Behavioral Telehealth (Video and Phone): Skill Development Webinar Series Questions & Answers

Effective Suicide and Crisis Intervention Using Telehealth

Webinar 7: June 10, 2020

Thank you for your questions. I enjoyed thinking about them and carefully considered my answers. I want to point out that the answers given are in response to how I am interpreting the question, and I am aware that others might have different perspectives. Please always seek consultation when considering challenging questions regarding suicidal ideation or behavior. Kristin Dempsey, EdD, LMFT, LPCC

Question	Answer
Can you clarify the difference between safety plan and contracting for safety? I also heard safety contracts are no longer evidence based. Can you speak to that?	**The way I approached this concept in the webinar is to explore the process of safety planning in order to ensure client safety. A safety contract, which is most typically written out and signed by the clinician and client, can be a part of such planning. Safety contracts are often desired for documentation "proof" that we did our best to make sure the client will not harm themselves*. Safety contracting gets a bad name in that it can be done in the spirit of covering our butts and not as the result of engaged connection with the client. If it is a cover yourself situation, the client might comply to avoid a confrontation but be no safer than when the conversation began. There is little and conflicting evidence regarding whether suicide contracts are effective, especially with adolescents. (Edwards & Sachmann, 2010; Hansen, Heath, Williams, Fox, Hudnall, & Bledsoe, 2012)** **Entering a caring relationship is the pathway to ensuring client safety.** ***third person singular used throughout answer to indicate non-binary gender.**

Question	Answer
How do you manage responses to whether they have a plan that involves "There's so many ways to die (list)"?	**Approach with curiosity and compassion: How is someone who presents me with such a list feeling? What are they needing in terms of my response?** **Create a reflective response that non-judgmentally addresses such affect and need:** **e.g.** ***"You really want me to know that you have thought so much about suicide."*** **This is an attempt to engage. I am going to continue to follow up and engage. They are not leaving me or the room without a safety plan.**
Will you be talking about working with children and adolescents who are suicidal via Telehealth?	**We have been working with individuals, including young people, for over 50 years on using telehealth – telephones! More recently, chatlines and chatrooms have been used to effectively work with youth in crisis (Redmore, Ramchand, Ayer, Kotzias, Engel, Ebener, Kemp,Karras, Haas, 2017). Video rooms provide more potential in that we can see youth and have additional ability to assess their physical presentation and non-verbal communication. The challenges are in making sure youth show themselves in the camera and finding out where they are located. However, some young people do not want us to look at them when they are distressed. This gets back to using the phone lines. If we are warm, genuine and engaged, we are likely to make the connection needed to save their lives.**
Although I know it is best to ask directly about suicide, I often hesitate due to being concerned that it may upset the client more.	**The reactions to being asked directly about suicide can vary. Some individuals are appreciative that the practitioner has broken the ice and demonstrates they can handle the question. Others recommend normalizing suicidal thoughts or using "gentle assumptions" that one might have had suicidal thoughts (e.g. "when was the last time you had a suicidal thought…") (Sommers-Flannagan & Shaw, 2017). Remember, your relationship will help prevent and/or help you repair ruptures that might occur as the result of asking this question.**

Question	Answer
Why do we see multiples SA's in a close time frame to another suicide?	**Ample evidence exists to support suicide *contagion*. It appears that media reports and proximity to someone who has died by suicide might contribute to vulnerable individuals considering suicidal behavior (Coleman, 2018). It is important to have conversations about local or high-profile suicides to assess how much identification or interest might be developing as the result of the suicide so options can be explored.**
I had a teenager tell me, "I wouldn't tell you if I was suicidal, you'd stop me!" I managed it OK, but any good suggestions for a response?	**I am interested in how you responded!** **With curiosity and compassion, I might say something like, *"It is important for you to have control over your life, and you are concerned if I knew you were suicidal, I'd stop you and you would lose control".*** **More than likely, conversation will follow, and I can continue to assess and engage. Ultimately, if I am feeling this person is not safe, I would do what was needed to ensure safety (welfare check, talk with parents, etc.).** **By the way, they want to talk about suicide, and they want us to do something.**
What if clients are adamant that they have thought about it but they state they would never commit suicide due to children or spiritual beliefs - how do you continue to explore this without making them upset if they are denying intent or plan but continue to present with significant risk factors and warning signs?	**I would continue to explore the pain they are presenting while honoring the important resources they have that are keeping them alive:** ***"I hear that you are so connected to your children and your faith, and that keeps you from planning suicide, AND I am also aware that you are in a lot of pain that brings you back to this hopeless place."*** **After you make this kind of reflection, you have to opportunity to offer hope and resources to help reduce the pain. Someone with kids and faith has something to hold onto while they do the hard work of recovering.**

Question	Answer
A big concern with Telehealth is multiple clients do not have a private place to talk and no headphones, so it can be challenging to discuss certain issues.	**Yes, this is very difficult. We should make a priority to problem solve with such individuals about a quiet safe place. I am doing therapy with many clients who sit in cars, garages, laundry rooms, and bathrooms. Almost everyone has a bathroom with a lock on it. I would encourage you to keep brainstorming with them.**
In time of pandemic, I've had an individual exhibiting overwhelming warning signs (along with risk factors) and using statements like "if anything happens to me..." but when asked about suicide, they completely deny ideation. Do any suggestions of how to handle, or follow up questions statements to use?	**I can understand your concern because, "if anything happens to me…", is an ominous statement.** **You likely have asked this, but what I would want to know is what do they mean by that statement. I might even provide a more concrete clarification by stating something like…** ***"I know I have asked you a lot about suicide and you say you are not having any. I find that I keep asking you as I am so concerned about your statement 'if anything happens to me?'. What do you think might happen to you?"*** **I think it is important to continue to explore ominous statements if they keep coming up, so you are showing concern and helping the client tell his story.**
As LA country PMRT can take up to 6 hours to respond to a crisis, yet, with families of color, we may want to stay away from police intervention. In the current climate with police brutality, is there a recommendation to call local agency psychiatric mobile response teams first, as opposed to dialing 911 for police psychiatric response?	**I like that you are thinking in advance how to keep your community safe. I would recommend doing some research into your local mobile response teams and see if you can learn more about their response times and practices. It is a great opportunity for partnering with these agencies so you can start to have dialogues about what practices are beneficial and which are harmful for your communities. You can also see if any of your police responders are Crisis Intervention Teams. CIT teams have the training to use non-aggressive tactics. You would need to explore their actual practices and outcomes to make sure they are responding respectfully to communities of color.**
What about a depressed patient that has unexpected moments of increase happiness?	**You can see what motivates such happiness and potentially build on it. We always want to make sure that sudden happiness in a depressed**

Question	Answer
	person is not due to their new resolve to die by suicide. That can happen. We also know if when someone is significantly depressed, they might become more suicidal when the depression lifts as they have more energy to engage in self-harm.
We have an emergency psych unit here with a terrible reputation, we are having more and more clients traumatized to the point of avoiding hospitalization at all costs. Can you speak to navigating risk assessment and safety planning with clients for whom hospitalization is particularly triggering? And how to navigate a local system that has a traumatizing psych unit?	**It is important to allow the client space to talk about their fears. Given that you know the psych unit is traumatizing, it is important to find ways to advocate and support for client and commit to them that you will do such advocacy (or find someone who will).** **The next step is what can you do to promote some change within the psych unit. You might not have direct control over the unit but documenting abuses and researching how to report and hold a poorly functioning psych unit accountable is possible.**
What about with children during assessment phase when I don't have enough information or warning signs? Can being so direct be off putting to parent or child?	**Yes, I might be inappropriate to start a conversation with a child when there clearly is no indication regarding suicidality. It is possible to ask the parent regarding any historical suicide concerns, or to soften the question with a prior preparation statement, such as,** ***"When we get to know someone and figure out how to help them, we ask a lot of questions regarding things they think about and some of these questions might fit or you, or not. We ask them so we can make sure to help them in the best way we can…"*** **Again, if it's not indicated immediately, you might wait to build rapport before asking such a question. You also want to adjust the language to be age and culture appropriate.**
Can you speak more towards the unique challenges presented by telehealth and crisis/suicide assessment and intervention?	**Start by remembering that many suicide conversations are happing via phones, so we can make some good connections using tele-technology. For video, you want to make sure someone has good internet. If they don't, see if you can call them on land or cellular and turn off the video audio. If you get disconnected, you can still see them. If on video, encourage them to**

Question	Answer
	show their face, not just turn on the camera. It is not helpful if the camera is showing the ceiling. Help them brainstorm where to hold a session. I mentioned some earlier: cars, garages, private yards, balconies, closets, and bathrooms. I know some of these locations seem truly odd, but we need to do what we can to ensure privacy so we can help them feel safe to talk. You also need to know where they are physically located in case you need to send for a welfare check, and his might mean doing some research on the crisis support services in their community. The rest of the protocol would essentially be the same as in person.
What about engaging family who is around due to the distance of telehealth? Cat plus family?	**See the next answer.**
Or for TAY who live with roommates...seeing if roommates can help provide support that normally an in-person session could be yourself/therapist	**When involving family and friends, you are wanting to do this in collaboration with the client and be very intentional about why the others are being involved and the role they will play. Clearly for children, you would involve adult family members in the home for several potential issues, but it is always important to give the client (regardless of age) some control over who is involved and how they will be used. Ultimately, if you are working with someone who refuses to involve others in the home and who is a grave danger to themselves or others, you would likely break the frame and connect with the supportive people in the home. I would always recommend having conversations at your agency or with your consult team as how to proceed in such situations.**
What about for adolescents? Can you discuss how you would do this with adolescents?	**See above answer – and for adolescents I offer additional elaboration, the family and friends would be involved in helping to disable a suicide plan, transport to in-person crisis care, and/or provide emotional or practical support. It is possible to talk with them when they client is exploring suicide, but I would not immediately recommend this as they might be reluctant to speak around others. You would use your clinical judgment to determine the best next step.**

Question	Answer
We are told that safety plans do not work, would you speak about this and what DOES work in preventing suicide?	**Safety *planning* absolutely works and should be done for anyone with suicidal ideation. A safety plan needs to be done in collaboration with the client while honoring their specific preferences and needs. A safety *contract* is more difficult. The safety contract can be excellent when done as part of thoughtful or client-centered safety planning. If it's just a list of things the provider lists that the client needs to agree to do (or not do), you might not have real engagement. Part of the problems with safety contracts is that practitioners are told to do them, but they are not necessarily trained well in how to use them well (Hansen, Heath, Williams, Fox, Hudnall, & Bledsoe, 2012).**
I am trying to link an Adult client with comorbid disorder to virtual 12 step in Los Angeles/Long Beach area. Would you be able to provide some guidance to connect him as he has experienced losses and expressed need for emotional support?	**I like that you are considered online 12 Step as a resource for him. I am not sure if the losses make it hard for him to go online, but maybe you can "go with" him to a virtual meeting. This might be consistent with how you work, but such partnering can be helpful.** **I will include a Google list on online meetings at the bottom of this document. (The link distorts this table formatting).**
Do patients who practice religions with beliefs in an afterlife have a higher incidence of suicide than those religions without?	**It appears that the relationship between religion and suicidality is complex. A 2018 study found "The type of God representation is an independent statistical predictor of the severity of suicide ideation. A positive-supportive God representation is negatively correlated with suicide ideation. A passive-distressing God representation has a positive correlation with suicide ideation." (Jongkind, van den Brink, Schaap-Jonker, van der Velde, & Braam, 2019)** **The takeaway should be that spirituality is complex and we need to have conversations with clients we can develop a full understanding of the protective vs. risk factors associated with spirituality.**

Question	Answer
As a case manager how can we assist the person and stay within our boundaries	**Check with your supervisor on how they would like you to set boundaries regarding suicide. My belief is that everyone can take part in preventing suicide. Many suicide prevention programs are designed for community members who are not doing therapy with clients based on the philosophy that any of us can provide caring and meaningful support. If hearing someone's distress and asking about suicide is not a usual part of our work, is it not still an important thing that we do when indicated?** **You might want to think through (with your team) if someone is suicidal, how can you be prepared to be a part of the safety exploration and planning process and knowing when you might "hand off" to another staff member.**
How can a counselor help someone with Dissociative Identity Disorder, some of whose "alters" are holding suicidal ideation and engaged in planning?	**I work with individuals who have dissociative processes, but I do not have significant experience with DID. Given that, I am going to pass on giving advice on working with alters. (I have some ideas, but I want to avoid thinking this through without expertise in this forum).**
With long-term therapy clients who you know experience SI at baseline, what are the some of the ways you assess and ask them about it every session? Do you ask every session?	**I do ask every, or most every, session. I check in on suicide like how I might check on depression, anxiety, substance use, or other thoughts and ideas that might be an issue for the client. I have had very productive and powerful conversations about the function of suicidal ideation and ways we can work on other "coping" options. After several sessions, often there is more comfort and willingness to approach the pain and loss that contributes to such ideation.**
What if a youth is at very high risk of suicide (depression, past attempts, hopelessness, alcohol use) and is not wanting to have any support?	**We still need to do an assessment and consider more directive action if we cannot be sure they can care for themselves. I think you might be asking about the youth who is consistently in pain and doing risky behavior but not interested in actively changing behavior. Your talking to them and reaching out is the support they can tolerate now. Take a breath and keep being curious and reflective. Slowing it down and staying in touch will allow you to be there if they become more at risk and/or can be protective as**

Question	Answer
	they know you are there. Ultimately, we need to work at their pace.
In doing a welfare check, what if a mobile crisis clinician is unavailable to visit them in person to assess? What if instead an untrained cop shows up? I'm asking this question specifically for marginalized people of color who may have had a bad experience with the police and/or the police may approach the situation in an inappropriate manner. Sending someone to a psychiatric institution is not always helpful and can even make people worse!	This is a very difficult and challenging situation that is important to be asking now. Have a conversation with your team or consultants to figure out how you might build in support for at-risk individuals in marginalized communities. Exploring your options before the crisis, you can think of who in your community might be able to provide support or how you might develop relationships with your local police to have them send CIT-trained officers. I do not have the space or time to write all the options here, but I do encourage a next step of reaching out to community partners to create a plan of action for such situations.
Any thoughts about how to address SI with clients exhibiting symptoms of bipolar or borderline personality d/o?	This depends on how symptomatic they are. Are thy emotionally regulated enough that they can track you, stay focused, and engage in the conversation? If someone is so dysregulated, they cannot reliably focus or engage, you might have a situation in which they need to be assessed in a psychiatric ER.
A few weeks ago, one of patients, who is Black, was experiencing a crisis. HIs family contacted 911 and patient was assaulted by law enforcement. With the current climate, the family has expressed they do not feel comfortable/is ambivalent about contacting 911 if an emergency occurs again. What is your recommendation?	My recommendation is like the one above for creating community partnering before the crisis in order to problem-solve who to call in emergencies. I would recommend talking to the family now so you can be proactive with determining who they can call to obtain support if a crisis occurs in the future. I also recommend calling your county mental health agency or NAMI chapter to obtain recommendations for peer support and outreach services. Peers can be very helpful in provide emotional connection and options for the client and can be excellent partners in prevention and crisis support.
What was the name of that resource for post intervention?	American Association for Suicidality: https://suicidology.org/resources/suicide-loss-survivors/
What can one do when the person served tries to avoid the	Reflect on the person's dilemma that they don't think there is a problem, but their parents do

Question	Answer
topic, but the parent is really concerned about the signs that are presenting?	**think there is a problem. We are developing discrepancy between the two perspectives and being curious as to why their parents might be concerned.**
How can you know when it is too many questions?!?	**Great question ☺** **We know we are asking too many when the client starts to shut down and gives short and (typically) non-revealing answers. Motivational interviewing best practice encourages "sandwiching" the questions with at least two reflections.** **It's a helpful guideline.**
What I struggle with is operant suicidal (chronic suicidal ideations) vs respondent (triggered by a circumstance). Any suggestions on managing this?	**I think I answered this above, but I find it helpful to consider the function of chronic suicidal ideation and remain curious with the client about their pain.**
If we feel like it's warranted to move more into the action phase after assessing with a client, would you recommend calling a first responder (e.g., local crisis evaluation team) with the client?	**That would be a good option if the client was not able to disable a suicide plan and/or if you come to the conclusion that the client needs further assessment. If the client can engage in such partnering practices, we want to encourage such participation. It helps them obtain a stronger sense of control.**
How would you recommend engaging with someone who you're having a consultation with, but are not engaged in therapy with, that brings up potential suicidality?	**I would do the same process that we discussed in the webinar. Suicide intervention can happen in any setting. It is not a therapy-specific intervention.**
At the beginning Ms. Dempsey mentioned number/stats/etc., is there a way that we can get that information emailed to us because it was a lot of updated research information that is very important for us to keep in mind...thank you!	**Here is the resource I used in the webinar:** **American Foundation for Suicide Prevention:** **https://afsp.org/suicide-statistics/**

Question	Answer
How would you respond to a client that has no history of suicide attempts but experiences suicide ideations daily/near daily as well as lack of motivation to prevent dangerous situations (i.e. "if truck stops on the train tracks then I won't move out of the way immediately")?	**See the prior comments regarding exploring the function of suicide ideation. I would also be interested in this person's goals for therapy and work to help them engage in valued and pleasurable activities in order to decrease the rumination. Not mentioned before, but always important to consider is encouraging a medical work up as well.**
How can therapist help an adult child who is living with parents who are physically abusive towards each other causing adult child to feel suicidal?	**The parents are physically abusive to each toward each other or toward the youth?** **Work on understanding the meaning of the violence from the youth's perspective and how it creates such despair. At some point, it is possible to engage in problem solving, boundary setting, and distress tolerance strategies to reduce the impact of the violence and provide additional choices.**
Please provide the website of the organization the speaker referenced regarding resources for clinicians after a completed suicide.	**Here is the resource I used in the webinar: American Association of Suicidology:** **http://cliniciansurvivor.org/**
What about if a client (adolescent)is denying their S/I however, therapist notices otherwise. How would a therapist address that?	**Start with develop discrepancy between what they are saying and what you are observing.** **e.g.:** **"*I am noticing that you say you do not want to hurt yourself, and I am also hearing you say that you often wake up telling yourself that you 'just want to die". Help me understand how these things fit together."*** **Such a response is a confrontation, but it is using what you observe instead of telling a client what you think is happening with them. It tends to be received more openly by the client.**
How do you address the same question with different age	**The second to last question on this list I speak more about working with younger children. In terms of asking about suicide, they might not**

Question	Answer
groups? I work with a lot of younger kids and risks are there.	understand the word "suicide". Children usually understand "killing yourself", so that might be the phrase you use in the question about suicide. As you are asking about questions, remember with kids to keep the questions as concrete as possible: *"How are you planning to kill yourself?"* and *"What is making you feel so sad right now?".* To be honest, you want to be as concrete as possible with adults as well. Concreteness is important when we are in crisis.
During this entire webinar I have been texting with a client who contacted me hurt, angry and talking about killing herself. I used the things you were talking about as you said them. She calmed, found reasons not to kill herself and based on what she said, felt heard. I am sure I went slower than I would have in the past, and it was more effective. Thank you! Suicidality isn't just in the moment, so now the question is looking for keys to continue the conversation toward healing/health. The triggers for this client are family and there isn't a place to go right now. She tends to suppress her feelings. Any suggestions on how to teach skills/strategies/relieve the pain or support the change commitment with suicide as a backdrop in the conversation and resistance to looking at these issues when the situation is not as intense is a factor. Thank you.	So glad you were able to put the skills into immediate use. Marsh Linehan created Dialectical Behavior Therapy for exactly the type of client challenges you present here. Other evidence-based approaches will likely be effective as well, but I encourage you to explore what DBT has to offer for helping your client "develop a life worth living" (Linehan, 2015). Check out the free resources and training opportunities at Behavioral Tech, which is the DBT parent organization: https://behavioraltech.org/ Learning DBT is a time investment, but it is the gold standard for working with individuals struggling with chronic suicide. In addition to the dialectical approach, DBT skills training will likely be useful for the individual you describe. The central skills help clients learn to regulate emotions, tolerate distress, communicate with others, and engage in the present moment (obtain mindfulness).
What about using their words and asking for clarification or meaning is a way to stay focused?	Yes. It is important to use the client's words and be curious about the meaning behind the words in order to understand the full meaning of their struggle.

Question	Answer
What about clients who are histrionic/borderline that feed off the intensity of the attention? Any recommendations with special populations?	**Even if there is an attention-seeking component to the suicide, that is meaningful. I always want to take it seriously and approach their pain with compassion, even if it is dramatic. I am assuming they feel they need to make their message loud in order to be heard. Ultimately, I will try to engage them in learning other strategies to get their needs met. See two questions above on DBT. I think I can safely say that DBT is the gold standard for treating individuals who have symptoms that meet the traditional borderline personality classification. The research on DBT and its effectiveness in treating BPD is abundant.**
I have lost contact with some individuals. Any ideas about ways to leave messages that are more likely to illicit a call back?	**It seems as this is a case for some detective work. Look back at their clinical history – here is where good notes are useful. Emergency contacts might be an option if there is a release. Check with your supervisor about calling if this is an emergency regarding safety. Do they have an MD or other licensed professional you can call? Do they attend other programs? All might be places you can contact to see if clients are available. In all these cases, be mindful of confidentiality and consult with your team or consultant regarding risk vs. reward of making such contact.**
What about addressing the secondary trauma for therapists with suicidal clients and clients that have completed suicides as well in their personal lives.	**American Association of Suicidality has some good resources for clinicians who have lost a client to suicide. It is also called post-intervention, but these services are designed specifically to assist the therapist who has lost a client to suicide. It can include psycho ed, but they also have peer clinician counselors who have also experienced suicide loss and want to support others. Here is a link to their clinician survivors' task force: http://cliniciansurvivor.org/** **Working with people in crisis takes its toll. I cannot say enough about maintaining self-care practices daily if possible. The self-care does not have to be elaborate, but it must be consistent to prevent burn out.**
What are some questions to ask to help differentiate between	***"Are you considering dying by suicide?"* or**

Question	Answer
someone who is having a meltdown and someone who is suicidal?	***"Are you considering killing yourself?"* or some other direct version of this question aimed specifically around making that distinction between significant distress and distress that has moved into suicidality.** **Anyone who says "yes" needs me to help them explore what is up for them. Even if it is "no" and they are simply significantly stressed, I want to continue to connect and help them find ways to reduce the distress.**
Is using MI to explore about suicide recommended only for adults or also for adolescents or any additional considerations for youth?	**Adults and adolescents can (but do not always) have enough ability to think abstractly and consider hypothetical options regarding change. Children are more concrete and the pain leading to suicidal thought is often very concrete and we need to reassure them we will help them out by stepping in and problem solving. For instance, significant bullying is so distressing as to cause kids to feel suicidal and we can have some effect by shutting down the bullies or their pathways. (It is not always easy, but it can be done). Although we want to support choice and autonomy, younger kids have less of both given their dependency status and they need us adults to be more directive advocates for their needs.**
Who is the response team live, does it involve police often?	**In most communities, police are the main responders for welfare checks. Check in advance as to some of your options regarding responders. I recommend finding community intervention team (CIT) first responders and/or mobile crisis response teams. Great question as this is the time to investigate options in your community so you can find the best responders for your clients.**

Google list for online 12-Step meetings:

https://recovertogether.withgoogle.com/?utm_source=houseads&utm_medium=ads&utm_campaign=onlineresources&gclid=EAIaIQobChMItLH6kcOT6gIVFQnnCh3gwwZ0EAAYASAAEgLrhvD_BwE#online-meetings