



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

Brief Cognitive–Behavioral Therapy for Suicide Prevention (BCBT–SP) via Video Telehealth: A Case Example During the COVID–19 Outbreak

Sasha M. Rojas, VA Puget Sound Health Care System and VISN 20 Clinical Resource Hub,
Boise, ID 83702

Sari D. Gold, VA Puget Sound Health Care System and University of Washington

Craig J. Bryan, The Ohio State University Wexner Medical Center

Larry D. Pruitt, Bradford L. Felker, Mark A. Reger, VA Puget Sound Health Care System and
University of Washington

Although veterans living in remote/rural areas are at elevated risk for suicide, there is very little research specific to treating suicidal veterans who present with barriers to in-person care. The current study aims to examine the delivery of brief cognitive-behavioral therapy for suicide prevention (BCBT-SP) via Clinical Video Telehealth (CVT) to the home of a veteran discharged from the psychiatric inpatient unit after a recent suicide attempt. Preliminary data on acceptability, feasibility, and changes in symptoms were gathered. The veteran received treatment during the 2020 COVID-19 outbreak and additional adaptations were made accordingly. The veteran did not engage in any suicidal behavior during the course of treatment, and suicidal ideation, depression, and anxiety decreased as treatment progressed. The results provide initial support for the feasibility of BCBT-SP via CVT to the home.

SUICIDE rates continue to rise among the U.S. veteran population, representing a mortality rate 1.5 times greater than that of the nonveteran adult population (U.S. Department of Veterans Affairs, 2019). Suicide rates may continue to increase following the secondary consequences of the coronavirus disease 2019 (COVID-19; Reger et al., 2020). Therefore, a comprehensive approach to veteran suicide prevention (U.S. Department of Veterans Affairs, 2018) is needed, including implementation of approaches that increase access to evidence-based treatments for suicidal behavior.

There are currently 5,565 mental health-designated health professional shortage areas in the United States (Health Resources & Services Administration Data Warehouse, 2018). The shortage of evidence-based treatment is even more significant (Harvey & Gumport, 2016), which leaves many individuals with

no options for obtaining evidence-based treatment that directly target suicide risk. These concerns are magnified among veterans because a high proportion of veterans reside in rural areas compared to civilians, and rural residence is associated with veteran suicide (McCarthy, Blow, Ignacio, Ilgen, & Austin, 2012).

The U.S. Department of Veterans Affairs (VA) expanded access to Clinical Video Telehealth (CVT; Congressional Research Service, 2019) to mitigate access to care disparities among veterans. CVT allows for synchronous delivery of telemental services to veterans from a provider separated by distance via real-time interactive video conferencing. Although CVT services are used widely for the delivery of evidence-based treatments (Hilty et al., 2013), there is minimal research to support the management of suicide risk via CVT (e.g., suicide-safety planning and risk management, Luxton et al., 2014; dialectical behavior therapy [DBT] group, Lopez et al., 2020).

Brief cognitive-behavioral therapy for suicide prevention (BCBT-SP) is a theory-driven empirically supported, manualized treatment that directly targets suicide risk (Bryan & Rudd, 2018). Recent data from

Keywords: BCBT-SP; clinical video telehealth; veteran; COVID-19

1077-7229/20/© 2022 Association for Behavioral and Cognitive Therapies. Published by Elsevier Ltd. All rights reserved.

a 2-year randomized clinical trial (RCT) among 152 active duty military personnel found that those who received BCBT-SP were 60% less likely to make a suicide attempt compared to participants in treatment as usual (Rudd et al., 2015). The structure of BCBT-SP is brief and flexible, which allows for wide implementation.

The time period following psychiatric hospitalization discharge is an extremely high-risk period for suicide (Chung et al., 2017, 2019; Qin & Nordentoft, 2005). Drop-out rates from outpatient mental care are high following discharge (Bowersox et al., 2013) and failure to establish follow-up care is associated with negative outcomes (e.g., readmission; Nelson et al., 2000). As such, CVT may be an advantageous modality to deliver BCBT-SP for suicidal veterans presenting with barriers to establishing outpatient care following hospitalization discharge.

The importance of these opportunities was only heightened during the 2020 COVID-19 crisis. Some patients were avoidant of emergency clinics during the pandemic (Moroni et al., 2020), and some clinics closed to nonemergencies. Furthermore, clinicians are sometimes reluctant to provide CVT services to suicidal individuals due to the lack of research in the area, fear of liability, and/or lack of confidence in the ability to effectively manage a crisis remotely. During future waves of the COVID-19 crisis (or similar events), real or perceived barriers to suicide prevention services in outpatient settings may add to the risk of suicide for these individuals due to receiving no follow-up psychotherapy.

Given these pressing needs and the scarcity of research available in the field, preliminary studies are needed to lay a foundation for progress. The current study was designed as a multiple case study design to examine the delivery of BCBT-SP via CVT. However, all recruitment was halted following the COVID-19 outbreak, as was recommended by the Research Service Line for our local VA facility. As such, the current study examined the delivery of BCBT-SP via CVT to the home of one veteran who was discharged after psychiatric hospitalization for a recent suicide attempt. The primary aim of the study was to gather preliminary evidence about the acceptability and feasibility of BCBT-SP via CVT-to-home. Preliminary data on the change in suicide-specific symptoms and other mental health outcomes were also documented.

Method

Recruitment

As described, the study was originally designed to recruit multiple veterans as part of a multiple case

study design prior to recruitment being halted following COVID-19. For this reason, only one veteran was included in the study. The veteran was a middle-age White male. General clinical details about the veteran and in-session anecdotes are not included to protect the patient's confidentiality.

The veteran was eligible for recruitment because he met all the inclusion and exclusion criteria. These included that he was a psychiatric inpatient, between the ages of 18 and 89 years, who had acute suicide risk before or during hospitalization. He was judged to be clinically stable regarding risk to self and others at hospitalization discharge. He had a discharge plan that did not include a higher level of care. He did not have psychosis/paranoia or adverse behavioral problems. Moreover, he did not have a mental health diagnosis or behavior that was deemed to require in-person observation, and did not have sensory limitations that may negatively impact care delivered by CVT. Additionally, he was able to provide a stable address and phone number, was not incarcerated, and was English proficient. He also had access to a private space for care and attended all sessions from a private room. A private space for care was used as an inclusion criterion to ensure the veteran's confidentiality was respected and that distractions were limited during the course of treatment. A private space for CVT may be challenging for individuals to obtain, especially during COVID-19. As such, creative solutions may need to be applied to obtain privacy (e.g., use of headphones in bathroom, closet, vehicle, private area in yard, garage). Finally, the veteran was able to provide informed consent.

Intervention

BCBT-SP uses a phased treatment approach (i.e., Phases 1–3) to directly target suicide risk. The treatment lasts for approximately 12 sessions. The goal of BCBT-SP is to teach patients to better understand their patterns of suicide risk, solve problems, manage crises, and think about themselves differently. The phased approach used with the veteran in the current study is described below.

Phase 1 (Sessions 1–4)

The first phase of BCBT-SP was focused on deactivation of the *suicidal mode* by targeting behavioral risk factors via crisis management and building emotion regulation skills. Phase 1 began with an initial assessment (i.e., narrative assessment) of the veteran's index suicide attempt that prompted psychiatric hospitalization. The narrative assessment provided the veteran with the opportunity to give a subjective account of his suicide attempt in his own words. Next, the veteran

was introduced to the treatment log, a notebook that was used for case conceptualization at the first session and to document lessons learned at the end of each subsequent session. For case conceptualization, the veteran was provided with psychoeducation about the fluid vulnerability theory and reviewed the different components (i.e., behavioral, emotional, cognitive, and physical) of his baseline risk for suicide and his suicidal mode (i.e., suicidal crisis). He was also asked to think about the activating events that prompted the transition into his suicidal mode. The veteran drew out an illustration of this model on his treatment log. Following review of the suicidal mode, the veteran and the study therapist collaboratively created a crisis response plan—a modifiable plan to manage personal crises. Other components completed in Session 1 included treatment planning, means safety planning, creation of a reasons for living list, and progressive muscle relaxation.

Phase 2 (Sessions 5–8)

The next four sessions were dedicated to Phase 2 of BCBT-SP, aimed to undermine the suicidal belief system by targeting cognitive risk factors and reinforce engagement in value-driven activities. The veteran also continued to practice the skills learned in Phase 1 and modified his crisis response plan as needed. Interventions used in Phase 2 included the use of several worksheets (i.e., ABC, Challenging Questions, and Patterns of Problematic Thinking) to develop cognitive reappraisal skills. A step-by-step guide on how to use these worksheets is provided in the BCBT-SP treatment manual (Bryan & Rudd, 2018). The veteran also completed a values assessment to identify value-driven activities for activity planning. Activity planning was used to encourage the veteran to engage in value-driven activities to encourage adaptive behaviors that improve mood by promoting a sense of mastery and pleasure.

Phase 3 (Session 9)

The third phase was dedicated to the relapse prevention task, which is an imagery task that involved the veteran visualizing himself experiencing suicidal crises and effectively resolving them. The primary objective of the relapse prevention task is to promote competency in using skills learned in treatment to effectively manage a future emotional crisis without making a suicide attempt or engaging in another maladaptive behavior associated with the patient's suicidal mode. The veteran completed the relapse prevention task during a 2-hour session. First, the veteran imagined the index suicidal crisis that brought him to treatment and incorporated his learned skills to resolve the crisis. The index suicidal crisis was reviewed multiple times

with different iterations that increased in difficulty. After successful completion, hypothetical suicidal crises were reviewed.

CVT Adaptations

Multiple adaptations were made to deliver BCBT-SP via CVT-to-home. A pretreatment session occurred before BCBT-SP sessions to review CVT guidelines and to create a plan to troubleshoot technical failures and to address any clinical emergencies. The veteran and study therapist reviewed the importance of having a step-by-step plan for clinical emergencies when using CVT. Specifically, the veteran agreed to stay connected by video during a clinical emergency. If the video connection was lost during an emergency, the veteran agreed to try to reconnect via CVT or wait for the study therapist to reconnect by phone. The veteran also provided a local emergency contact that could be called to check in with the veteran and invited to join the session during an emergency. The veteran agreed to the study therapist using emergency services (e.g., VA Suicide Prevention Team, 911 for a welfare check) if warranted. Finally, the veteran was asked to consider whether he had any medical conditions that may require additional treatment planning (i.e., seizures that limit ability to vocalize need for help).

All treatment worksheets used throughout the course of treatment were converted to pdf fillable versions and reviewed in session via the video screen sharing function. The screen sharing function allowed for better engagement while the therapist presented material. For example, the writer used the screen sharing function to illustrate the suicide mode, which was drawn by the veteran in his treatment log. Fillable versions of the worksheets were also sent via a secure message to the veteran to use for homework. Moreover, all self-report inventories were presented using the screen sharing function.

Measures

Treatment and Modality Acceptance

Successful participant retention was defined as completion of the third module in BCBT-SP. Client satisfaction was measured via the Helping Alliance Questionnaire–II (HAQ-II; Luborsky et al., 1996), Patient version. Modality feasibility was indexed by interruption by technical failures. The Telehealth Usability Questionnaire (TUQ; Parmanto, Lewis, Graham, & Bertolet, 2016) was used to index acceptance of CVT modality. The TUQ includes five subscales: Usefulness, Ease of Use, Effectiveness, Reliability, and Satisfaction. Qualitative feedback solic-

iting any comments or suggestions about the treatment and modality was also collected.

Suicidal Thoughts and Behaviors

The Columbia–Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011) Baseline version was used to assess lifetime history and last-month suicidal thoughts and behaviors at baseline. The C-SSRS Since Last Visit version was used at all other sessions. Consistent with work by Gipson et al. (2015), two suicidal ideation scales were used. The Severity scale was based on a 6-point ordinal scale (0 = *no ideation*; 1 = *wish to be dead*; 2 = *nonspecific active suicidal thoughts*; 3 = *active suicidal ideation with any methods [not plan] without intent to act*; 4 = *active suicidal ideation with some intent to act, without specific plan*; 5 = *active with specific plan intent*). The Intensity scale included five items (i.e., frequency, duration, controllability, deterrents, reasons for ideation) rated on a 5-point scale and was based on the most severe ideation recorded. The Suicide Cognitions Scale (SCS; Bryan et al., 2014) was used to measure suicide-specific beliefs; scores were computed for unbearability, unlovability, and total SCS. An analogue scale, based on a Suicide Visual Analog Scale (S-VAS; Bryan, 2018), was used to measure the veteran's current *urge to kill self* on a scale ranging from 0 to 100.

Other Mental Health Symptoms

The Depression, Anxiety and Stress Scale (DASS-21; Antony et al., 1998) was used to measure depression, anxiety, and stress. The Self-Stigma of Seeking Help (SSOSH; Vogel et al., 2006) scale was used to assess self-stigma with seeking psychological help.

Procedure

All study procedures were approved by the Institutional Review Board (IRB) of the VA health care system where the veteran was hospitalized. First, the veteran passed an initial screening and was provided with study information from a member of his inpatient treatment team. Next, he was invited to learn more about the study and completed additional screening by the study therapist, provided written informed consent, and completed the baseline assessment. At this planning visit, the study therapist provided treatment materials and obtained information to initiate the CVT technology setup. Secure messaging, the VA's safe and secure web-based electronic communication service, enrollment was also initiated. The planning visit occurred in person on the same day of his hospitalization discharge and lasted a total of 60 minutes. The veteran completed technology setup with a VA telehealth

clinical technician via CVT 2 days after hospitalization discharge.

In accord with CVT-to-home best practices, session location and preferred contact information to be used during any technical failures were verified at the beginning of each CVT session. The initial visit via CVT with the study therapist was the pretreatment session and occurred approximately 7 days after hospitalization discharge. The pretreatment session included a review of CVT-to-home guidelines, creation of an emergency plan and a plan for technical failures, and suicide risk assessment and a brief mental health evaluation. The veteran completed nine BCBT-SP sessions. Time in session ranged between 60 and 120 minutes. Post-treatment assessment occurred the next day after his last BCBT-SP session.

The study therapist was a postdoctoral fellow who received specialized training in (a) BCBT-SP, (b) CVT-to-home, (c) administration of the assessments delivered, and (d) suicide risk management. The study therapist had prior experience providing BCBT-SP and received weekly clinical supervision from a clinical supervisor.

Data Management

Measures pertaining to suicidal thoughts and behaviors were administered at each visit. The DASS-21 and SSOSH were administered only at baseline and post-treatment. Acceptability and feasibility data (measures and the qualitative interview) were gathered post-treatment. All measures were administered by the study therapist.

Results

Patient Acceptance and Feasibility

Regarding treatment retention, the veteran successfully completed the third module of BCBT-SP in 9 sessions. Multiple sessions were longer than 60 minutes; the relapse prevention session lasted 120 minutes. The veteran's scores on the HAQ-II ($M = 5.9$) indicated high perceived therapeutic alliance. TUQ scores indicated high acceptability of CVT (usefulness $M = 6.7$, ease to use $M = 6.5$, effectiveness $M = 7.0$, reliability $M = 6.7$, satisfaction $M = 7.0$, total $M = 6.7$). There was one technical failure that occurred during the course of treatment: the audio cut out, leaving only video content with no sound. In accord with the plan for technical failures, computer video was complemented by phone audio for the session. The veteran did not indicate any distress during in-session technical troubleshooting. Overall, qualitative feedback regarding BCBT-SP was positive. The veteran stated, "This

treatment was very different from other treatment I have done in the past. It was structured and made more sense to me. I was able to be myself; learning ways to talk about suicide are helpful.” Regarding CVT, the veteran stated, “It was much more convenient; my commute could be over an hour and a half; I’d arrive to the office agitated by traffic; it’s more relaxing; finishing the treatment in office would have not been feasible with COVID-19.” He also described feeling safe during treatment. His primary suggestions for improvement were (a) the ability to share the screen from the patient side would be useful, and (b) the treatment log could have been bigger to draw out his suicidal mode.

Suicide and Mental Health Symptoms

See Table 1 for results on the measures administered at each assessment point. At baseline, the veteran reported active suicidal ideation with a plan and intent in the last month, a score of 15 on the Intensity subscale on the C-SSRS, a suicide attempt in the last month, and nine suicide attempts in his lifetime. However, the veteran did not engage in any suicidal behavior or endorse suicidal intent to act on suicidal thoughts during the course of treatment. As captured in Table 1, the severity of the veteran’s suicidal ideation decreased throughout treatment. After Session 3, the veteran either endorsed passive suicidal ideation or no suicidal ideation. The veteran reported a 0 for *urge to kill himself right now* at all assessments. Suicidal beliefs captured by the SCS remained similar and were slightly

lower at the end of treatment. His scores on the DASS-21 indicated depression reduced from *extremely severe* to *mild*, anxiety reduced from *moderate* to *normal*, and stress reduced from *mild* to *normal*. Self-stigma about seeking psychological help remained low on the SSOSH.

COVID-19 Adaptations

A pandemic was declared on the same day of Session 3. After social distancing practices were put in place due to COVID-19, the veteran’s crisis response plan was modified considerably. The veteran and study therapist collaboratively replaced items that were no longer feasible with new strategies that retained the function of the original item. For example, the veteran replaced exercise completed outside of the home (distraction) with exercise that could be completed in the home. Moreover, creative ways to engage in social connection with others were discussed and added to his crisis response plan and activity planning.

Discussion

Despite the progress in suicide prevention programs and the expansion of telemental health via CVT, there has yet to be there has yet been a published randomized controlled clinical trial evaluating the intersection of the two. Nonetheless, there are now suicide-specific treatments (i.e., BCBT-SP) ready for dissemination and testing via CVT. The current case example serves as an examination of BCBT-SP delivered via CVT to the

Table 1
Symptom Severity of Suicidal and Other Clinical Symptoms at Assessment Points Prior, During, and After Completion of BCBT-SP

| Measure | BL | Pre – S | Phase 1 | | | | Phase 2 | | | | Phase 3 | Post – S |
|--------------------------|------------------|---------|---------|-----|-----|-----|---------|-----|-----|-----|---------|----------|
| | | | S 1 | S 2 | S 3 | S 4 | S 5 | S 6 | S 7 | S 8 | S 9 | |
| C-SSRS - Severity | LT: 5 LM: 5 | 1 | 3 | 3 | 3 | 1 | 1 | 0 | 1 | 1 | 0 | 0 |
| C-SSRS - Intensity | LT: 14 LM: 15 | 7 | 12 | 11 | 12 | 8 | 9 | – | 8 | 11 | – | – |
| C-SSRS - Suicide attempt | LT: 9 LM: 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| SCS – Total | 41 | 38 | 42 | 42 | 42 | 42 | 36 | 38 | 38 | 38 | 37 | 37 |
| SCS – Unlovability | 28 | 26 | 30 | 30 | 30 | 30 | 24 | 26 | 26 | 26 | 25 | 25 |
| SCS – Unbearability | 13 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| Analog | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| DASS-21 – Anxiety | 14 | – | – | – | – | – | – | – | – | – | – | 2 |
| DASS-21 – Depression | 34 | – | – | – | – | – | – | – | – | – | – | 14 |
| DASS-21 – Stress | 16 | – | – | – | – | – | – | – | – | – | – | 10 |
| SSOSH | 19 | – | – | – | – | – | – | – | – | – | – | 22 |

Note. BL = Baseline; S = Session; C-SRSS = Columbia Suicide Severity Rating Scale; LT = Lifetime; LM = Last Month; C-SSRS scores reported for S1 – Post – S are based on experience since last visit; SCS = Suicide Cognitions Scale; Analog = “Urge to kill myself right now”; DASS-21 = Depression Anxiety Stress Scale-21; SSOSH = Self-Stigma of Seeking Help Scale.

home of a veteran discharged from psychiatric hospitalization following a suicide attempt.

BCBT-SP via a CVT-to-home appeared feasible and acceptable. Consistent with previous findings suggesting therapeutic alliance is comparable between CVT and in-person care (Jenkins-Guarnieri et al., 2015), the veteran expressed high perceived therapeutic alliance. Prior to the delivery of BCBT-SP via CVT, a pre-treatment session was designed to provide sufficient time to review CVT considerations and engage in collaborative planning. As suggested by telemental health best practices (Shore et al., 2018), a plan for emergencies was developed during this session. A plan for technical failures was also created. There was only one technical failure that required the use of the agreed-upon plan. Importantly, the veteran did not express increased distress during the technical troubleshooting, which is likely directly related to the collaborative planning that occurred prior to treatment onset. The veteran also described high satisfaction with the CVT modality. Considering previous work has found technical problems to be a barrier to CVT use among providers (Perry et al., 2019), future work should dedicate time to CVT introduction and planning for not only emergencies but also technical failures.

Overall, the veteran expressed satisfaction with the structured nature of BCBT-SP and did not describe any notable limitations of learning the material via CVT. BCBT-SP has been shown to reduce the likelihood of a future suicide attempt among military personnel (Rudd et al., 2015). Similarly, in the current case example the veteran did not engage in any suicidal behavior despite endorsing nine previous suicide attempts. The veteran's suicidal thoughts decreased in severity and intensity, which is also consistent to BCBT-SP delivered in person (Rudd et al., 2015). In fact, the veteran only endorsed passive suicidal thoughts or no suicidal ideation after completion of BCBT-SP Phase 1. Depression reduced from *extremely severe* to *mild*, anxiety reduced from *moderate* to *normal*, and stress reduced from *mild* to *normal*.

Perceived risks among providers regarding providing CVT to suicidal patients have been documented (Gilmore & Ward-Ciesielski, 2019). Nonetheless, this case example demonstrates that the delivery of a structured treatment that exceeds the standard of care for suicide risk was feasible and safe for this high-risk veteran. The veteran also described feeling safe throughout the treatment. One notable concern that providers describe is the feasibility of hospitalization via CVT. Although hospitalization was not needed while BCBT-SP was delivered in the current case example, CVT recommendations to address acute suicide

risk that requires psychiatric hospitalization have been outlined (McGinn et al., 2019).

Although suicide prevention via CVT has not been evaluated to the same extent as other evidence based psychotherapies at this point in time, the COVID-19 pandemic required mental health care teams to rapidly adapt and deliver CVT for multiple mental health problems, including suicide risk. Many traditional in-person therapies that target suicide risk were used to meet the needs of high-risk patients during the COVID-19 outbreak. For example, group-based therapy was disseminated via CVT as part of an intensive outpatient program during the COVID-19 outbreak (e.g., Childs et al., 2020). In fact, many telehealth restrictions were lifted during the pandemic to assist with telemental health expansion (Whaibeh et al., 2020). As such, the current study was positioned well to adapt to the changes called for during COVID-19. The need for social distancing during the pandemic introduced additional suicide prevention challenges (e.g., barriers to social support, off-site storage of firearms). Nonetheless, the structure of BCBT-SP encourages flexibility that allowed for adaptations to address additional stress from COVID-19. For example, the crisis response plan is considered a living document and regular modifications are expected (Bryan & Rudd, 2018). To this end, the veteran in the case example was well-prepared to think through new interventions that could replace interventions that were no longer feasible in light of social distancing practices. Importantly, the CVT-to-home modality allowed for real-time preparation (e.g., ability to look around the house for exercise equipment or other materials needed for self-management strategies) and practice of new interventions. The CVT modality also permitted regular contact between the veteran and study therapist during a time of less social connection. The pandemic highlighted the need for more widespread training of suicide preventative treatments via CVT, not only in times of crisis but also for routine care of patients who have no access to evidence-based care for suicide risk.

The case example provides preliminary support for BCBT-SP via CVT—however, conclusions are constrained by several limitations. First, given that only a single veteran was enrolled in this study, results cannot be generalized. Second, the study clinician administered all measures at each assessment point, thereby increasing vulnerability for experimenter expectancy effects. Third, there was no control group so it is not possible to determine whether the clinical improvements can be attributed to the treatment; some recovery after a high-risk hospitalization might be expected without treatment, although we also note that the period immediately following psychiatric hospitalizations

is an extremely high-risk time for patients (Chung et al., 2017, 2019; Luxton et al., 2013; Qin & Nordentoft, 2005). Considering the high-risk period following hospitalization (Chung et al., 2017, 2019), we were unable to implement a single-case research design that controlled for a baseline phase with no treatment (e.g., Tau-U; Parker et al., 2011). A randomized, noninferiority trial of BCBT-SP via CVT versus in-person treatment is needed to provide more compelling support of the delivery, feasibility, and effectiveness of BCBT-SP via CVT. The veteran included in the study conveyed comfort with technology. As such, it is possible that individuals with little technology experience may have expressed additional difficulties with the modality that were not captured in this study.

Notwithstanding these limitations, the current case example suggests BCBT-SP was acceptable and feasible for delivery via CVT-to-home for one veteran deemed to be at high risk for suicide. For some individuals, addressing suicide risk post-hospitalization is limited by many factors (e.g., distance to treatment, work schedules, caregiving responsibilities). As such, future work in this area is greatly needed to support the delivery of evidence-based suicide-specific treatments via CVT and dissemination of training in this area.

References

- Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10*(2), 176–181.
- Bowersox, N. W., Saunders, S. M., & Berger, B. (2013). Post-inpatient attrition from care “as usual” in veterans with multiple psychiatric admissions. *Community Mental Health Journal, 49*, 694–703. <https://doi.org/10.1007/s10597-012-9544-8>.
- Bryan, C. J. (2018). A preliminary validation study of two ultra-brief measures of suicide risk: The Suicide and Perceived Burdensomeness Visual Analog Scales. *Suicide and Life-Threatening Behavior, 49*, 343–352. <https://doi.org/10.1111/sltb.12447>.
- Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention*. Guilford Press.
- Bryan, C. J., Rudd, M. D., Wertenberger, E., Etienne, N., Ray-Sannerud, B. N., Morrow, C. E., Peterson, A. L., & Young-McCaughon, S. (2014). Improving the detection and prediction of suicidal behavior among military personnel by measuring suicidal beliefs: An evaluation of the Suicide Cognitions Scale. *Journal of Affective Disorders, 159*, 15–22. <https://doi.org/10.1016/j.jad.2014.02.021>.
- Childs, A. W., Unger, A., & Li, L. (2020). Rapid design and deployment of intensive outpatient group-based psychiatric care using telehealth during COVID-19. *Journal of the American Medical Informatics Association, 1–5*. <https://doi.org/10.1093/jamia/ocaa138>.
- Chung, D., Hadzi-Pavlovic, D., Wang, M., Swaraj, S., Olfson, M., & Large, M. (2019). Meta-analysis of suicide rates in the first week and the first month after psychiatric hospitalization. *BMJ Open, 9*, e023883. <https://doi.org/10.1136/bmjopen-2018-023883>.
- Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: A systematic review and meta-analysis. *JAMA Psychiatry, 74*, 694–702. <https://doi.org/10.1001/jamapsychiatry.2017.1044>.
- Congressional Research Service (2019). Department of Veterans Affairs: A primer on telehealth. Available at <https://fas.org/sgp/crs/misc/R45834.pdf>.
- Gilmore, A. K., & Ward-Ciesielski, E. F. (2019). Perceived risks and use of psychotherapy via telemedicine for patients at risk for suicide. *Journal of Telemedicine and Telecare, 25*, 59–63. <https://doi.org/10.1177/1357633X17735559>.
- Gipson, P. Y., Agarwala, P., Opperman, K. J., Horwitz, A., & King, C. A. (2015). Columbia-Suicide Severity Rating Scale: Predictive validity with adolescent psychiatric emergency patients. *Pediatric Emergency Care, 31*, 88–94. <https://doi.org/10.1097/PEC.0000000000000225>.
- Harvey, A. G., & Gumport, N. B. (2016). Evidence-based psychological treatments for mental health disorders: Modifiable barriers to access and possible solutions. *Behavior Research and Therapy, 68*, 1–12. <https://doi.org/10.1016/j.brat.2015.02.004>.
- Health Resources & Services Administration Data Warehouse (2018). Shortage areas. U.S. Department of Health & Human Services. Available at <https://datawarehouse.hrsa.gov/topics/shortageareas.aspx>.
- Hilty, D. M., Ferrer, D. C., Parish, M. B., Johnston, B., Callahan, E. J., & Yellowlees, P. M. (2013). The effectiveness of telemental health: A 2013 review. *Telemedicine and e-Health, 19*, 444–454.
- Jenkins-Guarnieri, M. A., Pruitt, L. D., Luxton, D. D., & Johnson, K. (2015). Patient perceptions of telemental health: Systematic review of direct comparisons to in-person psychotherapeutic treatments. *Telemedicine and e-Health, 21*, 652–660. <https://doi.org/10.1089/tmj.2014.0165>.
- Lopez, A., Rothberg, B., Reaser, E., Schwenk, S., & Griffin, R. (2020). Therapeutic groups via video conferencing and the impact on group cohesion. *Mhealth, 6*, 1–9. <https://doi.org/10.21037/mhealth.2019.11.04>.
- Luborsky, L., Barber, J. P., Siqueland, L., Johnson, S., Najavitz, L. M., Frank, A., & Daley, D. (1996). The revised Helping Alliance Questionnaire (Haq-II): Psychometric properties. *Journal of Psychotherapy Practice and Research, 6*, 260–271.
- Luxton, D. D., O'Brien, K., Pruitt, L. D., Johnson, K., & Kramer, G. (2014). Suicide risk management during clinical telepractice. *International Journal of Psychiatry in Medicine, 48*, 19–31. <https://doi.org/10.2190/PM.48.1.c>.
- Luxton, D. D., Trofimovich, L., & Clark, L. L. (2013). Suicide risk among US service members after psychiatric hospitalization, 2001–2011. *Psychiatric Services, 64*, 626–629. <https://doi.org/10.1176/appi.ps.201200413>.
- McCarthy, J. F., Blow, F. C., Ignacio, R. V., Ilgen, M. A., Austin, K. L., & Valenstein, M. (2012). Suicide Among Patients in the Veterans Affairs Health System: Rural–Urban Differences in Rates, Risks, and Methods. *American Journal of Public Health, 102* (S1), S111–S117. <https://doi.org/10.2105/AJPH.2011.300463>. In press.
- McGinn, M. M., Roussev, M. S., Shearer, E. M., McCann, R. A., Rojas, S. M., & Felker, B. L. (2019). Recommendations for using clinical video telehealth with patients at high risk for suicide. *Psychiatric Clinics, 42*, 587–595. <https://doi.org/10.1016/j.psc.2019.08.009>.
- Moroni, F., Gramegna, M., Ajello, S., Beneduce, A., Baldetti, L., Vilca, L. M., ... Azzalini, L. (2020). Collateral damage: Medical care avoidance behavior among patients with myocardial infarction during the COVID-19 pandemic. *JACC Case Reports, 2*(10), 1620–1624. <https://doi.org/10.1016/j.jaccas.2020.04.010>.

- Nelson, E. A., Maruish, M. E., & Axler, J. L. (2000). Effects of discharge planning and compliance with outpatient appointments on readmission rates. *Psychiatric Services, 51*, 885–889. <https://doi.org/10.1176/appi.ps.51.7.885>.
- Parker, R. I., Vannest, K. J., Davis, J. L., & Sauber, S. B. (2011). Combining nonoverlap and trend for single-case research: Tau-U. *Behavior Therapy, 42*, 284–299. <https://doi.org/10.1016/j.beth.2010.08.006>.
- Parmanto, B., Lewis, A. N., Jr., Graham, K. M., & Bertolet, M. H. (2016). Development of the Telehealth Usability Questionnaire (TUQ). *International Journal of Telerehabilitation, 8*, 3–10. <https://doi.org/10.5195/ijt.2016.6196>.
- Perry, K., Gold, S., & Shearer, E. M. (2019). Identifying and addressing mental health providers' perceived barriers to clinical video telehealth utilization. *Journal of Clinical Psychology, 1*–10. <https://doi.org/10.1002/jclp.22770>.
- Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., ... Mann, J. J. (2011). The Columbia-Suicide Severity Rating Scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry, 168*, 1266–1277. <https://doi.org/10.1176/appi.ajp.2011.10111704>.
- Qin, P., & Nordentoft, M. (2005). Suicide risk in relation to psychiatric hospitalization: Evidence based on longitudinal registers. *Archives of General Psychiatry, 62*, 427–432. <https://doi.org/10.1001/archpsyc.62.4.427>.
- Reger, M. A., Stanley, I. H., & Joiner, T. E. (2020). Suicide mortality and coronavirus disease 2019—a perfect storm?. *JAMA Psychiatry, 77*(11), 1093–1094. <https://doi.org/10.1001/jamapsychiatry.2020.1060>.
- Rudd, M. D., Bryan, C. J., Wertenberger, E. G., Peterson, A. L., Young-McCaughan, S., Mintz, J., ... Wilkinson, E. (2015). Brief cognitive-behavioral therapy effects on posttreatment suicide attempts in a military sample: Results of a randomized clinical trial with 2-year follow-up. *American Journal of Psychiatry, 172*, 441–449. <https://doi.org/10.1176/appi.ajp.2014.14070843>.
- Shore, J. H., Yellowlees, P., Caudill, R., Johnston, B., Turvey, C., Mishkind, M., ... Hilty, D. (2018). Best practices in videoconferencing-based telemental health April 2018. *Telemedicine and e-Health, 24*, 827–832. <https://doi.org/10.1089/tmj.2018.0237>.
- U.S. Department of Veterans Affairs (2018). *National strategy for preventing veteran suicide: 2018–2028*. Author.
- U.S. Department of Veterans Affairs (2019). *National veteran suicide prevention annual report*. Available at <https://www.mentalhealth.va.gov/docs/data-sheets/20>.
- Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*, 325–337. <https://doi.org/10.1037/0022-0167.53.3.325>.
- Whaibeh, E., Mahmoud, H., & Naal, H. (2020). Telemental health in the context of a pandemic: The COVID-19 experience. *Current Treatment Options in Psychiatry, 7*, 198–202. <https://doi.org/10.1007/s40501-020-00210-2>.

The contents do not represent the views of the U.S. Department of Veterans Affairs or the U.S. government.

Address correspondence to Sasha M. Rojas, Ph.D., VISN 20 Clinical Resource Hub, 500 W. Fort St, Boise, Idaho 83720 e-mail: sasha.rojas@va.gov.

Received: July 20, 2020

Accepted: December 19, 2020

Available online 4 February 2021