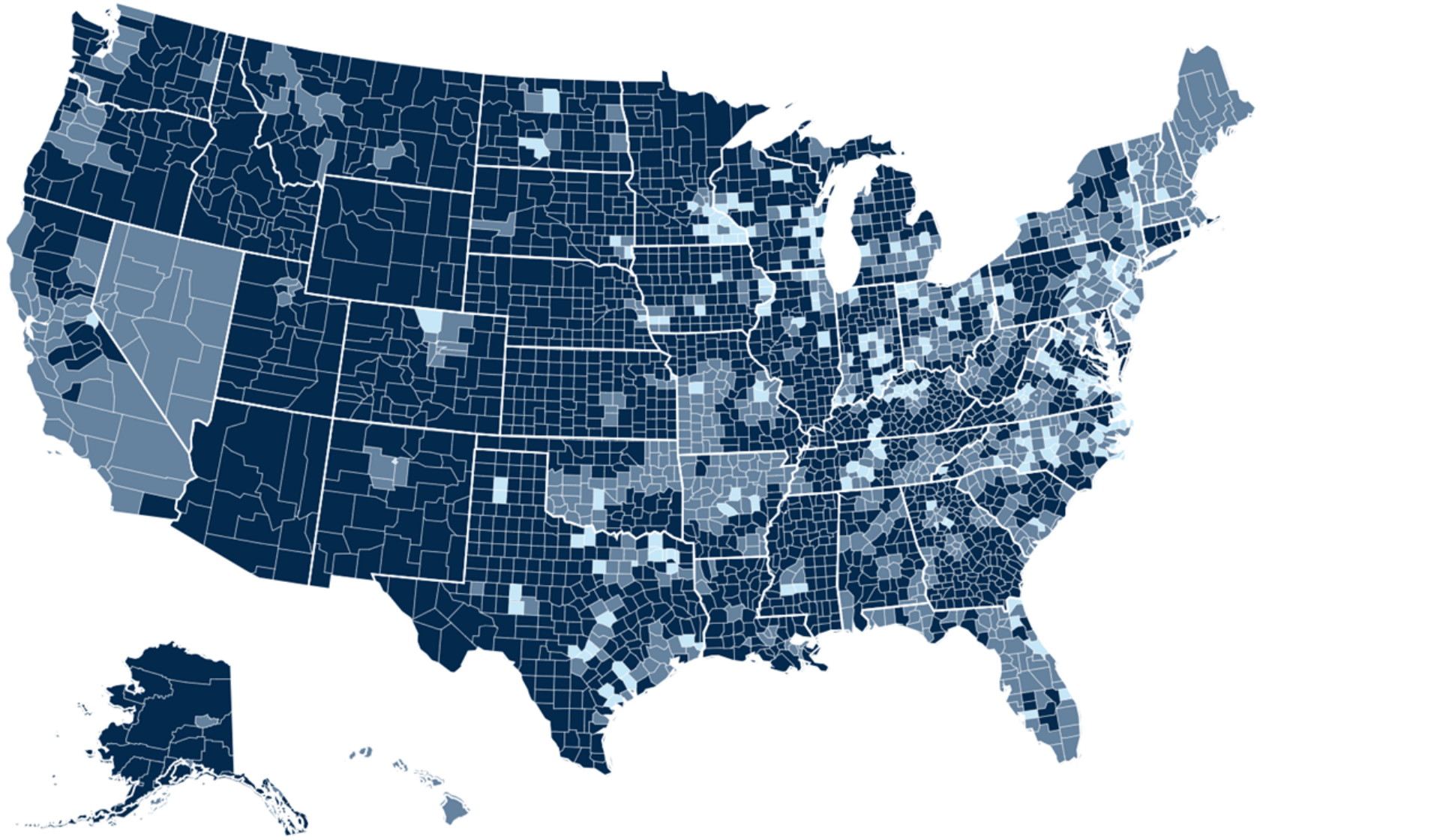
VA Puget Sound, Seattle Division

Learning Objectives

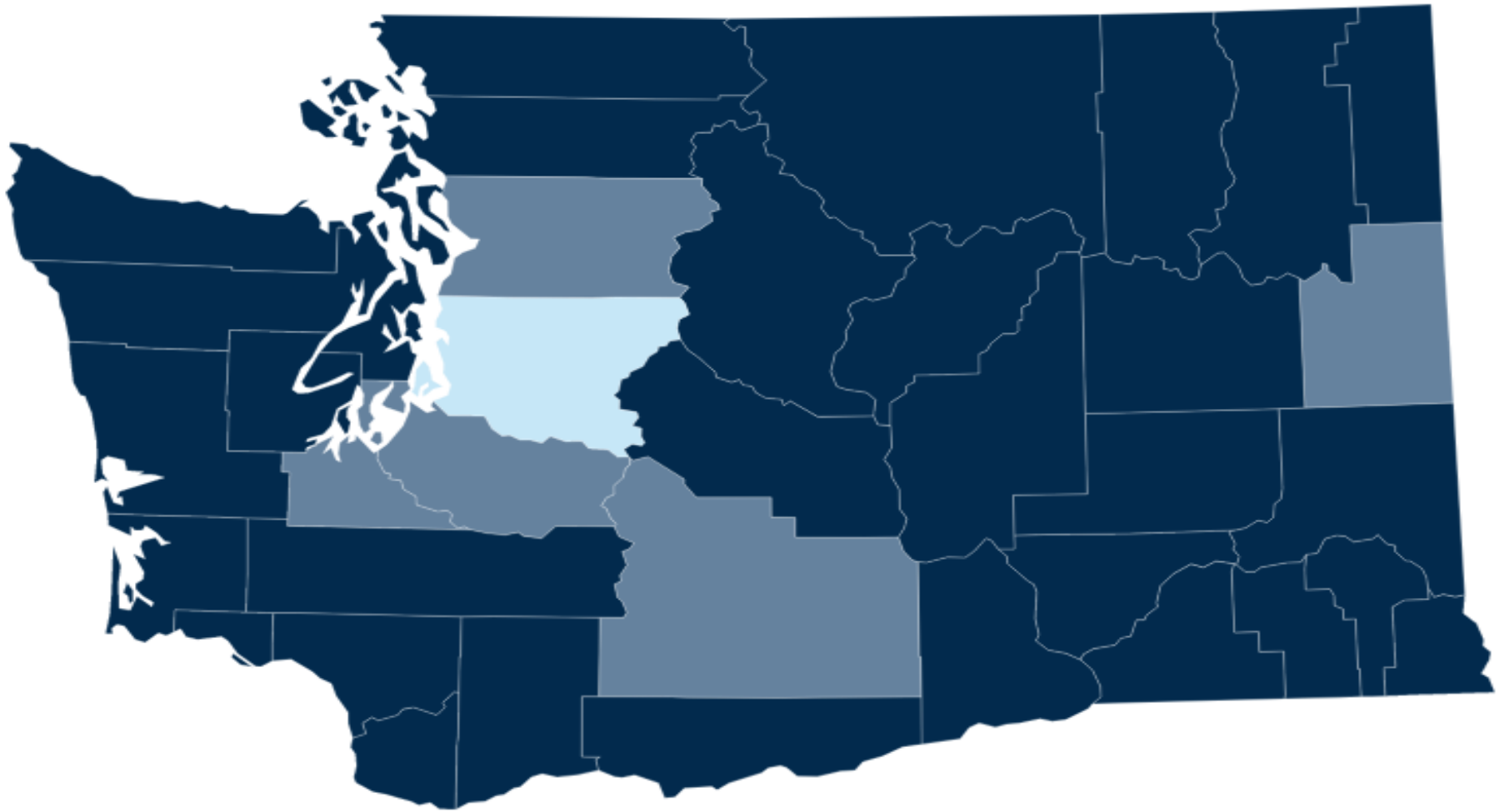
- **Describe how telemental health can be used to address Veteran suicide risk**
- **Identify one clinical consideration for addressing suicide risk via Telemental Health (TMH) via Clinical Video Telehealth**
- **Describe evidence-based interventions for suicide risk that may be suitable for TMH**

Landscape of the population

Health Professional Shortage Areas: Mental Health, by County, 2017



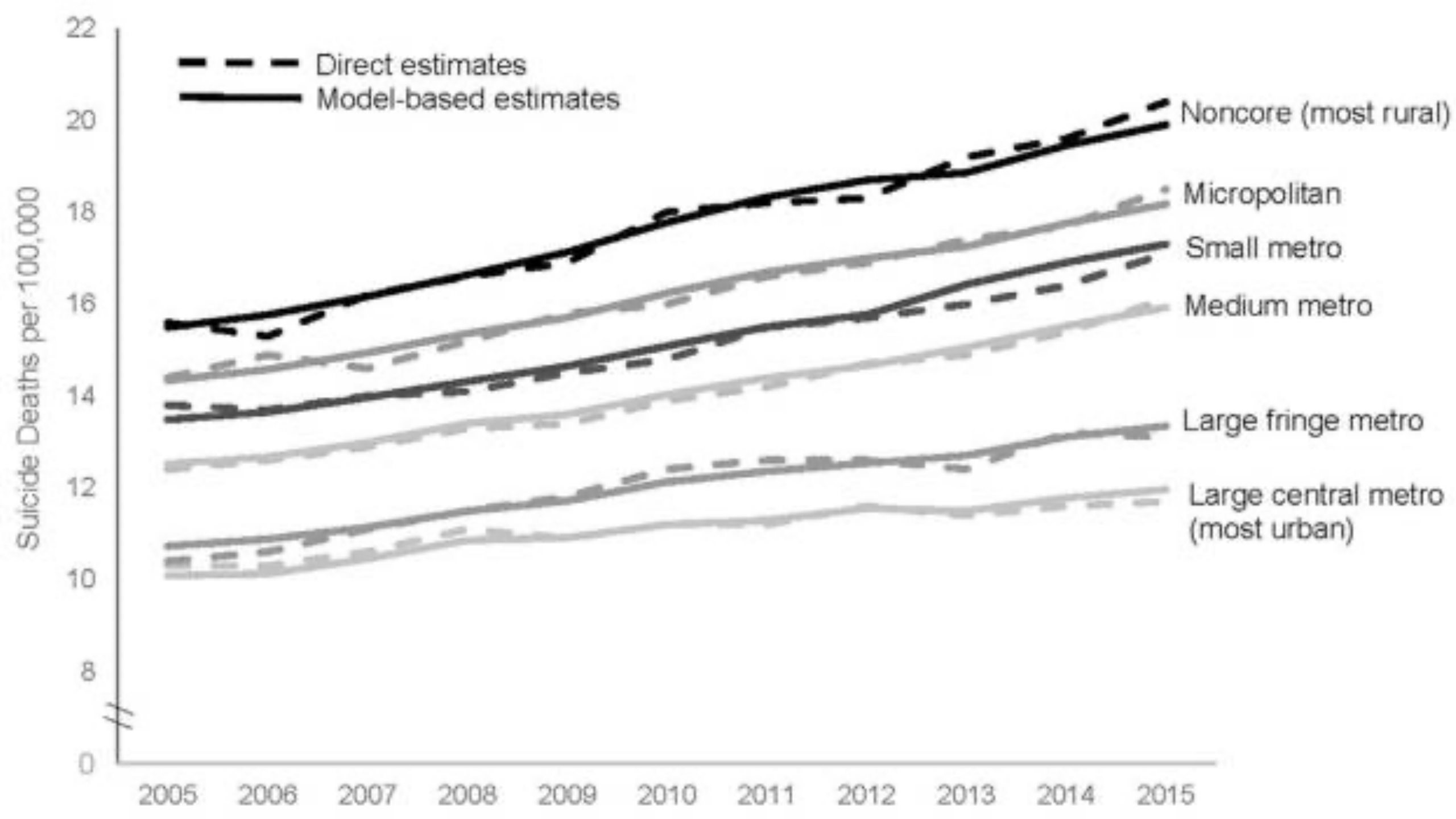
Health Professional Shortage Areas: Mental Health, by County, 2019 - Washington



None of county is shortage area | Part of county is shortage area | Whole county is shortage area

RHIhub Rural Health Information Hub

Source: data.HRSA.gov, January 2020.


Direct estimates
Model-based estimates
Noncore (most rural)
Micropolitan
Small metro
Medium metro
Large fringe metro
Large central metro (most urban)
Suicide Deaths per 100,000
22
20
18
16
14
12
10
8
0
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015

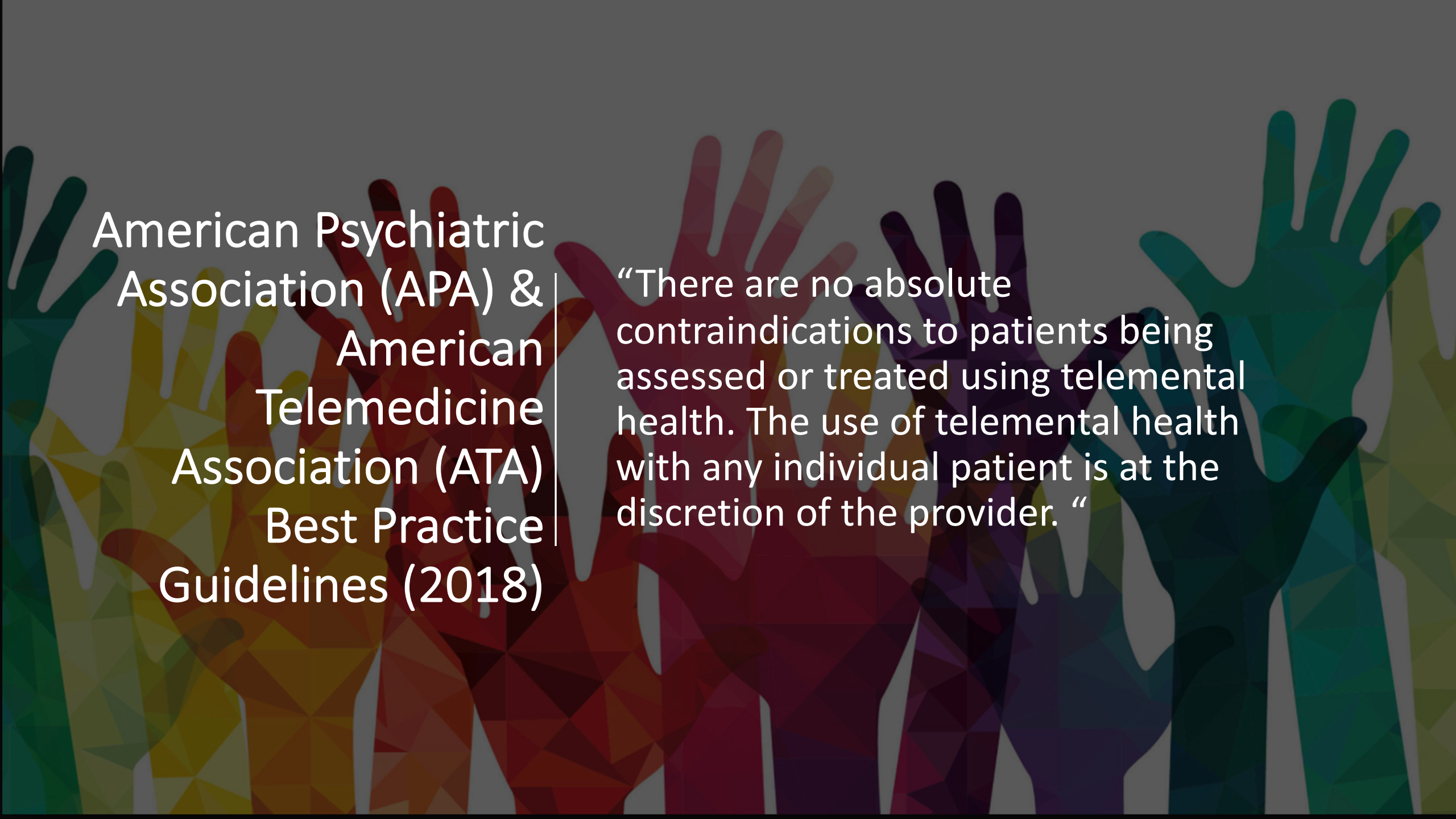
Telemental Health Expands Access to Care

Telemental Health

- Effective for variety of MH problems (e.g., PTSD, depression) Hilty et al., 2013
- Case examples demonstrate management of suicide risk is feasible. Gros et al., 2010; Luxton et al., 2015
- TMH adds a visual component to telephone-based risk assessment that may allow for more comprehensive assessment of risk. Godleski et al, 2008

Telemental Health

- Many clinical TMH trials have excluded individuals with any suicidal ideation or previous suicidal behavior. Hilty et al., 2013
- Providers have also expressed concerns about suicide risk management via TMH. Gilmore & Ward, 2019; Ciesielski, 2017



American Psychiatric Association (APA) & American Telemedicine Association (ATA) Best Practice Guidelines (2018)

"There are no absolute contraindications to patients being assessed or treated using telemental health. The use of telemental health with any individual patient is at the discretion of the provider. "

To what extent is TMH being implemented among Veterans at high-risk for suicide?

Quality Improvement Study

1) Examine the demographic and clinical characteristics of Veterans receiving TMH vs. in-person services

2) Compare Suicide Behavior Reports (SBR) before and after Veterans' first individual mental health appointment as a function of treatment modality (i.e., CVT; in-person only)

Table 1.

Demographic and clinical characteristics as a function of treatment modality of individual mental health appointments in 2017

	Clinical Video Telehealth (n = 1,011)		In-person Only (n = 6,083)	
	n (%)	Mean (SD)	n (%)	Mean (SD)
Age in years	--	54.77 years (15.12)	--	53.05 years (15.34)
Gender (male)	826 (81.7%)	--	5,036 (82.8%)	--
Race				
White	821 (81.7%)	--	4,203 (69.1%)	--
Black	34 (3.4%)	--	922 (15.2%)	--
American Indian or Alaska Native	25 (2.5%)	--	90 (1.5%)	--
Asian	22 (2.2%)	--	187 (3.1%)	--
Native Hawaiian/Pacific Islander	11 (1.1%)	--	149 (2.4%)	
Multiple Races endorsed	18 (1.8%)	--	148 (2.4%)	--
Declined/Unknown	80 (7.9%)	--	384 (6.3%)	--
Ethnicity (Hispanic/Latinx)	66 (6.5%)	--	337 (5.5%)	--
Service Connected	780 (77.2%)	--	4,851 (79.7%)	--
Rurality Status (Rural)	427 (42.2%)	--	1133 (18.6%)	--
War Era				
World War II	--	--	15 (.2%)	--
Korean	9 (.9%)	--	37 (.6%)	--
Post-Korean	8 (.8%)	--	21 (.3%)	--
Vietnam	304 (30.1%)	--	1639 (26.9%)	--
Post-Vietnam	140 (13.8%)	--	771 (12.7%)	--
Persian Gulf War	314 (31.1%)	--	1821 (29.9%)	--
OIF/OEF	233 (23%)	--	1751 28.8%)	--
Other	3 (.3%)	--	(.1%)	--
CVT appointments in 2017	--	4.79 (5.62)	--	--
In-Person appointments in 2017	--	.99 (3.47)	--	4 (4.57)
SBR 6 months before 1st apt. in 2017	10 (1%)	--	147 (2.4%)	--
SBR 12 months after 1st apt. in 2017	19 (1.9%)	--	128 (2.1%)	--

Note. SBR = Suicide Behavior Report.

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TMH appointments in 2017	--	4.79 (5.62)	--	--
In-Person appointments in 2017	--	.99 (3.47)	--	4 (4.57)
SBR 6 months before 1st apt. in 2017	10 (1%)	--	147 (2.4%)	--
SBR 12 months after 1st apt. in 2017	19 (1.9%)	--	128 (2.1%)	--

Note. SBR = Suicide Behavior Report.

RESULTS

- Veterans who received TMH were less likely to present with a SBR in the 6 months prior to their first appointment, X^2 (1, N = 7,094) = 8.16, p = 0.003.
- No differences in SBR rates or time to SBR during the 12 months following their first appointment
- Age was a significant protective factor for suicide risk, β = -.031, p < 0.0001, 95% CI [.958, .981].

Recommendations for Suicide Prevention via TMH

First, familiarize yourself with relevant guidelines for assessing suicide risk and facilitating a higher level of care when warranted.

Delivering TMH to high risk patients

- National Association of Social Workers
- American Psychological Association
- American Psychiatric Association and American Telemedicine Association Joint Taskforce

Assessment and Management of Suicide Risk

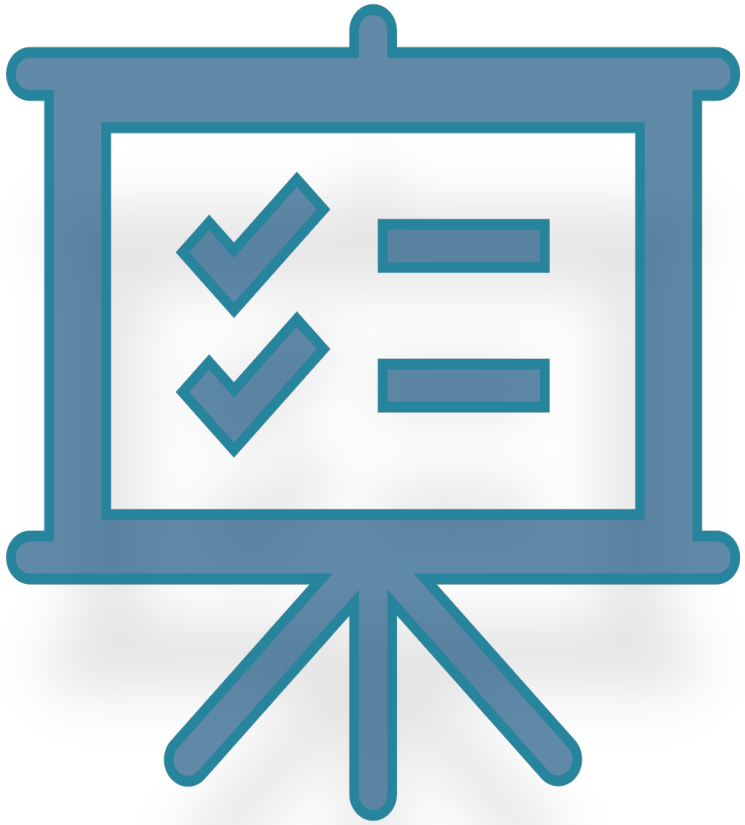
- Department of Defense (DOD) and VA

Second, prepare for the appointment.

Consider	HIPAA-compliant options for sending and receiving written questionnaires (e.g., secure messaging, postal mail, patient holding completed measure up to the screen).
Consider	If the patient is located out of state, familiarize yourself with the laws of that state, such as for involuntary commitment, duty to notify, and abuse reporting.
Consider	Local resources, hospitals, support staff for the patient's location, emergency contact.

Third, session 1 assessment and orientation

- Informed consent around confidentiality and limitations
- Verify location and contact information
- Establish a plan for clinical emergencies and technical failures
- Establish a protocol for contact between sessions
- Discuss conditions under which services may be terminated and a referral made to in-person care



Fourth, engage in comprehensive suicide risk assessment.

- Comprehensive suicide risk assessment should be performed at intake.
- Along with additional assessment throughout treatment
- Assessment should be multidimensional:
  - Routinely administered screening measures (e.g., C-SSRS; PHQ-9; SCS)
  - Visual cues indicating depressed mood (e.g., grooming, surroundings)
  - Collateral reports from loved ones
  - Patient’s verbal report

Appropriateness of TMH for high-risk pts

- Clinical appropriateness and expectations should be discussed at the onset of treatment and throughout treatment.
- Primary concern is patient willingness, at a minimum:
  - Willingness to be open about risk
  - Willingness to engage in means restriction
  - Willingness to engage in safety planning
  - Willingness to ensure private location for appts and to share exact location with provider
- Use clinical judgment to determine whether patient can abstain from therapy interfering behaviors such as substance use, self-harm behaviors, etc.
- Continue to evaluate willingness throughout treatment.

Additional considerations when evaluating appropriateness

- Patient willingness is critical for effective safety management and the following must also be considered when evaluating patient willingness (ATA, 2013):
  - Cognitive capacity
  - History of cooperativeness w/ providers
  - Substance use and abuse
  - Violence or self-injurious behavior
  - Nearest emergency medical facility
  - Support system
  - Current medical status
  - Competence around technology

PLAN FOR CLINICAL EMERGENCY

1. Follow agreed upon emergency plan, which was established during first session.
2. Stay connected by video. If technical failure & connection is lost, reconnect by phone.
3. Involve others in patient's home, such as an agreed upon safety contact.
4. Utilize support from other staff in your institution by phone, pager, internal messaging.
5. Coordinate involvement of emergency services by telephone (911)

Team and system support makes a difference

- Consult, consult, consult
  - Telehealth team
  - Other telehealth providers
  - Suicide Prevention Team

Putting it all together

- Follow your plan & training.
- Remember there are currently no contradictions.
- Training full teams in telehealth & suicide risk management expands patient access & team support for the providers managing risk remotely.

Evidence-Based Interventions for Suicide Risk via TMH

The best suicide safety plans are:

- Individualized
- Flexible
- Feasible
- Collaborative

Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place_____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact # _____
3. Local Urgent Care Services_____
   Urgent Care Services Address_____
   Urgent Care Services Phone_____
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. _____
2. _____

Collaborative Suicide Safety Planning

It is possible (and critical!) to create a strong safety plan via TMH

- TMH specific strategies:
  - Promote accessibility
    - Individual can take a screenshot of the plan (via screen-sharing)
    - Send a copy of the plan via a secure messaging platform
    - You and the individual can complete your own copies
    - Send an official copy (or duplicate) in the mail
  - Keep the plan simple by focusing on the core components.

Lethal Means Safety Counseling

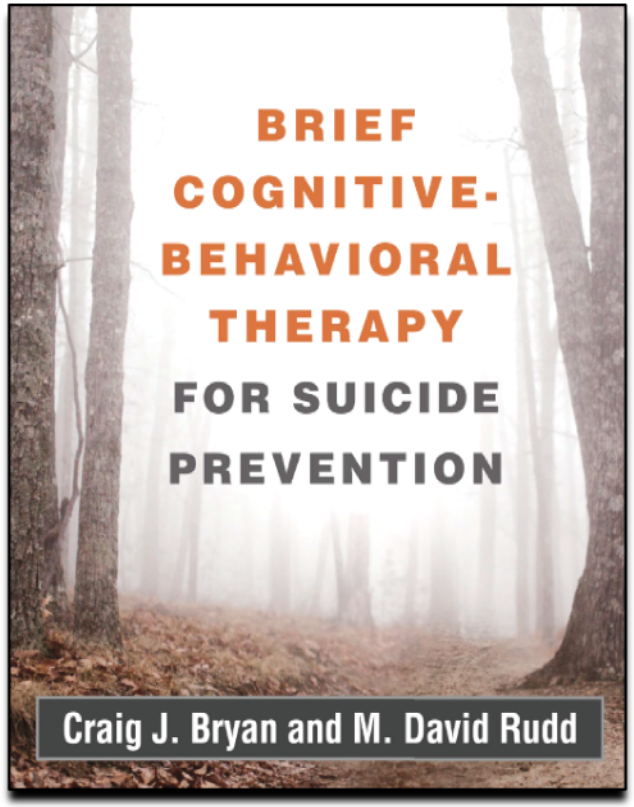
- Why do it?
  - Periods of acute suicidal distress are brief and temporary.
  - 90% of attempters who survive do NOT go on to die by suicide later.
  - Easy access to lethal means is the strongest determinant of a suicide attempt outcome.

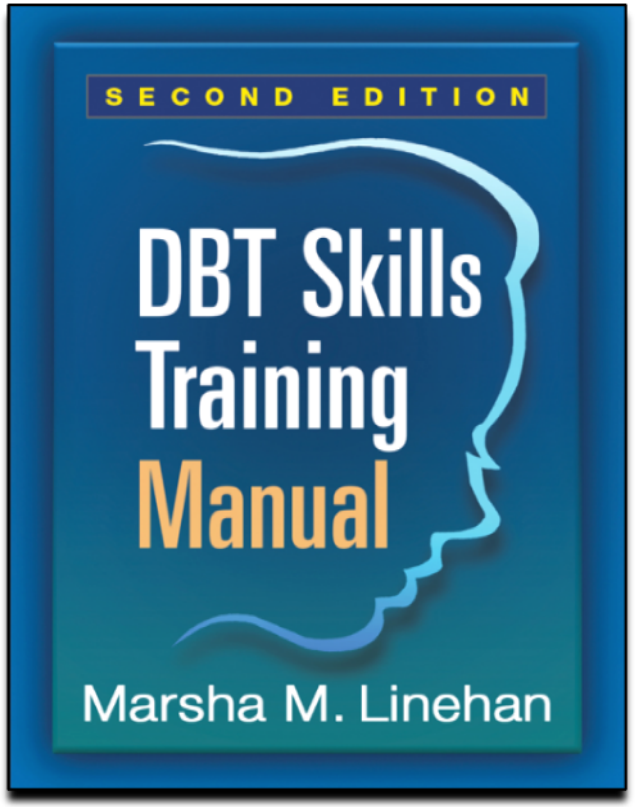
Lethal Means Safety Counseling

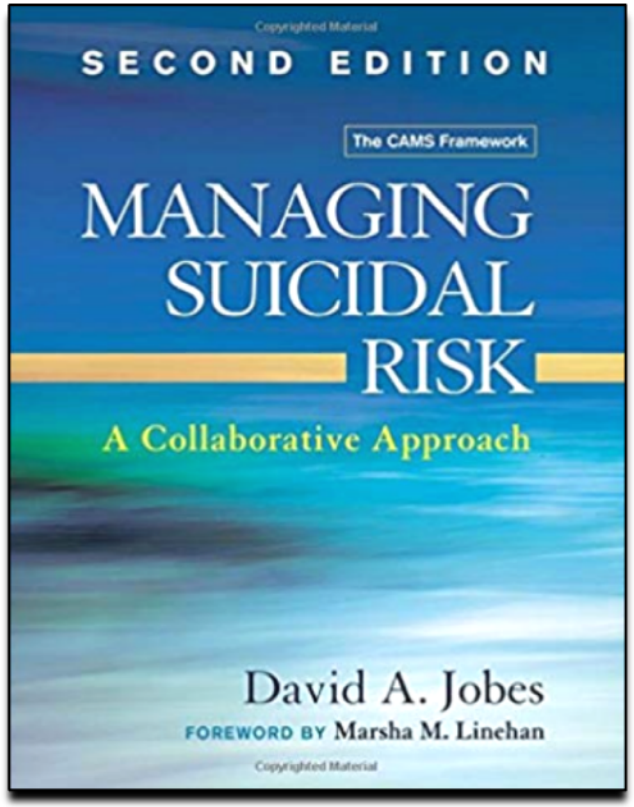
Lethal means safety counseling is important & feasible via TMH.

- TMH Specific Strategies
  - When discussing temporary offsite storage of firearms consider inviting a trusted emergency contact to video call.
  - Create a Means Safety Plan on video call by sharing screen.
  - For firearms, discuss gun lock options and mail a gun lock to home.
  - A VA pharmacist may be able to send an envelope for safe medication disposal. DEA also has a search function to identify disposal sites in the community.

Suicide-Specific Psychotherapies







Suicide-Specific Psychotherapies

No research on these treatments specifically; however, there are no contradictions in using these treatments.

- TMH-specific Strategies
  - Create fillable form versions of homework sheets and self-report inventories.
  - Send helpful handouts via a secure messaging platform.
  - Present and practice new material by sharing screens.
  - Consider mailing patient material by mail.

Resources

- Lethal Means Safety:
  1. https://www.mirecc.va.gov/lethalmeanssafety/index.asp
  2. https://www.hsph.harvard.edu/means-matter/
  3. http://depts.washington.edu/hiprc/firearm-storage-wa/
  4. https://apps2.deadiversion.usdoj.gov/pubdispsearch/spring/main?execution=e1s1
- Safety Planning and Therapeutic Risk Management:
  1. https://www.mentalhealth.va.gov/docs/VASafetyPlanColor.pdf
  2. https://www.mirecc.va.gov/visn19/trm/docs/RM_MIRECC_SuicideRisk_Table.pdf
- Suicide Risk Management Consultation Program:
  - https://www.mirecc.va.gov/visn19/consult/index.asp

Thank you
for listening.

COVID-19 Suicide Safety Planning

- Social distancing practices will affect implementation of safety plan
  - New or exacerbated triggers for suicide risk?
  - How can technology be used to increase social contact?
  - Make a proactive (not reactive) social connection plan
  - Weigh the pros and cons of increased social media use (e.g., Facebook)
  - Explore virtual options – many gyms and public spaces (e.g., museums) offer virtual ways to connect

Case Example: Assessment and Hospitalization

- During a home-based TMH appointment, a 33-year-old divorced male Veteran stated that he “just can’t take it anymore” and discussed his concerns related to suicide. Through assessment, it was deemed that the Veteran was at imminent risk for suicide and that his risk level warranted a higher level of care. The Veteran was amenable to hospitalization. Because the Veteran was at home, did not have a support person nearby to drive him to the hospital, and was not able to drive himself, the decision was made to contact emergency services for immediate evaluation and transport to the local hospital Emergency Department.

Case Example: Assessment and Hospitalization (continued)

- The Veteran was given the option of either calling the 911 himself or having his provider call 911, both while maintaining CVT connection with this provider. The Veteran opted to call 911 himself. He maintained the CVT connection while he called 911 so that this provider could continue to observe and hear the interaction. While waiting for emergency services to arrive, the Veteran continued with his provider and was able to engage in grounding techniques and discuss coordination of care related to the hospitalization. When emergency services arrived, the Veteran was able to introduce his provider to emergency services personnel via CVT, and together they discussed the clinical situation. The Veteran was voluntarily hospitalized due to acute suicidal risk.

Case Example: Ongoing Management of Risk Following Inpatient Discharge

- A 47-year-old partnered male Veteran was discharged from a 72-hour hospitalization following recent suicide attempt. He was discharged back to his home-based CVT provider with whom he been engaged in bi-weekly treatment for PTSD. The Veteran was unsure regarding whether he had suicidal intent as he had been so intoxicated that he could “not remember” whether his intention was to commit suicide or to serve as a “cry for help.” The Veteran’s distance from the VA as well as his lack of driver’s license due to previous DUI made access to in-person treatment difficult. His substance use and abuse was assessed and it was determined that Veteran’s alcohol use had increased dramatically and warranted additional treatment beyond his current provider’s expertise.

Case Example: Ongoing Management of Risk Following Inpatient Discharge (continued)

- The Veteran's home-based CVT provider consulted with the local VA Addictions Treatment Center (ATC) regarding coordinating care. A plan was made for the Veteran to meet with a provider on the ATC team for home-based treatment via CVT in addition to his PTSD treatment to increase the level of care due to his recent hospitalization as well as to provide alcohol use disorder treatment. The ATC provider was able to coordinate with a Community-Based Outpatient Clinic to collect urinalysis as necessary. Ultimately, after some work with the Veteran, he was amenable to engaging in residential treatment for Alcohol Use Disorder and PTSD. Upon discharge from the residential programs, he resumed home-based treatment with both his ATC and PTSD providers via CVT.