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## **SUICIDE RISK MANAGEMENT DURING CLINICAL TELEPRACTICE\***

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### **ABSTRACT**

The effective assessment and management of suicidal patients is an essential component of telehealth-based care. With this article, we describe how we have implemented procedures for the ongoing assessment and management of suicide risk in a clinical trial that compares in-office treatment to home-based treatment delivered via web-cam to U.S. military service members and veterans with depression. We describe our safety protocol and how it was adapted from current recommended best practices, published guidelines, and local requirements for managing patient safety during home-based telepractice. We conclude with discussion of other key safety issues associated with telepractice. The topics discussed are relevant to all mental health practitioners who are interested in clinical telepractice services.

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**Key Words:** suicide risk, patient safety, risk management, telehealth, telemedicine

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## INTRODUCTION

The effective assessment and management of suicidal patients is a critical component of both conventional in-office care and telehealth-based care. There are aspects of telepractice, however, that require additional considerations for managing the safety of patients who are or become high risk for suicidal behavior while under care. In clinically supervised settings (e.g., a provider's office, clinics, hospitals, etc.), clinical staff are typically available to assist during a clinical crisis by coordinating emergency services, providing consultation, or escorting a patient to the emergency department. The same is not necessarily true when care is delivered to settings that do not have clinical supervision at the remote site (e.g., a patient's home). Thus, management of suicide risk and patient safety during telepractice involves additional considerations and requirements. A particular concern is what to do in situations where a patient expresses intent to harm him/herself at the end of a telehealth session or before unexpectedly disconnecting from the session [1]. In order to effectively manage this type of crisis or other emergency situations (e.g., medical emergencies), it is necessary for telehealth providers to have a pre-planned process in place.

The assessment and management of patients' suicidal behavior while under care can be a very difficult and stressful experience for mental health clinicians [2, 3]. In the case of clinical telepractice, stress and anxiety can be exacerbated by the fear of having less control of the situation, unfamiliarity with safety procedures, technology issues, and concerns about liability [1]. The issue of potential liability is of particular concern for many mental health practitioners because inadequate suicide risk management can result in licensure complaints and/or malpractice lawsuits. Due to the ethical and legal responsibilities mental health practitioners have toward patients, liability can occur from even the briefest of patient contacts. The use of technology to deliver care (e.g., video conferencing, e-mail, web chat) introduces additional ways that a professional relationship can form and with it raises responsibilities to assess and manage suicide risk. The anxiety and concern about liability issues among individual practitioners and healthcare organizations as a result of these additional methods of delivering care can present a barrier to the wider adoption of telehealth-based services.

Several organizations, such as the American Psychological Association (APA) and the American Telemedicine Association (ATA) have issued guidelines that include provisions for patient safety management during telepractice [4, 5]. The American Psychiatric Association does not have its own telepractice guidebook, although the association refers its constituents interested in telemedicine to the ATA guidelines [6]. Clinical best practices regarding safety management specific to telemental health have also been published [7, 8], as have telemental health guidebooks that address patient safety [9]. Although the available guidelines, extant telepractice literature, and the general suicide risk management literature [2, 10-14] provide frameworks for effective risk management, the

literature is limited in detailed information regarding real-world implementation of suicide risk assessment and management protocols for telehealth-based services, particularly to clinically unsupervised settings such as the home.

With this article we address this limitation by describing how we have translated safety guidelines, practice recommendations, and local requirements into ongoing assessment and management of suicidal risk as part of a clinical trial that compares in-office treatment to care delivered to the home via web-cam to patients with depression. We describe our safety protocol, suicide risk assessment and management procedures, and how we have applied our safety protocol to mitigate risk during telepractice. We recognize that our protocol is limited by the specific clinical setting and population (clinical research at U.S. military and VA Hospitals); however, the principles and issues that we describe have applicability to other clinical telepractice settings. We do not elaborate on the issues surrounding licensure and liability as these have been adequately covered elsewhere [15].

### **CLINICAL TRIAL DESCRIPTION AND SAFETY PROCEDURES**

The clinical trial (ClinicalTrials.gov Identifier #NCT01599585) is being conducted at the U.S. Department of Defense's National Center for Telehealth and Technology (T2) located at Joint Base Lewis-McChord (JBLM) in Washington State and at the Portland VA Healthcare System in Oregon. The aim of the trial is to compare in-office to home-based delivery of an abbreviated (eight-session) version of the revised Brief Behavioral Activation for Depression protocol (BATD-R) [16]. BATD-R is a behavioral reinforcement-based treatment that has received extensive empirical support as a treatment for depression [17]. Patients in our trial include both U.S. military personnel and veterans who either self-refer or are referred to the study by behavioral health providers at each respective site. While home-based telemental health treatments are already being expanded in the VA Health System, home-based telemental healthcare is not presently the standard of care in the U.S. military. Thus, the primary purpose of the trial is to examine the feasibility, safety, and effectiveness of home-based telemental health in the military setting to inform policy for broader implementation of home-based treatments. The study protocol adheres to the principles and recommendations of the World Medical Association, Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects, as well as all applicable Codes of Federal Regulation and Department of Army Regulations. This study was approved by the Madigan Army Medical Center Institutional Review Board and the Army Human Research Protection Office.

For our trial, eligible participants are randomized to either the in-office or in-home treatment groups. All participants are provided with eight sessions of BATD that follows a treatment manual [17]. Participants in both intervention

groups follow the same assessment schedule with clinical assessments at baseline (before first treatment session), mid-treatment (week 4), 1-week post-treatment, and 3-months post-treatment. A detailed description of the trial's methodology is published elsewhere [16].

### **Safety Protocol**

The essential components of our safety protocol planning steps and processes are shown in Table 1. The safety protocol was designed in accordance with the professional guidelines and best practices literature available at the time [5, 7] and is consistent with the most recent applicable guidelines from both the American Telemedicine Association [18] and American Psychological Association [4]. Our safety protocol was made into a formal written plan that is part of our trial's research protocol.

The development of our safety protocol began with review of applicable local regulatory requirements and guidance. Our study clinicians (clinical psychologists) are credentialed providers at Federal facilities; Madigan Army Medical Center (MAMC) and Portland VA Medical Center (PVAMC). Thus, the standard operating procedures (SOP) of the Army and PVAMC were reviewed and included in our plan. This review included examination of duty-to-warn and mandated safety reporting requirements. For active-duty military personnel, their command must be notified when the service member's safety is a concern. Thus, these patients are asked to provide command contact information. The use of support persons is a recommended approach to telehealth safety planning [5, 7]. Depending on the type of clinical setting, an additional support person to assist with coordination in emergencies could include another treatment provider, other designated staff at the patient site, a family member, or a local community contact who knows the patient and agrees to remain reachable during telehealth sessions [19]. Thus, we ask patients at both sites to identify another person (e.g., family member, partner, or friend) who can be notified in case of an emergency. Patients at both sites are asked to complete a site specific release of information form so that the third party can assist in cases of emergency or imminent risk. These processes are discussed with our patients during the informed consent process upon entry into the clinical trial.

### **Screening and Assessment**

Telepractice guidelines uniformly urge clinicians to determine appropriateness of each patient for telehealth care prior to initiating services [4, 5]. "Appropriateness" varies across contexts based on several factors including technology considerations, patient needs and preferences, and administrative regulations [1, 7]. In mental health care, suicide risk assessment is a critical aspect of determining appropriateness for varied treatment modalities. In our trial, suicide risk assessment begins during the initial in-person screening of patients. We first administer

Table 1. Overarching Safety Plan Steps and Process

Safety planning step	Process
Practice within institutional rules, regulations, and state laws	<ul style="list-style-type: none"> <li>• Review local and health systems regulations.</li> <li>• Providers receive training and supervision on pertinent institutional and legal regulations for providing telehealth-based care.</li> </ul>
Determine appropriateness of telehealth-based care	<ul style="list-style-type: none"> <li>• Conduct pre-treatment clinical assessment and suicide screen to determine risks, contraindications, etc.</li> </ul>
Ensure adequacy of home-environment, technology, and devices	<ul style="list-style-type: none"> <li>• Test infrastructure for adequate bandwidth.</li> <li>• Assess quality of environment (e.g., sound, lighting, privacy, etc.) and equipment (e.g., computer, microphones, cameras, etc.).</li> <li>• Ensure tech support plan and materials (troubleshooting guides).</li> <li>• Plan for maintaining privacy at patient's end.</li> </ul>
Conduct site assessments and establish procedures	<ul style="list-style-type: none"> <li>• Obtain alternative contact numbers from patient.</li> <li>• Obtain patient's local emergency contact information and confirm with EMS agency (using non-emergency line).</li> <li>• Identify local collaborators (e.g., Patient Support Person) that can be called to support patient safety during crisis.</li> <li>• Obtain needed authorizations to release information.</li> <li>• Provider ensures that he/she has access to a secondary phone line in the clinical room during appointments.</li> <li>• Have secondary staff available during appointments to coordinate with EMS, if needed.</li> </ul>
Discuss roles and responsibilities with patient	<ul style="list-style-type: none"> <li>• Discuss technical troubleshooting with patient and have an agreed upon method for re-establishing contact during service disruption (e.g., via telephone).</li> </ul>
Evaluate patient risk during and after treatment	<ul style="list-style-type: none"> <li>• Monitor psychiatric symptom levels.</li> <li>• Assess for presence and/or change in suicidality.</li> <li>• Monitor relevant changes in patient's home environment.</li> <li>• <i>(If indicated by risk level)</i> Develop multi-step safety plan and provide patient with a copy of the plan. Lead a direct and candid discussion about patient's access to firearms or other lethal means, and generate strategies to restrict access. Determine how transportation, if necessary, will be handled and whether to utilize a local collaborator.</li> <li>• <i>(If indicated by risk level)</i> Try to remain connected to patient via VTC while coordinating involvement of EMS by telephone. Involve secondary staff and notify third parties as warranted.</li> </ul>

**Note:** This list is based on that presented by Luxton and colleagues [7].

the Structured Clinical Interview for the DSM-IV Axis I Disorders, Research Version, Patient Edition (SCID-I/P) [20] to determine initial study eligibility and to screen for current suicidal ideation and past self-injurious events. Potential patients are ineligible for the trial if they report a suicide attempt during the past 6 months or if they have current ideation with stated intent. These exclusion criteria may eliminate the highest risk patients that are encountered in other clinical settings; however, these exclusion criteria were deemed necessary for this study because home-based care is not the standard of care in our setting (and thus deemed experimental by our IRB).

As part of our overall safety plan, we use the Standard Operating Procedure (SOP) for the Assessment and Management of Suicide and Homicide Risk in Active Duty Service Members that is used at MAMC [21]. This official SOP was updated during the course of our study, therefore we updated our procedures to remain consistent with the SOP. The SOP is based on information from several sources including the VA/DoD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide [22], U.S. Air Force Guidelines for managing suicide behavior [23], and several other DoD policies and procedures. The same SOP guides assessments completed in-person or during telehealth sessions.

The SOP specifies a five-step process. Step one consists of a screen for the presence of suicidal, violent, or homicidal ideation, intent, or behavior. If the screen suggests presence of any risk, a full assessment interview is administered (step two) that assesses for frequency, intensity, and duration of ideation, content of thoughts and/or plans, impulsivity, history of suicidal and violent behavior, and other warning signs, risk, and protective factors. At the third step, clinicians integrate all information gathered from the assessment interview and compare that information to the SOP's guidelines in order to arrive at and document the current level of risk (i.e., not at elevated risk, low risk, intermediate risk, or high risk). The general descriptions of the levels of risk and associated clinical interventions specified in the SOP are shown in Table 2. In step four, clinicians are to document and provide rationale for the clinical responses provided. Finally, in step five of the risk assessment, clinicians develop and document safety plans with all patients with any elevation of risk. Safety plans can vary based on idiographic factors; however, the SOP encourages use of a safety plan to assist patients in identification of healthy coping strategies to be used when distressed, people to contact for additional support, ways to reduce risk in their environments (i.e., limiting substance use and restricting access to means), emergency/crisis response contact numbers, and making a commitment to living and to engage in treatment.

In our trial, the suicide risk assessment SOP is administered both at the intake/screening assessment and again during the first treatment session. It is also administered during subsequent assessment and/or treatment sessions as needed. That is, if a patient were to indicate a change in the severity or frequency of

Table 2. Determination of Suicide and Homicide Risk Level

Risk level	Criteria used to determine risk <sup>a</sup>	Clinical response <sup>b</sup>
Not at elevated risk	Denial of recent violent or suicidal ideation, intent, plans, or preparations. No history of violent behavior or suicide attempt in the previous 2 years.	No change necessary in routine outpatient clinical practice. Provide contact information for emergency responders. May consider devising safety plan for highly distressed patients.
Low risk	Endorsement of recent violent, homicidal, or suicidal ideation without intent to act or devise. Frequency and duration of ideation is low. No evidence of preparations or difficulty controlling impulses. No violent behavior or suicide attempt in the previous year.	Establish a safety plan with patient that addresses coping strategies, contact information for social supports, means restriction and limiting of substance use, and emergency contact information. Elicit a commitment to living and to engaging in treatment.
Intermediate risk	Endorsement of current homicidal or suicidal ideation without intent to act or difficulty controlling impulses. Frequency and duration of ideation is moderate to high. No recent violent behavior, suicide attempt, or preparations.	Take precautions of low risk and consider increasing frequency and/or intensity of contact to ≥ one time per week. Engage in peer consultation to share and track decision-making process and determine need for internal and external reporting/disclosures and means restrictions.
High risk	Endorsement of persistent homicidal or suicidal ideation with a plan or intent to act on a plan, and difficulty controlling impulses. Or, recent violent act, suicide attempt, or preparations.	Engage lower level precautions (including development of detailed safety plan with means restriction) and increase treatment intensity. Strongly consider implementing emergency response to arrange for safe transport of patient for evaluation and possible inpatient hospitalization. Initiate reporting/disclosure processes as indicated.

**Note:** The contents of this table are based on the MAMC risk assessment SOP [20].  
<sup>a</sup>In addition to these criteria, clinical judgment is used to integrate additional known risk factors (e.g., agitation, significant psychosocial stressors, hopelessness) and protective factors (e.g., interpersonal connections, help seeking, optimism) to ultimately arrive at and document a current risk-level determination. Further, if a patient has greater than one previous suicide attempt or violent act, risk level automatically advances at least one level.  
<sup>b</sup>These clinical responses reflect the minimum indicated response. Clinical judgment is always part of risk evaluation and clinicians may elect to engage a higher level of intervention if deemed appropriate.



suicidal ideation, the treatment provider would again assess for suicide risk per the SOP. If a patient is assessed to be at not elevated or low risk, s/he would not be assessed again until the final treatment session. Patients at or above intermediate risk are assessed during each treatment session until level of risk decreases below the intermediate risk threshold.

### **Patient Monitoring and Telehealth Session Checklist**

As part of the clinical assessment battery in our trial, patients are asked to complete the Beck Depression Inventory-II (BDI-II) [24] during the clinical outcomes assessments and to complete the Patient Health Questionnaire (nine item) [25] before each treatment session. During telehealth sessions, patients provide their responses to the self-report items verbally and the clinicians record the responses in the patient's treatment folder (clinical chart notes). These assessment measures provide a method for regular monitoring of clinical symptom levels and the presence of and/or change in suicide risk throughout treatment.

For all patients, regardless of their initial risk level determination, ideation and other signs of risk for suicide and violence are documented by study clinicians via a treatment session checklist. Our telehealth treatment session checklist was developed in part to provide clinicians with specific patient safety and suicide risk assessment, monitoring, and documentation procedures. The complete checklist used in the current study is published elsewhere [16]; however, its components and rationale are summarized as follows. The checklist begins with a verification of patient location and contact information. Prior to the first session, study clinicians obtain contact information for local emergency services based on patient's place of residence. Patients are also asked whether they feel that their home environment is safe and private. Additional questions assess whether the patient appeared intoxicated or otherwise disheveled, distressed, or upset; suicidal desire and ideation, such as whether the patient showed any signs of suicidal ideation or self-harm behavior; and plans and preparatory behavior, such as whether a weapon (firearm) was observed in the patient's home.

### **Risk Escalation and Continuity of Care Procedures**

For the purposes of our trial, if a study clinician observes a significant elevation in patient risk for suicide or violent behavior, the clinician is to immediately notify a supervisory psychologist who assists in determining what additional steps of the safety protocol are appropriate. Although determining the most appropriate clinical response for a given patient requires consideration of multiple factors, our safety protocol specifies minimum levels of intervention to be offered at each risk level. For example, at any time an assessment yields a risk level determination beyond no elevated risk, clinicians are expected to collaboratively develop a detailed safety plan with the patient, which may include identification of

safe coping strategies, working with the patient to remove lethal means (e.g., storing firearms in secured locations) and involving support persons with the plan.

While safety plans are familiar to many clinicians, providing patients with a copy of the plan during telepractice necessitates additional consideration. In our trial, telehealth patients are provided with blank copies of our safety plan at their in-person intake assessments so that the plans are available for use throughout treatment. In the event a telehealth patient does not have a blank copy of the safety plan, clinicians collaborate with the patients via telehealth in the drafting of a safety plan and then, once drafted, review the contents with the patient and allow the patient to indicate their comfort and agreement with the plan. Clinicians then mail a hard copy and/or scan and e-mail a copy of the plan to the patient. As with conventional in-office care, if a patient is assessed to be at high risk during a telehealth session, clinicians are expected to consider coordinating an evaluation of the patient for possible hospitalization. By gathering contact information for local emergency services and command, and identifying an emergency contact on behalf of the patient at the outset of telehealth services, our safety protocol is designed to enable clinicians to efficiently and effectively coordinate safe transport and evaluation of high risk patients.

We also have preplanned procedures in place to assure continuity of care for when patients complete treatment, are referred but do not enroll in treatment, or if they leave treatment early. To begin, we work with each patient to establish a continuity of care plan. This involves discussing with patients what may be the best options for them given their preferences and clinical needs. We also facilitate coordination with the initial referring care providers or other mental health professionals as appropriate. In addition, we provide all of our patients (regardless of risk level) with a list of local community mental health resources that they may keep as a reference. We follow-up with patients and/or the referring care providers when necessary and document as appropriate. Our continuity of care process helps to assure patient safety after they leave our care.

## SUMMARY

Our safety protocol and suicide risk assessment procedures include gathering patient information so that we can make informed risk assessments and enact indicated, effective responses to psychiatric emergencies. While the patients in our study may be at somewhat lower risk for suicide than other clinical patient populations because of our prescreening criteria, we have encountered patients ranging from low to high risk. The majority of our patients in the in-home treatment condition ( $n = 20$  at the time of this writing) began and ended treatment identified as “not at elevated risk” for suicide. The next most frequent risk category for our in-home patients has been low ( $n = 6$  at initial treatment session). In each of these cases, the patient endorsed a history of suicidal thinking with limited frequency, intensity, and duration, with no or limited plans and no

preparatory behavior, and few other risk factors identified. We have had three patients receiving care in the home who were identified as intermediate risk for suicide during their initial risk assessment. For each of these cases, the steps to take in the event of increased suicide risk were discussed with the patients. We have also experienced one case that escalated from “low” to “high risk” and one patient that was assessed to be “high risk” during our initial assessment. For both of these cases a “warm hand-off” was made to a supervisory clinician for further risk assessment. Given the high level of risk in these cases, the clinician discussed voluntary hospitalization with these patients and, on both occasions, the patients agreed that presenting to inpatient behavioral health for evaluation was the best option. Per U.S. Army regulations, the study staff contacted the Soldiers’ unit commanders and requested escorts to transport the patients to the ED. One evaluation resulted in inpatient admission; the other did not, although it did result in increased intensity of care. In all cases, we have successfully managed suicide risk by following pre-planned recommended procedures. Our work demonstrates that with appropriate planning and training, patient safety can be effectively managed during telepractice, even when patients are in settings that are not supervised by clinical staff (e.g., their own home).

One of the principal concerns regarding safety management during telehealth is how to effectively manage a suicidal patient when the telehealth connection is lost or disconnected during a clinical encounter. In our trial there have not been any situations where technology failures caused any difficulties with risk assessment, monitoring, or intervention procedures. However, consistent with practice recommendations and guidelines, we are careful to collect alternate methods of contact in case the videoconferencing connection is lost. We also identify a support person who can assist in an emergency. It is also important to tailor safety plans to the specific situations that may be encountered, particularly if patients are located in another geographical or jurisdictional area. Having knowledge of the requirements for civil commitment and *Tarasoff* type duty to warn/protect and incorporating these elements into your safety plan is essential. Even at a local level, simple safety procedures, such as what number to contact for emergency response services may vary based on geographic region.

Suicide risk assessment should be an ongoing process as risk levels are fluid and risk determination is based on integration of multiple pieces of information and clinical judgment [2, 26]. While assessment guidelines and checklists may enhance the standardization of the assessment process and reduce errors, suicide risk is conceptualized as existing along a continuum from no significant risk to imminent risk and it is the clinician who is ultimately charged with integrating present and historical information, considering the duration and severity of explicit and implicit risk factors, and differentially weighting risk and protective factors to arrive at a clinical determination [2, 26]. Maintaining a comprehensive risk management or safety protocol that guides the assessment process, encourages consultation with colleagues and supervisors, and informs clinical

decision making can reduce patient and clinician anxiety, enhance accuracy and reliability of the assessment, and thereby, supports patient safety [27].

Safety planning with patients during telepractice may also carry additional clinical benefits [28]. For example, the process of working collaboratively with patients to establish a safety plan for telehealth encounters may provide the patient with increased confidence and therefore contribute to improved comfort and acceptance of the treatment process. Discussion of technical procedures as well as initial testing of telehealth equipment may also help to facilitate a collaborative therapeutic relationship. In some cases, the involvement of a family member or other supportive person during technical set-up and as part of safety planning may help facilitate patient support and overall treatment adherence. Of course, it is necessary to consider the preferences of patients, their autonomy, and privacy risks when involving others in their care. Telehealth capabilities also provide increased access to care, especially for patients who reside in remote or underserved areas. For these patients, access to care via telehealth services may be critical for ongoing treatment of suicidality, including assessment, intervention, medication management, and follow-up care.

In conclusion, telehealth is a growing area of practice that provides opportunities to increase access to care, improve convenience, and expand the range of clinical services. The effective assessment and management of patients experiencing a psychiatric crisis raises important legal, operational, and clinical issues that telepractitioners must be cognizant of. These issues, however, should not dissuade practitioners from clinical telepractice. With appropriate safety planning, training, and familiarity with published guidelines, telepractice is as feasible as traditional in-office clinical care delivery.

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### REFERENCES

1. Luxton DD, Sirotnin AP, Mishkind MC. Safety of telemental healthcare delivered to clinically unsupervised settings: A systematic review. *Telemedicine and e-Health* 2010;16:705-711. doi: 10.1089/tmj.2009.0179
2. Bryan CJ, Rudd MD. Advances in the assessment of suicide risk. *Journal of Clinical Psychology* 2006;62:185-200.
3. Wingate LR, Joiner TE, Walker RL, Rudd MD, Jobes DA. Empirically informed approaches to topics in suicide risk assessment. *Behavioral Sciences and the Law* 2004;22:651-665.
4. American Psychological Association. *Guidelines for the practice of telepsychology*. Retrieved January 2014, from <http://www.apapracticecentral.org/ce/guidelines/telepsychology-guidelines.pdf>

5. American Telemedicine Association. *Practice guidelines for videoconferencing-based telemental health*. Retrieved January 2014, from <http://www.americantelemed.org/practice/standards/ata-standards-guidelines/videoconferencing-based-telemental-health>
6. American Psychiatric Association. *Telepsychiatry Internet Resources*. Retrieved January 2014, from <http://www.psychiatry.org/practice/professional-interests/underserved-communities/telepsychiatry-internet-resources>
7. Luxton DD, O'Brien K, McCann RA, Mishkind MC. Home-based telemental healthcare safety planning: What you need to know. *Telemedicine and e-Health* 2012;18:629-633. doi: 10.1089/tmj.2012.0004
8. Godleski L, Nieves JE, Darkins A, Lehmann L. VA telemental health: Suicide assessment. *Behavioral Sciences and the Law* 2008;26:271-286. doi: 10.1002/bsl.811
9. Kramer GK, Mishkind M, Ayers T, Boyd A. *DoD telemental health guidebook* (2nd ed.). National Center for Telehealth and Technology. Retrieved January 2014, from <http://www.t2.health.mil/sites/default/files/TMH-Guidebook-Dec2013.pdf>
10. American Psychiatric Association. *A quick reference guide to assessing and treating suicidal behaviors*. Retrieved January 2014, from [http://www.valueoptions.com/providers/Handbook/treatment/Assessing\\_and\\_Treating\\_Suicidal\\_Behaviors.pdf](http://www.valueoptions.com/providers/Handbook/treatment/Assessing_and_Treating_Suicidal_Behaviors.pdf)
11. American Psychological Association. *Practice guidelines for the assessment and treatment of patients with suicidal behavior*. Washington, DC: American Psychological Association, 2003.
12. Rudd MD, Berman AL, Joiner TE, Nock MK, Silverman MM, Mandrusiak M, Van Orden K, Witte T. Warning signs for suicide: Theory, research, and clinical applications. *Suicide and Life Threatening Behavior* 2006;36:255-262.
13. Cukrowicz KC, Wingate LR, Driscoll KA, Joiner TE. A standard of care for the assessment of suicide risk and associated treatment: The Florida State University Psychology Clinic as an example. *Journal of Contemporary Psychotherapy* 2004;34:87-99.
14. Skopp NA, Luxton DD, Bush N, Rudd D. Managing the service member with suicidal ideation. In Moore BA, Penk WE, Editors), *Handbook for the treatment of PTSD in military personnel*. New York, NY: The Guilford Press, 2011.
15. Kramer GM, Mishkind MC, Luxton DD, Shore JH. Managing risk and protecting privacy in telemental health: An overview of legal, regulatory, and risk management issues. In Myers K, Turvey C, Editors, *Telemental health: Clinical, technical and administrative foundations for evidence-based practice*. Waltham, MA: Elsevier, 2012:83-104.
16. Luxton DD, Pruitt LD, O'Brien K, Stanfill K, Jenkins-Guarnieri MA, Johnson KA, Wagner A, Thomas E, Gahm G. Design and methodology of a randomized clinical trial of home-based telemental health treatment for U.S. military personnel and veterans with depression. *Contemporary Clinical Trials* 2014; 38:134-144.
17. Lejuez CW, Hopko DR, Acierno R, Daughters SB, Pagoto SL. Ten year revision of the brief behavioral activation treatment for depression (BATD): Revised treatment manual (BATD-R). *Behavioral Modification* 2011;35:111-161.
18. American Telemedicine Association. *Practice guidelines for video-based online mental health services*. Retrieved January 2014, from <http://www.americantelemed.org/practice/standards/ata-standards-guidelines/practice-guidelines-for-video-based-online-mental-health-service>

QA: Update? **yes**

19. Gros DF, Veronee K, Strachan M, Ruggiero KJ, Acierno, R. Managing suicidality in home-based telehealth. *Journal of Telemedicine and Telecare* 2011;17:332-335. doi: 10.1258/jtt.2011.101207
20. First MB, Spitzer RL, Gibbon M, Williams JB. *Structured clinical interview for DSM-IV-TR Axis I disorders, research version, patient edition (SCID-I/P)*. New York, NY: New York State Psychiatric Institute, 2002.
21. Madigan Army Medical Center. *Standard operating procedure (SOP) for the assessment and management of suicide and homicide risk in active duty service members*, 2013.
22. Department of Veterans Affairs and Department of Defense. *VA/DoD clinical practice guidelines for the assessment and management of patients at risk for suicide*. Retrieved January 2014, from [http://www.healthquality.va.gov/srb/VADODCP\\_SuicideRisk\\_Full.pdf](http://www.healthquality.va.gov/srb/VADODCP_SuicideRisk_Full.pdf)
23. United States Air Force Medical Service. *Air Force guide for suicide risk assessment, management, and treatment*. Scheduled to be retrievable from <https://kx2.afms.mil/kj/kx8/MentalHealth>
24. Beck AT, Steer RA, Brown GK. *Beck depression inventory* (2nd ed.). San Antonio, TX: Psychological Corporation, 1996.
25. Kroenke K, Spitzer RL, Williams JB. The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine* 2001;16:606-613.
26. Sommers-Flanagan J, Sommers-Flanagan R. Intake interviewing with suicidal patients: A systematic approach. *Professional Psychology: Research and Practice* 1995;26: 41-47.
27. Riberiro JD, Bodell LP, Hames JL, Hagan CR, Joiner TE. An empirically based approach to the assessment and management of suicidal behavior. *Journal of Psychotherapy Integration* 2013;23:207-221.
28. Pruitt LD, Luxton DD, Shore P. Additional clinical benefits of home-based telemental health. *Professional Psychology: Research & Practice*. In press.

QA: Update? **no**

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