TeleBehavioral Health 2025 Training Series

Behavioral Health Institute (BHI)
Harborview Medical Center
Website: https://bhinstitute.uw.edu
Email: bhinstitute@uw.edu

Northwest Regional
Telehealth Resource Center (NRTRC)
Website: https://nrtrc.org
Email: info@nrtrc.org

June 20, 2025

Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The **Harborview Behavioral Health Institute** (BHI) is a program of Harborview Medical Center that is dedicated to advancing innovation, research and clinical practice to improve community mental health and addiction treatment. The BHI also serves as a resource for the advancement of behavioral health outcomes and policy, and supporting sustainable system change.

The BHI brings the expertise of Harborview Medical Center/UW Medicine and other university partners together to address the challenges facing Washington's behavioral health system, through innovation and improving access to effective behavioral health care. BHI pillars include:

- Clinical Services
- Research and Program Evaluation
- Training, Policy and Workforce Development
  - **Expanded Digital and Telehealth Services and Training**

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

The NRTRC delivers telehealth technical assistance and shares expertise through individual consults, trainings, webinars, conference presentations and the web.

Their mission is to advance telehealth programs' development, implementation and integration in rural and medically underserved communities.

The NRTRC aims to assist healthcare providers, organizations and networks in implementing cost-effective telehealth programs to increase access and equity in rural and medically underserved areas and populations.

These sessions were made possible in part by grant number U1UTH42531-03 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

Speaker Disclosures

None of the series speakers have any relevant conflicts of interest to disclose.

Planner disclosures

The following series planners and team have no relevant conflicts of interest to disclose:

Brad Felker MD
Cara Towle MSN RN
Topher Jerome
Melody McKee SUDP MS
Nicki Perisho RN
Jaleen Johnson

DISCLAIMER

Please be aware that policy changes may take place after the original date of this presentation.

Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.

Please consult with legal counsel, billing & coding experts, and compliance professionals, as well as current legislative and regulatory sources, for accurate and up-to-date information.

We gratefully acknowledge the support from

Washington State Health Care Authority

NRTRC NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER

AHEC WW
AREA HEALTH EDUCATION CENTER
FOR WESTERN WASHINGTON AT WHATCOM COMMUNITY COLLEGE

Suicide Risk Assessment and Management in the Age of Telehealth

Kate Comtois, PhD, MPH
Professor, Dept of Psychiatry and Behavioral Sciences
University of Washington
Clinical Psychologist, UWMC Outpatient Psychiatry Clinic
(formerly at Harborview Mental Health and Addiction Services)

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

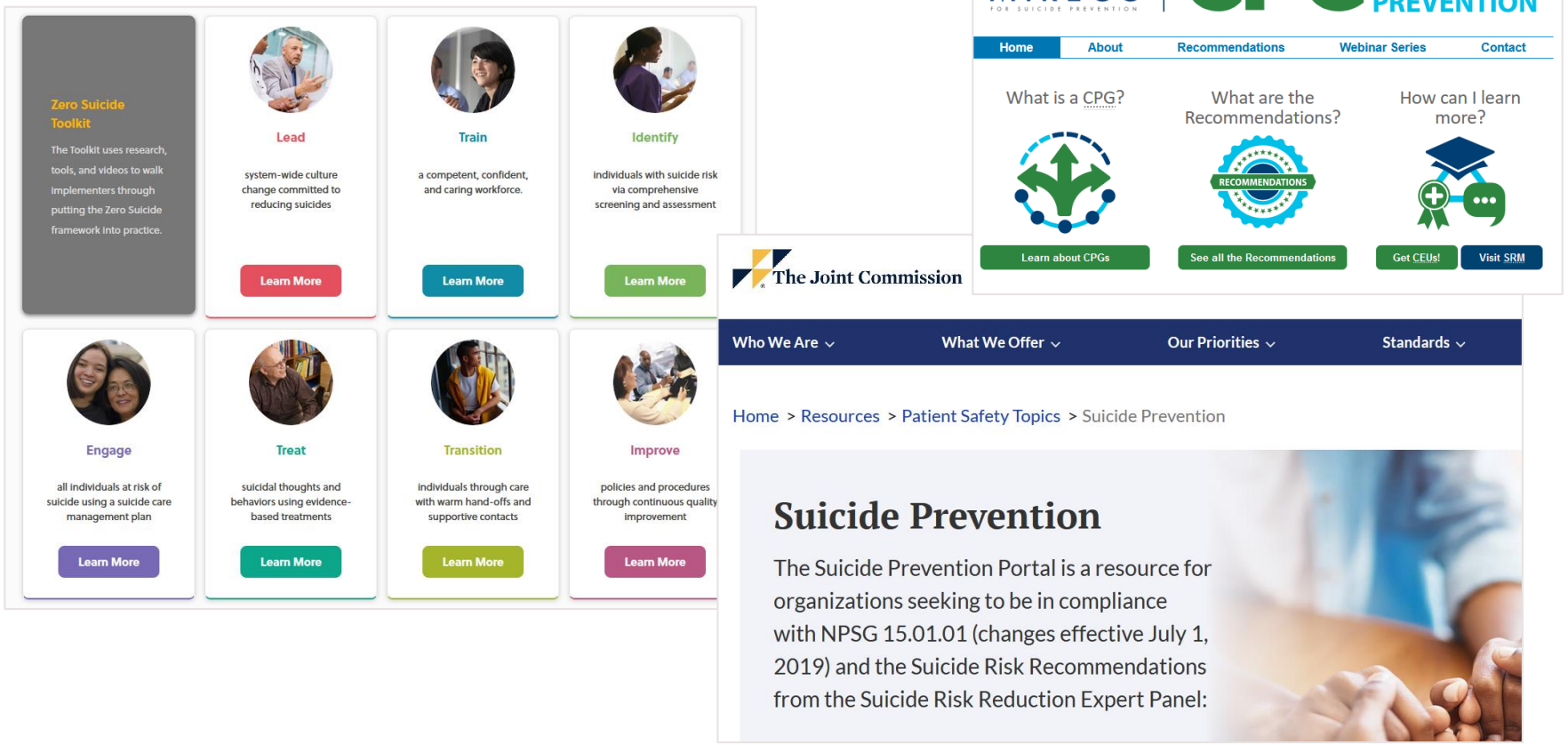
1. Observe the patients' living situation
2. Opportunity for visual inspection for lethal means counseling
3. Facilitate engagement with patients' family
4. Increase attendance in treatment and ability to reschedule
5. Less chance of spreading respiratory illness

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

2011-2019 Suicide Prevention Standards Focused Increasingly on a "Suicide Care Pathway"



Improving suicide care pathway =
Improved outcomes across the population

CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

Identification

Initial detection of suicide risk

Clinician client

Assessment

Identifying risk & protective factors

Formulation

Integrating findings to guide interventions

Interventions

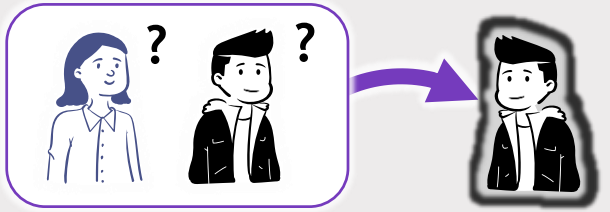
Follow-up

Management

Short and intermediate-term interventions to survive crises

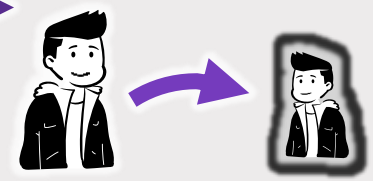
Treatment

Collaboration for self-recognition & self-management



Recovery

Life worth living

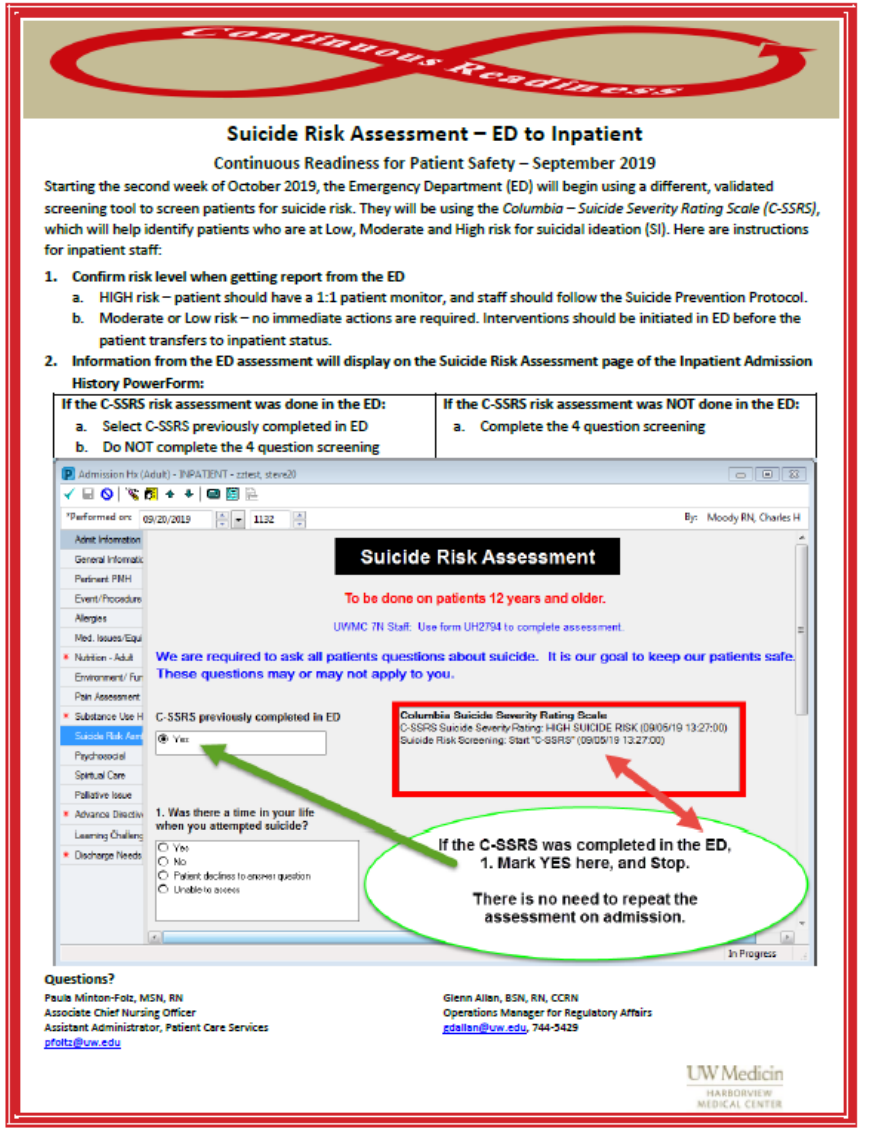


Standardized Screening

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) *Have you wished you were dead or wished you could go to sleep and not wake up?*		
2) *Have you actually had any thoughts of killing yourself?*		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) *Have you been thinking about how you might do this?* 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) *Have you had these thoughts and had some intention of acting on them?* As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) *Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*		
6) *Have you ever done anything, started to do anything, or prepared to do anything to end your life?* 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.	**Lifetime**	
If YES, ask: *Was this within the past three months?*	**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



Continuous Readiness

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:

1. **Confirm risk level when getting report from the ED**
   a. HIGH risk – patient should have a 1:1 patient monitor, and staff should follow the Suicide Prevention Protocol.
   b. Moderate or Low risk – no immediate actions are required. Interventions should be initiated in ED before the patient transfers to inpatient status.
2. **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:	If the C-SSRS risk assessment was NOT done in the ED:
a. Select C-SSRS previously completed in ED b. Do NOT complete the 4 question screening	a. Complete the 4 question screening

Questions?

Paula Minton-Foltz, MSN, RN
Associate Chief Nursing Officer
Assistant Administrator, Patient Care Services
pfoltz@uw.edu

Glenn Allan, BSN, RN, CCRN
Operations Manager for Regulatory Affairs
gdallan@uw.edu, 744-5429

UW Medicine HARBORVIEW MEDICAL CENTER

CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

Assessment: Standardized Assessments (1)

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 (2)

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

Hom et al, 20

Assessment: Risk Assessment (1)

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]

[1]School of Psychiatry, University of New South Wales, NSW, Australia; [2]Discipline of Psychiatry, Westmead Clinical School and Sydney Health Ethics, University of Sydney, Australia; [3]Centre for Brain and Mental Health, Faculty of Health and Medicine, University of Newcastle,; [4]Centre 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

CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

Assessment: Risk Assessment (2)

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

Large et al, 2017, British Medical Journal

Assessment: Culturally Based Assessment (1)

Cultural Assessment of Risk for Suicide (CARS)

Family conflict

- There is conflict between myself and members of my family

Social support

- I am accepted and valued by others (scored in reverse)
- I feel connected to, like I am a part of, a community (scored in reverse)

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

Chu et al, 2013, Psychological Assessment

Assessment: Culturally Based Assessment (2)

Cultural Assessment of Risk for Suicide (CARS) (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 (scored in reverse)
- I consider suicide to be morally wrong (scored in reverse)

Assessment: Culturally Based Assessment (3)

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.

Allen et al, 2019, Assessment

VA/DoD Clinical Practice Guidelines

https://www.mirecc.va.gov/visn19/trm/table.asp

Suicide Risk Assessment and Management

VA Suicide Risk Management (SRM) Consultation Program

Providing care for Veterans at risk of suicide may feel like a daunting responsibility. Why worry alone? The Rocky Mountain MIRECC offers free, one-on-one consultation for any provider (community as well as VA) who works with Veterans. Visit the SRM website to learn more and access our lecture series with free CEUs.
Tools + Support + Evidence-based Knowledge = Better Outcomes

Clinical Practice Guideline (CPG) for Suicide Prevention

The VA/DoD Clinical Practice Guideline (CPG) for Patients at Risk for Suicide uses evidence-based information to guide health care providers in screening, treatment and case management. This user-friendly website shares the twenty-two recommendations and accompanying resources in a centralized hub for easy access by mental health professionals. Visit our CPG website to learn more and to access our CPG webinars with free CEUs.

CPG for SUICIDE PREVENTION Webinar Series

Therapeutic Risk Management (TRM) with Patients at Risk for Suicide

The Rocky Mountain MIRECC model of Therapeutic Risk Management with Patients at Risk for Suicide is a clinically and medicolegally informed model for suicide risk assessment and management. Our Risk Stratification Table is a helpful tool designed to help providers accurately stratify risk and identify associated risk mitigation strategies. To order free copies for your team, visit our online order form .

ACUTE Risk for Suicide

HIGH ACUTE RISK

• Suicidal ideation with intent to die by suicide • Inability to maintain safety independently w/o external support/help	• Typically requires psychiatric hospitalization (vol. or invol.) to maintain safety and target modifiable factors

INTERMEDIATE ACUTE RISK

• Suicidal ideation to die by suicide (lack of intent) • Ability to maintain safety, independent of external support/help	• Consider hospitalization • OP mgt. with frequent contact, re-assessment of risk, development/update of safety plan, LMS

LOW ACUTE RISK

May have SI – but with ALL of: • No current suicidal intent • No specific & current plan • No preparatory behavior • Collective high confidence in the ability of the pt. to independently maintain safety	Focus on mitigating chronic risk by addressing risk and protective factors Consider upstream suicide prevention, health promotion interventions, applicable resources OP MH treatment if SI and psychiatric conditions are co-occurring

CHRONIC Risk for Suicide

HIGH CHRONIC RISK

Common warning sign: Chronic SI **Common risk factors:** Chronic SMI, PD, SUD, previous suicide attempts, medical illness or pain, limited coping skills, unstable psychosocial status, limited reasons for living	Chronic risk of becoming acutely suicidal Typically requires • Routine MH f/u • Safety plan • Means safety • Risk screening • Coping skills

INTERMEDIATE CHRONIC RISK

Similar to high chronic risk WITH protective factors, coping skills, psychosocial stability	Typically requires • Routine MH f/u • Safety plan with means safety

LOW CHRONIC RISK

Little in the way of MH or SUD – or MH and SUD problems with abundant strengths/resources	Mental health care on an as-needed basis, potentially in primary care

VA/DoD Clinical Practice Guidelines

https://www.mirecc.va.gov/visn19/trm/

Risk Stratification Table

Notice: The HTML, electronic PDF, and laminated print versions of the updated TRM Risk Stratification Table are all available for immediate use at the links below.

The Risk Stratification Table is a tool designed to:

1. help providers make determinations regarding suicide risk levels with respect to severity and temporality
2. aid in suicide risk management clinical decision making.

Visit the **HTML version** of the TRM Risk Stratification Table (*Updated: May 2024*)

Download the accessible **PDF version** of the TRM Risk Stratification Table (*Updated: June 2024*)

Order multiple laminated print copies for free from our Order Form.

Related Webinars

- **Suicide Risk Assessment Matters** presented by Drs. Hal Wortzel & Bridget Matarazzo
- **Suicide Risk Stratification and Documentation** presented by Dr. Hal Wortzel
- **Safety Planning- Basics and Beyond** presented by Drs. Megan Harvey & Suzanne McGarity
- **Evidence-Based Practice in Suicide Risk Screening and Evaluation: Why, What, How, and When?** presented by Dr. Nazanin Bahraini
- **Using Chain Analysis to Assess and Intervene on Suicidal Ideation and Behavior** presented by Drs. Sean Barnes & Lauren Borges
- **Welfare Checks and Therapeutic Risk Management** presented by Drs. Hal Wortzel & Edgar Villareal
- **Lethal Means Safety: Evidence Base, Current Practices and Next Steps** presented by Dr. Joseph Simonetti See links in Training section
- **Perspectives on Firearm-Related Conversations in Clinical Settings** presented by Dr. Joseph Simonetti
- **A Patient-Centered Approach to Lethal Means Safety with Veterans** presented by Drs. Ryan Holliday & Lindsey Monteith
- **Suicide Postvention** presented by Dr. Sarra Nazem

TRM Featured in National Suicide Prevention Guidance

Several national bodies, including VA/DoD and the Joint Commission, recommend therapeutic risk management:

VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide (2024)

Joint Commission National Patient Safety Goals (see NPSG.15.01.01 EP3) (Updated November, 2019)

RE
NTER

Management vs. Treatment of Suicide Risk

Management of Suicide Risk

Collaborative management

Clinician & client

Suicide risk

Non-collaborative management

Clinician

client

Suicide risk

Collaborative management

The clinician and client work together as a team

Focus on suicide risk

Short- and intermediate-term interventions intended to help the client survive crises

Non-collaborative

Management is *optimally* – though *not necessarily* – collaborative. Interventions might be unilateral or independent of pt. involvement

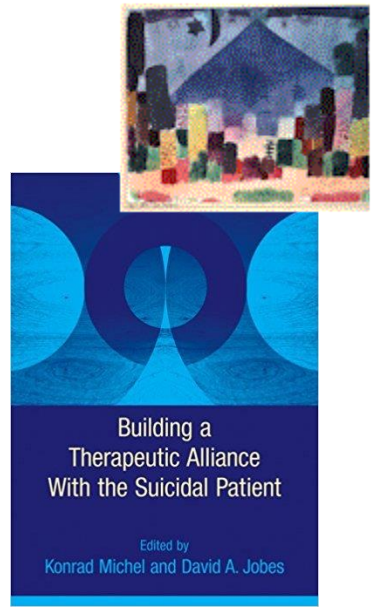
Feasibility

Multiple clinician, client and organizational factors might facilitate or hinder collaboration

Psychotherapeutic Expert Model of Suicide Care

Core Principles

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.



CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

Treatment of Suicide Risk

Treatment of suicide risk

Clinician & client

Suicide risk

Treatment process

Clinician

client

Suicide risk

Treatment outcome

client

Suicide risk

Collaborative relationship

Treatment is necessarily collaborative

Focus on suicide risk

Suicide-specific care focuses on direct drivers of suicide risk

Therapeutic stance

The clinician's role is consultative & collaborative

Self-recognition & management

Over time, the client is empowered to self-recognize and self-manage suicide risk

Recovery

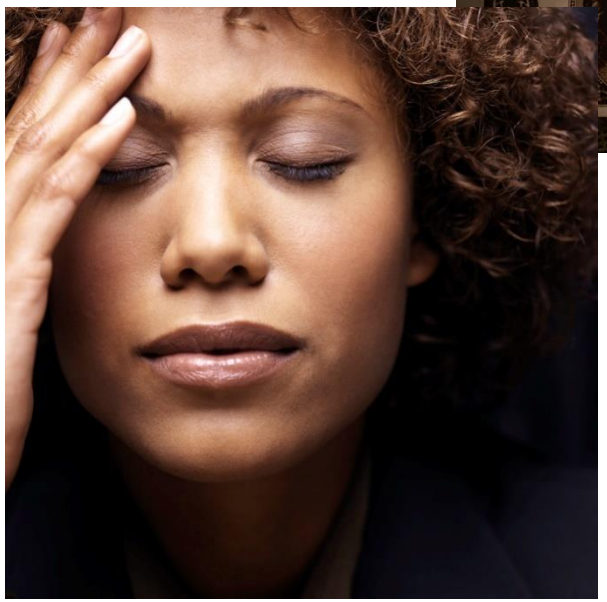
The pt. resolves drivers of suicide +/- learns effective self-management of chronic SI

So, what drives people to attempt or die by suicide?

"Indirect drivers" of suicidality

Financial problems

Homelessness



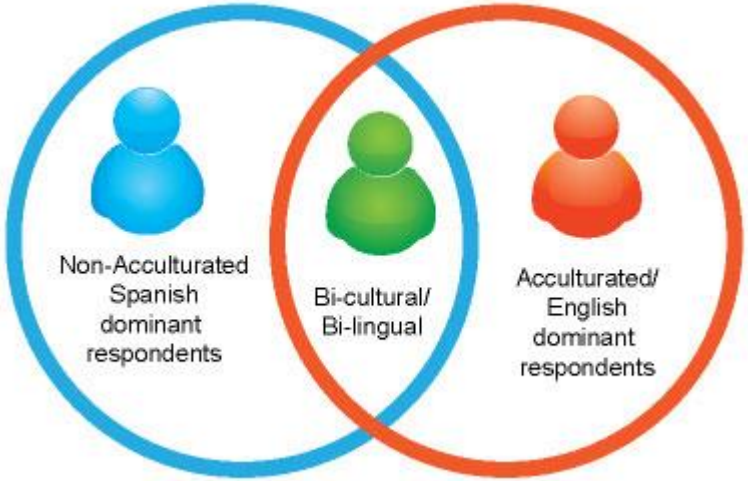
Depression

Relationship problems

CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

Minority and Cultural Risk and Protective Drivers



Acculturation

Minority Stress

Historical Trauma

Familism

Religiosity

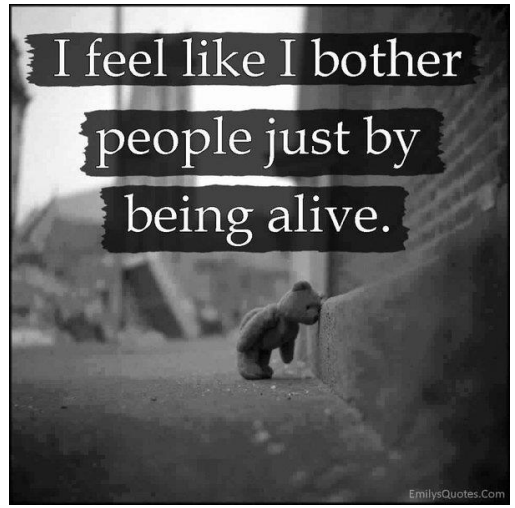
CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

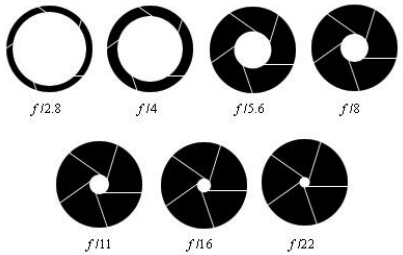
The most effective treatments focus on the unique problems of suicidal people that prevent them from solving their risk factors.

Stress & Agitation

Intense emotion dysregulation or pain



Burdensomeness



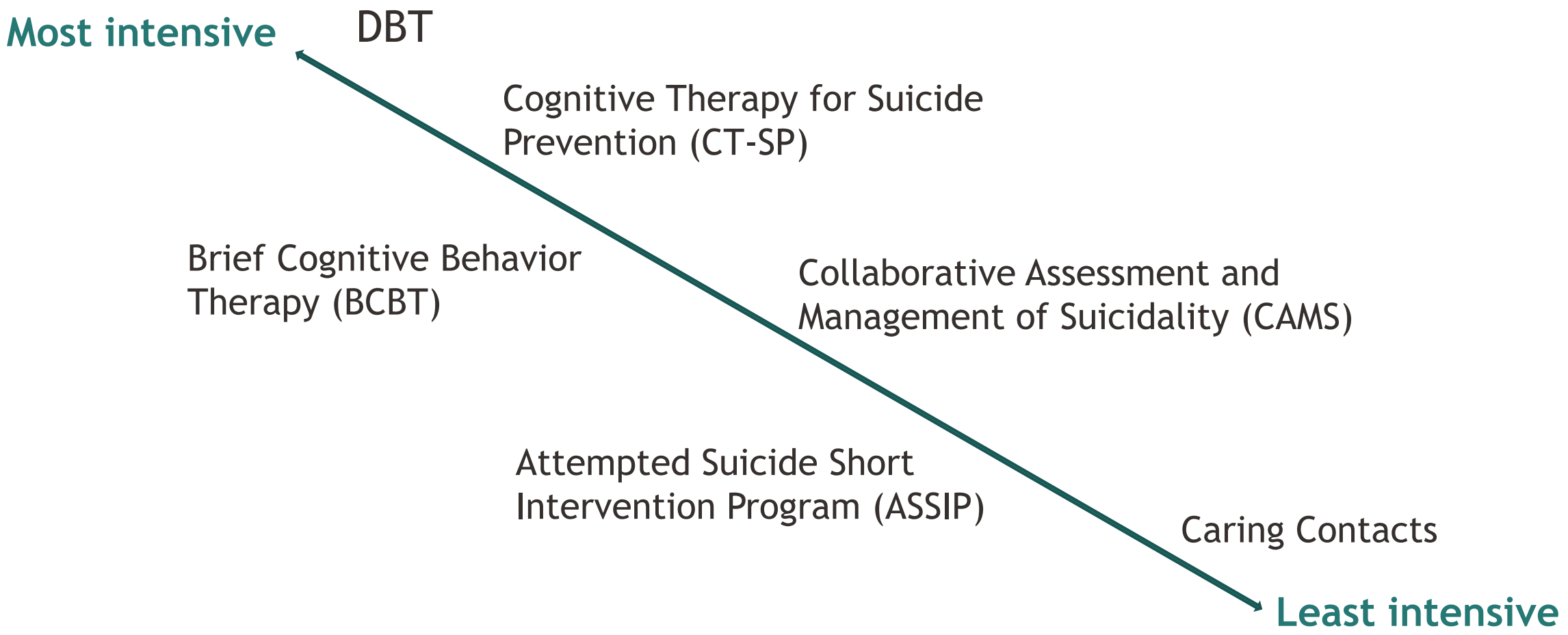
Attentional fixation on suicide

Lack of social connection

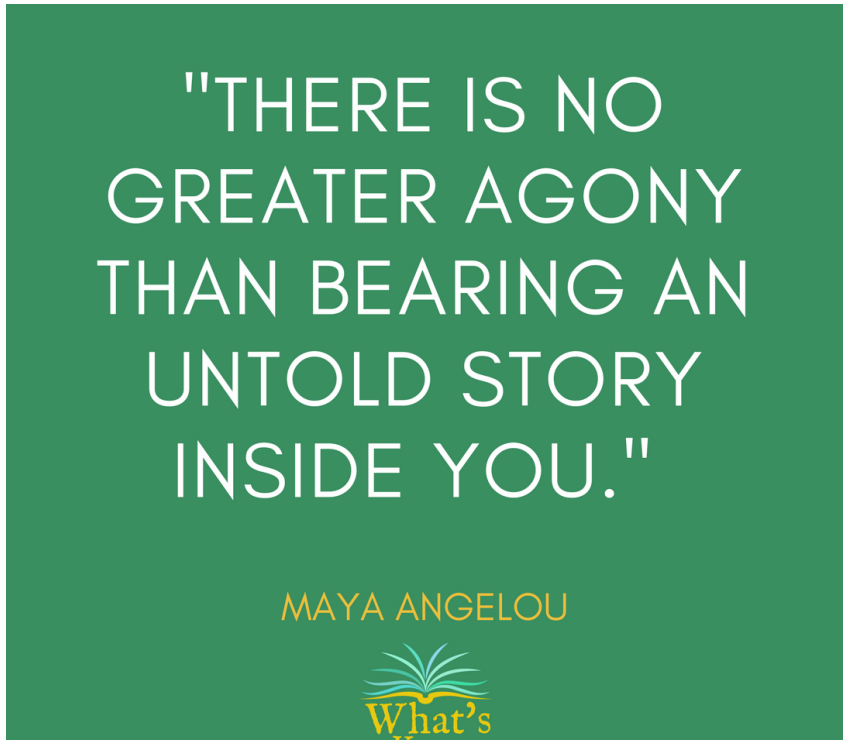
CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

Evidence Based Treatments for Suicidality: A Story for Another Day



Centering your Client's Story



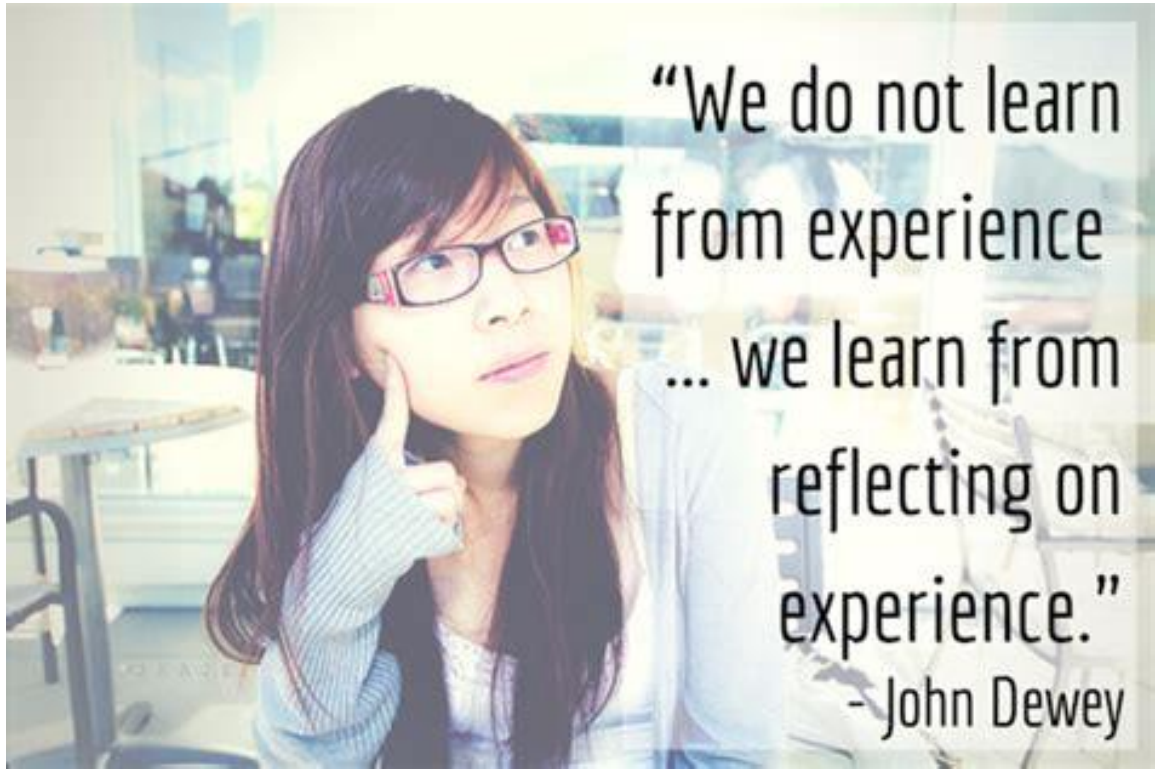
- The patient's story of suicidality is central to many evidence-based treatments for suicide risk
  - DBT
  - CAMS
  - Brief Cognitive Behavior Therapy
  - Cognitive Therapy for Suicide Prevention
  - Attempted Suicide Short Intervention Program

- Surprisingly, suicidal patients rarely get to tell the story of their suicidality

Centering your Client's Story

- Patients caught up in their suicidality cannot see the forest for the trees

- Offer clients the opportunity to reflect on their suicidality via telling their story and they often gain perspective that can
  - Reduce their risk in itself
  - Help them see alternatives
  - Help them see suicidal thinking as temporary



Centering your Client's Story

- Many of the questions we ask matter to us not to the client
- Many of the questions we ask are the most threatening to the client
- You can learn most of what you need from the story
- Ask what else you need to know afterward

"Let's start with you telling me the story of how you came to be thinking of suicide/make a suicide attempt. Afterward, I will likely have a few questions."

Telehealth Practice/Agency Plans (1)

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)

- Engage family where possible and patient is willing

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

Telehealth Practice/Agency Plans (2)

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 their behavior and are responsible for your behavior not theirs

Telehealth Options for Risk Assessment (1)

Online Surveys

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

PsychSurveys

Home | Login | Contact | Sign Up

Download on the App Store | GET IT ON Google Play

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

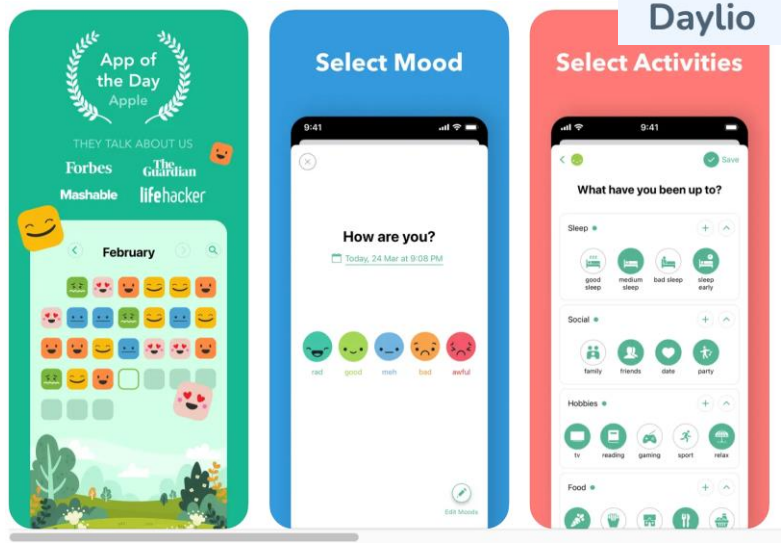
How it Works

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.

- Other self-monitoring apps

Daylio

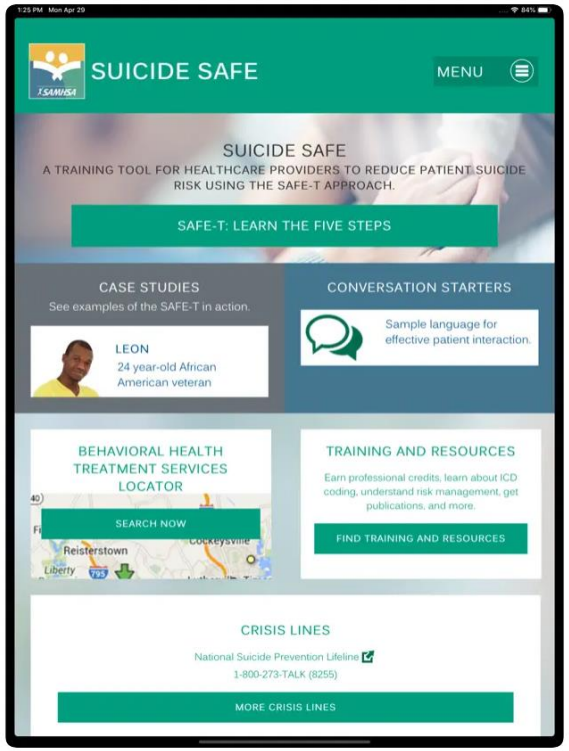


CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

Telehealth Options for Risk Assessment (2)

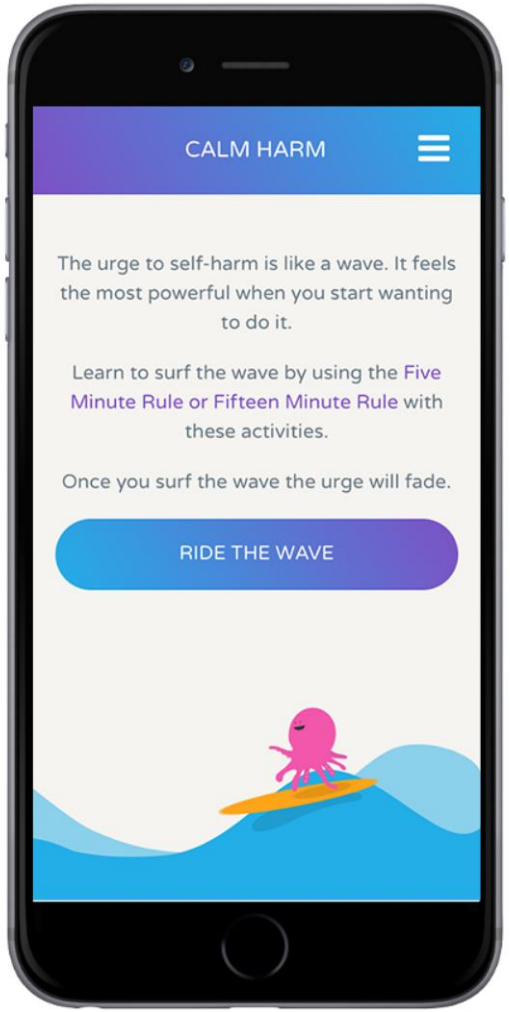
Safety Plan and Crisis Management Apps

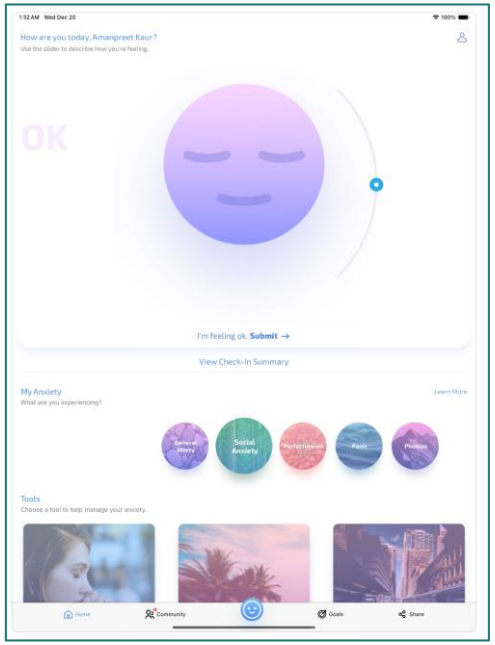


CSPAR The Center for Suicide Prevention and Recovery

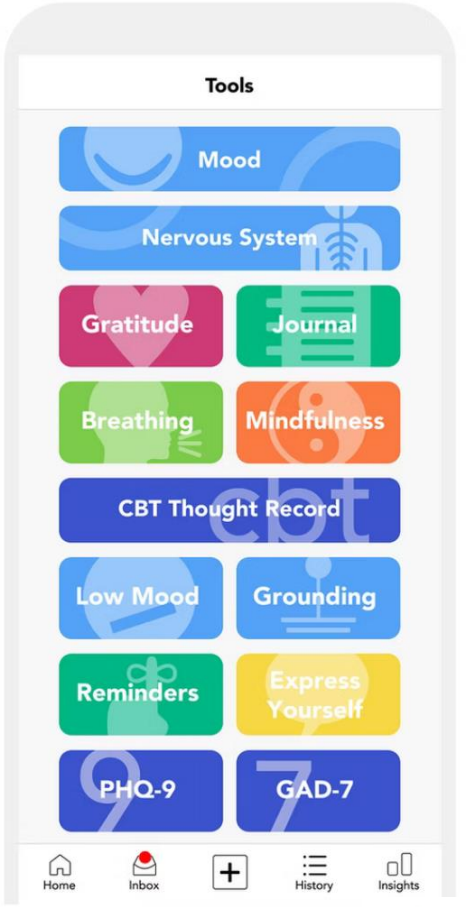
SUICIDE CARE RESEARCH CENTER

App Options for Coping Skills

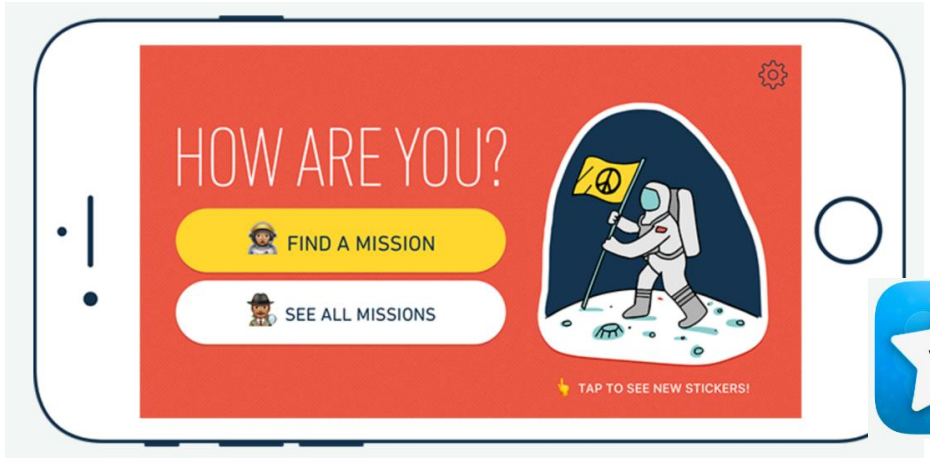




MindShift™ CBT



Moodfit



STOP, BREATHE & THINK KIDS

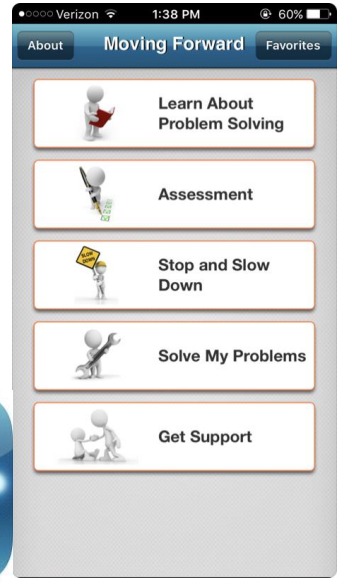
CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

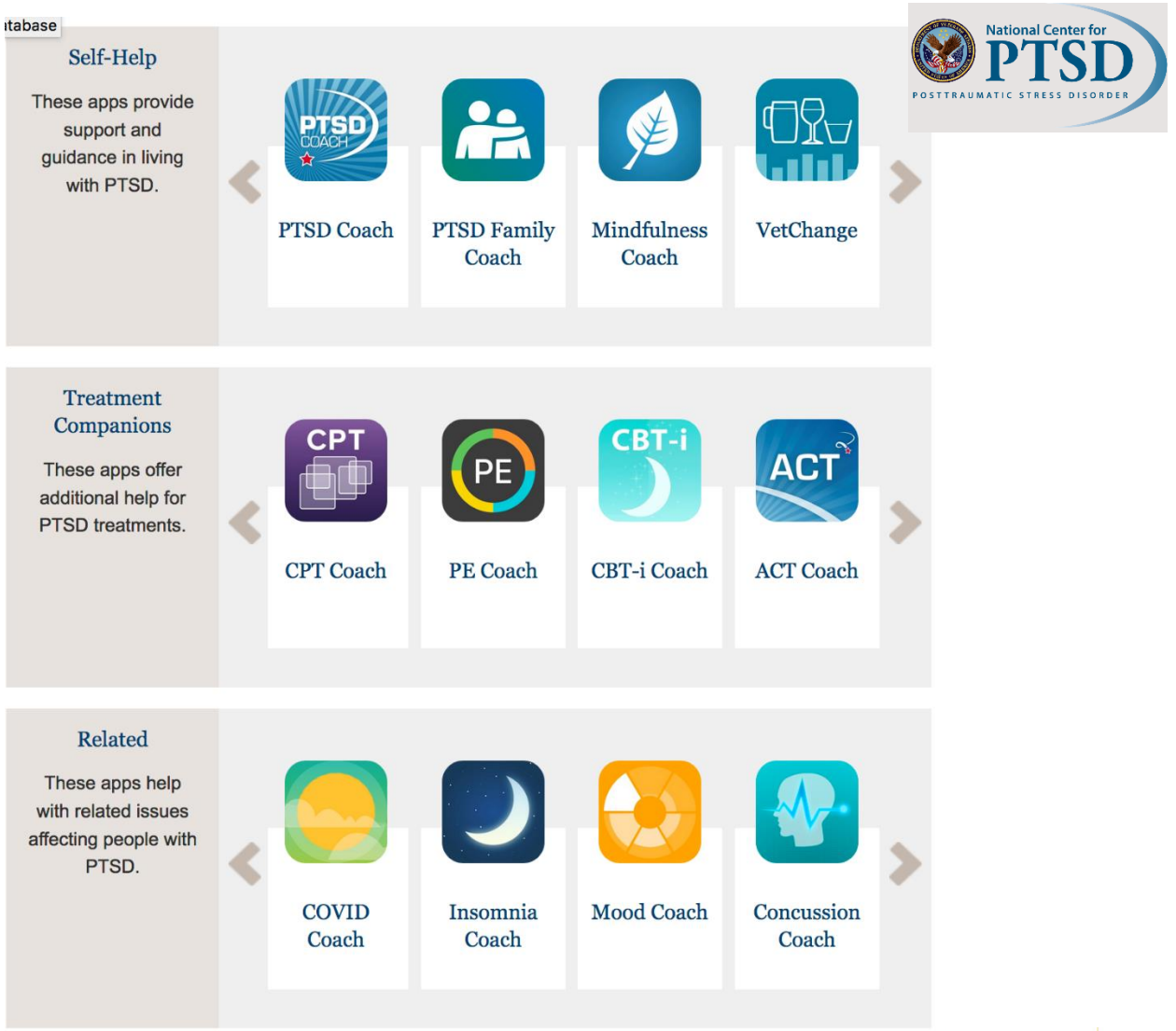
VA Free Telehealth and Suicide Resources

SUICIDE RISK MANAGEMENT
Consultation Program
FOR PROVIDERS WHO SERVE VETERANS

BROADCASTING
@rmirecc



MOVING FORWARD



National Center for PTSD
POSTTRAUMATIC STRESS DISORDER

CSPAR The Center for Suicide Prevention and Recovery

SUICIDE CARE RESEARCH CENTER

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

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…

Looking for Health Equity & Ethics Training?

Cultural Humility In Behavioral Health Care

- Free two-hour module
- On-demand & self-paced
- Meets **Health Equity** training requirements in WA State

Empowering Recovery: Ethics & Collaborative Decision-Making in Behavioral Health

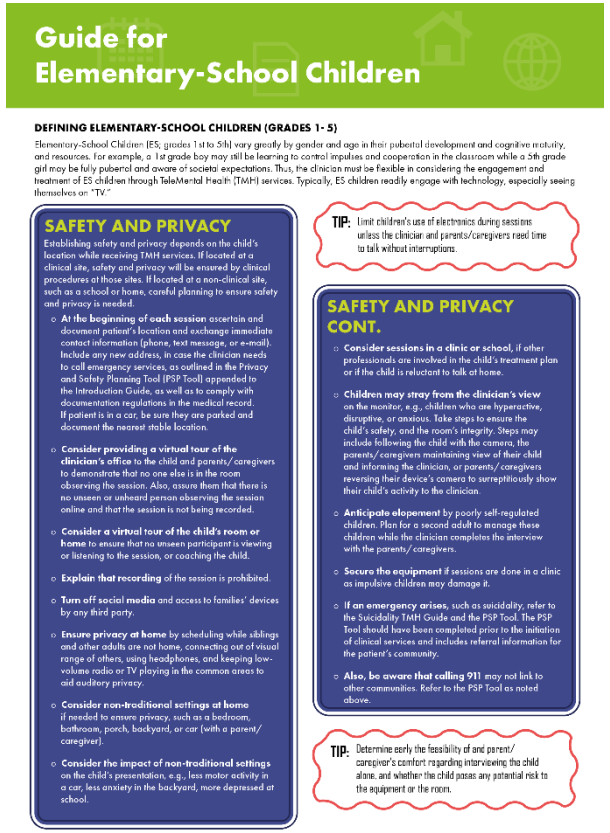
- Free two-hour module
- On-demand & self-paced
- Meets **Law & Ethics** training requirements in WA State

Learn more at: https://bhinstitute.uw.edu/learn-online

TeleMental Health Guides for Infancy to Young Adults

Guides (8)

- Infancy and Toddlers
- Pre-schoolers
- Elementary School Children
- Middle School Youth
- High School Teens
- Young Adults
- Neuropsychological Testing
- Suicidality



Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1- 5)

Elementary-School Children (ES; grades 1st to 5th) vary greatly by gender and age in their pubertal development and cognitive maturity, and resources. For example, a 1st grade boy may still be learning to control impulses and cooperation in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Thus, the clinician must be flexible in considering the engagement and treatment of ES children through TeleMental Health (TMH) services. Typically, ES children readily engage with technology, especially seeing themselves on "TV."

SAFETY AND PRIVACY

Establishing safety and privacy depends on the child's location while receiving TMH services. If located at a clinical site, safety and privacy will be ensured by clinical procedures at those sites. If located at a non-clinical site, such as a school or home, careful planning to ensure safety and privacy is needed.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patient is in a car, be sure they are parked and document the nearest stable location.
- **Consider providing a virtual tour of the clinician's office** to the child and parents/caregivers to demonstrate that no one else is in the room observing the session. Also, ensure them that there is no unseen or unheard person observing the session online and that the session is not being recorded.
- **Consider a virtual tour of the child's room or home** to ensure that no unseen participant is viewing or listening to the session, or coaching the child.
- **Explain that recording** of the session is prohibited.
- **Turn off social media** and access to families' devices by any third party.
- **Ensure privacy at home** by scheduling while siblings and other adults are not home, connecting out of visual range of others, using headphones, and keeping low-volume radio or TV playing in the common areas to aid auditory privacy.
- **Consider non-traditional settings at home** if needed to ensure privacy, such as a bedroom, bathroom, porch, backyard, or car (with a parent/caregiver).
- **Consider the impact of non-traditional settings** on the child's presentation, e.g., less motor activity in a car, less anxiety in the backyard, more depressed at school.

TIP: Limit children's use of electronics during sessions unless the clinician and parents/caregivers need time to talk without interruptions.

SAFETY AND PRIVACY CONT.

- **Consider sessions in a clinic or school,** if other professionals are involved in the child's treatment plan or if the child is reluctant to talk at home.
- **Children may stray from the clinician's view** on the monitor, e.g., children who are hyperactive, disruptive, or anxious. Take steps to ensure the child's safety, and the room's integrity. Steps may include following the child with the camera, the parents/caregivers maintaining view of their child and informing the clinician, or parents/caregivers reversing their device's camera to surreptitiously show their child's activity to the clinician.
- **Anticipate elopement** by poorly self-regulated children. Plan for a second adult to manage these children while the clinician completes the interview with the parents/caregivers.
- **Secure the equipment** if sessions are done in a clinic as impulsive children may damage it.
- **If an emergency arises,** such as suicidality, refer to the Suicidality TMH Guide and the PSP Tool. The PSP Tool should have been completed prior to the initiation of clinical services and includes referral information for the patient's community.
- **Also, be aware that calling 911** may not link to other communities. Refer to the PSP Tool as noted above.

TIP: Determine early the feasibility of and parent/caregiver's comfort regarding interviewing the child alone, and whether the child poses any potential risk to the equipment or the room.

TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

Abdul is a 10 y/o Afghani refugee boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and falling behind academically. The Mother noted similar difficulties in the home, especially regarding homework. Both parents worked and lived in an urban neighborhood with poor transportation options, so they agreed to home-based TMH. The family used their smartphone for the sessions, with adequate, but not optimal, cell reception. Sessions were held in the parent's bedroom, for privacy. An older sister watched the siblings in another room or took them for a walk.

Abdul was readily engaged over the smartphone and told of his favorite videogame, his love of Legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Even with the spotty connectivity, the clinician appreciated Abdul's good verbal skills, intellect, charming personality, as well his impulsive intrusiveness and mild mid-facial and guttural tic. To assess his gross motor skills, the clinician asked Abdul to do some movements, including some dance movements. He was awkward and had difficulty cooling down once wound up. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, Abdul was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly returned to the smartphone to show his artwork: not an animal, but he enthusiastically told of its meaning, demonstrating his creativity and knowledge.

The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services, and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

UW Medicine DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES | UW Medicine | CoLab | PURDUE UNIVERSITY

uwcolab.org/tmh-guides

Additional Free Resources for Washington State Behavioral Health Providers

EDUCATIONAL SERIES:

- UW Traumatic Brain Injury – Behavioral Health ECHO → → →
- UW Psychiatry & Addictions Case Conference ECHO
- **UW TelePain series**

PROVIDER CONSULTATION LINES

- **UW Pain & Opioid Provider Consultation Hotline**
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line

Post-TBI Depression –
Jesse Fann MD MPH

TODAY
12-1.30pm

UW Medicine
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Washington State Health Care Authority

Seattle Children's
HOSPITAL · RESEARCH · FOUNDATION

NRTRC
NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER