Telehealth Tips:

Managing Suicidal Clients During the COVID-19 Pandemic

The current need for social distancing and isolation related to the COVID-19 pandemic has necessitated a quick expansion of the provision of mental health services via remote platforms. Here are some tips for evaluating and treating suicidal individuals remotely via telehealth.

Basic guidelines initiating contact when your client may be suicidal

- Request the person's **location (address, apartment number)** at the start of the session in case you need to contact emergency services.
- Request or make sure you have **emergency contact information.**
- **Secure the client's privacy** during the telehealth session as much as possible
- **Prior to contact, develop a plan** for how to stay on the phone with the client while arranging emergency rescue, if needed

Adaptations for conducting comprehensive suicide risk assessment

- Considering the current stressful circumstances, broader assessment of suicide risk is indicated. Express concern and ask directly about recent suicidal ideation and behavior using a tool like the **Columbia Suicide Severity Scale (C-SSRS)**. Consider using a risk assessment tool like SAMHSA's **SAFE-T**.
- In addition to standard risk assessment, **assess for the emotional impact of the pandemic on suicide risk.** Examples that can escalate risk: 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 that can be emphasized:** 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** (particularly stockpiles of Tylenol or medications)

Adaptations for clinical management for suicidal clients

- Identify ways to increase safety short of sending client to the Emergency Department (ED)
- **Develop a safety plan** that will help clients manage their suicide risk on their own. (See below)
- Make provisions for **increased clinical contact** (even brief check-ins) until risk de-escalates
- Provide **crisis hotline (1-800-273-8255)** and **crisis text (Text "Got5 to 741741)** information
- **Identify individuals in the client's current environment** to help monitor the client's suicidal thoughts and behaviors in-person or remotely; seek permission to have direct contact with those individuals.
- If risk becomes imminent and cannot be managed remotely, arrange for the client to go to the nearest CPEP (if possible) or medical ED (if a CPEP is not available)
- **If risk is imminent, stay on the phone with the client until other care is present**

Adaptations to safety planning

- Safety planning works mostly the same as when done in-person. Use the **Safety Planning Intervention** form (attached). Let the client know that you want to develop a safety plan with them to help maintain their safety and that it will take about 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 e-mail or text to the client.

Center for Practice Innovations℠
at Columbia Psychiatry
New York State Psychiatric Institute
Building best practices with you.

SP-TIE
Suicide Prevention-
Training Implementation Evaluation

Steps in developing a safety plan

- **Step 1: Identify warning signs** that a suicide crisis is developing and the safety plan needs to be used
- **Step 2: Identify internal coping skills** that can distract from suicidal thoughts and de-escalate crises, taking into account limited access to resources
- **Step 3: Identify social contacts that can help distract from a suicidal crisis**. Many social distraction options have been limited by social distancing. **Focus on virtual activities** (virtual travel tours, opera, theater performances or concerts, museums or zoos; "meet-up" programs, like online painting, cooking, or karaoke; virtual hang-outs with friends via Skype/FaceTime/Zoom to watch movies or play board games; online support groups/forums or virtual AA/NA meetings) **and current social environment** (i.e., who the client is living with).
- **Step 4: Identify social supports who can help handle a suicidal crisis**. Determine who is currently available to help the client manage the suicidal crisis. If the client is currently living with others, determine together with the client who is the best source of support and who the client feels comfortable turning to. **Seek permission to contact and initiate contact** with one or two key people who will provide support to make sure they are willing to do so and have some tips on how to help the client. This takes time initially but 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; suicidepreventionlifeline.org)** and crisis text **(text "Got5" to741741; crisistextline.org)** information
- **Step 6: Plan for reducing access to lethal means** and review/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.
- **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 contact 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. Screening takes <2 minutes and should be done in conversational manner.
- **Review any changes in risk or protective factors** (changes in physical health in the individual or a loved one, new access to lethal means, interpersonal conflict in close quarters, social isolation and feelings of loneliness, or 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/support for yourself

- **Document all interactions** and your clinical thinking/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 extra important to **attend to our own isolation and mental health. Peer consultation groups** with other professionals using a secure platform like Zoom can help clinicians to brainstorm ideas for challenging cases and provide support.
- It is acknowledged that working with suicidal clients creates additional burden for clinicians in a time of great stress. **Periods of coverage, if possible, to allow for time off is important.**
- Clinician **self-care activities** are crucial, as is time off. Clients often respond positively and respectfully when clinicians explain that they will be unavailable for a period of time. **Informing suicidal clients in advance of when time away will occur and making alternate provisions enhances care.**

Contact SP-TIEInfo@nyspi.columbia.edu or Barbara Stanley bhs2@cumc.columbia.edu for more information.