CAMS-care
Preventing Suicide

Suicide-Focused Assessment and Management via Tele-Health

Kevin J. Crowley, Ph.D.
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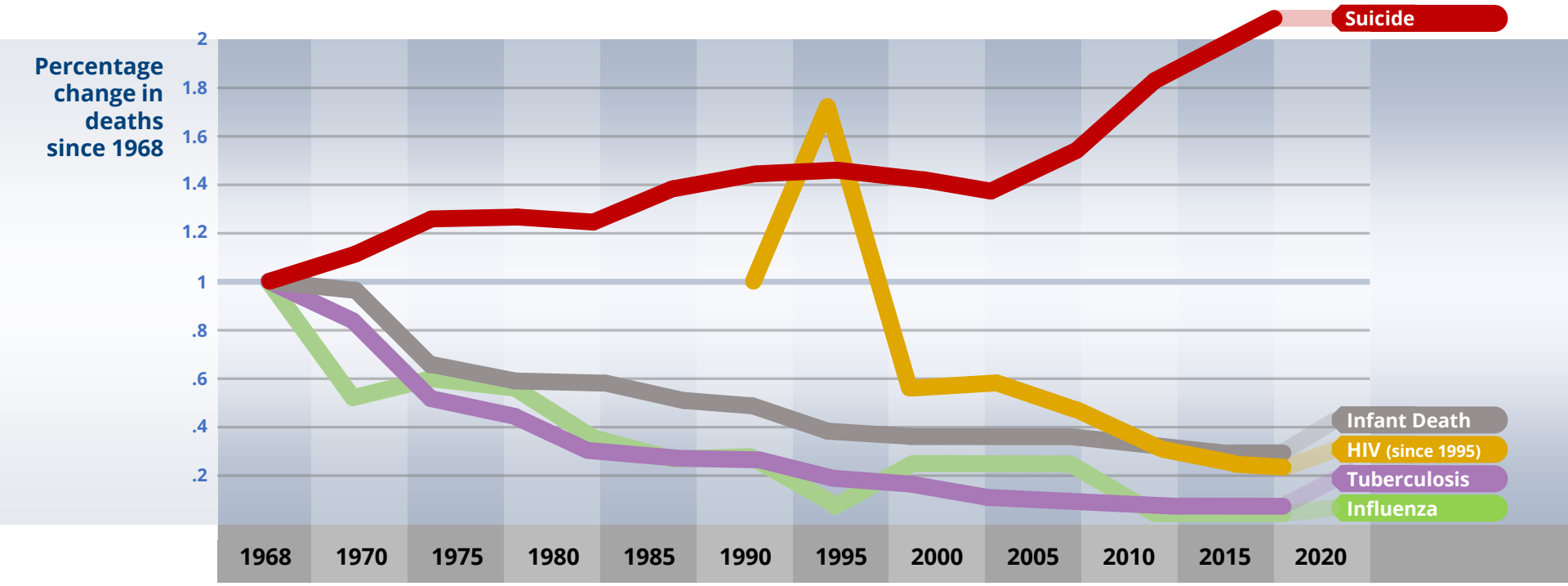
CAMS
Collaborative Assessment and Management of Suicidality

50 Years: Addressing the Leading Causes of Death



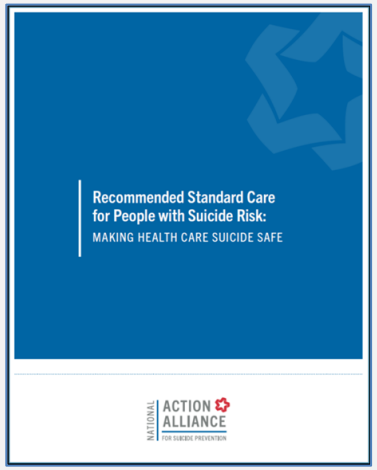
Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1968-2016 on CDC WONDER Online Database, released June 2017. Data are from the Compressed Mortality File 1999-2016 Series 20 No. 2U, 2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/cmf-icd10.html on Nov 10, 2019 7:07:31 PM

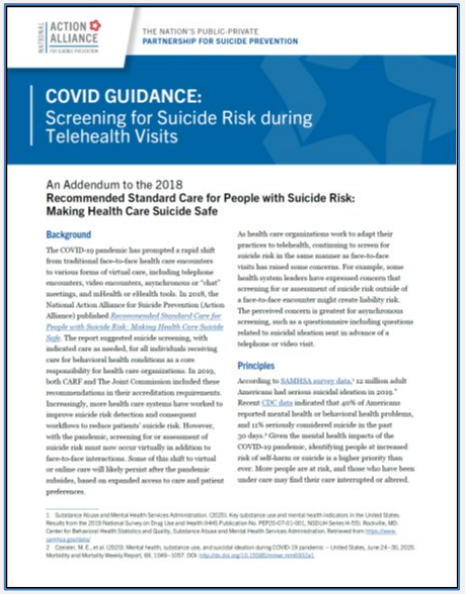
What do we need in place?

A controversial COVID response!

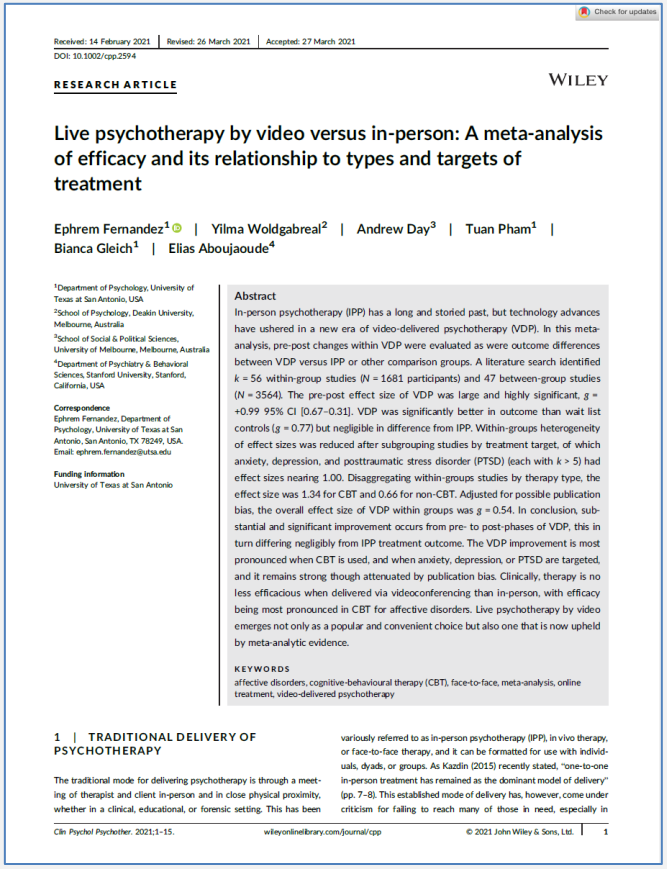
At the start of the pandemic, telehealth jumped 1400% in one month! BUT...

- Large healthcare systems suspended suicide screenings due to remote access.
- SIGNIFICANT concerns existed around delivering suicide-specific assessment and care. And still do!





What is “normal” post-pandemic? Fernandez et al. (2021)



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RESEARCH ARTICLE

WILEY

Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment

Ephrem Fernandez[1] | Yilma Woldgabreal[2] | Andrew Day[3] | Tuan Pham[1] | Bianca Gleich[1] | Elias Aboujaoude[4]

[1]Department of Psychology, University of Texas at San Antonio, USA
[2]School of Psychology, Deakin University, Melbourne, Australia
[3]School of Social & Political Sciences, University of Melbourne, Melbourne, Australia
[4]Department of Psychiatry & Behavioral Sciences, Stanford University, Stanford, California, USA

Correspondence
Ephrem Fernandez, Department of Psychology, University of Texas at San Antonio, San Antonio, TX 78249, USA.
Email: ephrem.fernandez@utsa.edu

Funding information
University of Texas at San Antonio

Abstract

In-person psychotherapy (IPP) has a long and storied past, but technology advances have ushered in a new era of video-delivered psychotherapy (VDP). In this meta-analysis, pre-post changes within VDP were evaluated as were outcome differences between VDP versus IPP or other comparison groups. A literature search identified $k = 56$ within-group studies ($N = 1681$ participants) and 47 between-group studies ($N = 3564$). The pre-post effect size of VDP was large and highly significant, $g = +0.99$ 95% CI [0.67–0.31]. VDP was significantly better in outcome than wait list controls ($g = 0.77$) but negligible in difference from IPP. Within-groups heterogeneity of effect sizes was reduced after subgrouping studies by treatment target, of which anxiety, depression, and posttraumatic stress disorder (PTSD) (each with $k > 5$) had effect sizes nearing 1.00. Disaggregating within-groups studies by therapy type, the effect size was 1.34 for CBT and 0.66 for non-CBT. Adjusted for possible publication bias, the overall effect size of VDP within groups was $g = 0.54$. In conclusion, substantial and significant improvement occurs from pre- to post-phases of VDP, this in turn differing negligibly from IPP treatment outcome. The VDP improvement is most pronounced when CBT is used, and when anxiety, depression, or PTSD are targeted, and it remains strong though attenuated by publication bias. Clinically, therapy is no less efficacious when delivered via videoconferencing than in-person, with efficacy being most pronounced in CBT for affective disorders. Live psychotherapy by video emerges not only as a popular and convenient choice but also one that is now upheld by meta-analytic evidence.

KEYWORDS
affective disorders, cognitive-behavioural therapy (CBT), face-to-face, meta-analysis, online treatment, video-delivered psychotherapy

1 | TRADITIONAL DELIVERY OF PSYCHOTHERAPY

The traditional mode for delivering psychotherapy is through a meeting of therapist and client in-person and in close physical proximity, whether in a clinical, educational, or forensic setting. This has been variously referred to as in-person psychotherapy (IPP), in vivo therapy, or face-to-face therapy, and it can be formatted for use with individuals, dyads, or groups. As Kazdin (2015) recently stated, “one-to-one in-person treatment has remained as the dominant model of delivery” (pp. 7–8). This established mode of delivery has, however, come under criticism for failing to reach many of those in need, especially in

- 56 within-group studies (*N*=1,681)
- 47 between-group studies (*N*=3,564)
- Psychotherapy is no less efficacious when delivered via telehealth than in-person/face-to-face therapy
- Effects are most pronounced for CBT with affective disorders
- “Live psychotherapy by video emerges as not only a popular and convenient choice but also one that is now upheld by meta-analytic evidence.”
- Is there a world where we don't have this service?

Where is the Field Now, with Respect to Suicide?

- Fernandez et al. (2021): Meta-analysis showing TH is comparable
- Aiello et al. (2021): Telehealth can reduce suicidal ideation
- Sullivan et al. (2022): MUCH more work needed to understand suicide; only 8 trials and one program evaluation
  - Not necessarily consistent methodology
- Baker et al. (2024): BCBT vs PCT; both reduced SI, BCBT reduced suicide attempts more
- CAMS studies ongoing, as well as others.

This is one new normal!

General Telehealth Guidelines for Clinicians

- Introduce a **telehealth-specific informed consent** document that includes state specific regulations

- Prioritize HIPAA-approved Video, when possible
  - Phone if not, but document recommendations

- **Develop a contact plan** should the call/video session be interrupted.
  - **Additional specificity needed for phone sessions.**

- **Secure the client's privacy** during the telehealth session as much as possible.
  - Who is "under the table"? How free are you to speak?

- DOCUMENT efforts made to check these and implementation barriers

Informed Consent/HIPAA

- Primary or hybrid
- What risks are we taking on? Is care impacted?
  - Is it safe?
- What forms of electronic communication are we using/not using?
  - What do we explicitly recommend/not recommend, and what services?
  - Public facing vs HIPAA compliant
- Where are you accessing sessions? What internet connection are you using?
- What will your insurance company reimburse?
- When/what criteria would I use to recommend resuming/prioritizing in person contacts?
- TELEHEALTH SPECIFIC FORMS (APA, NBCC, NASW)

Planning for Safety if Disconnected

Request the person's **location (address, apartment number)** at the start of the session.

- Where are you NOW? CAN I provide services here?

Establish a clear, direct plan for when/how emergency services would be accessed

- What happens when? What if we get disconnected?

Request or make sure you have **emergency contact information, ideally proximal**

- When would I use it?
- How would I use it?

DOCUMENT

WHAT IF someone isn't in a place where you're licensed to practice?

What about CAMS?

- Early directions

- Fillable forms

Thank you!

Questions or Comments? Please contact:

kevin.Crowley@cams-care.com