Increasing the Reach and Accessibility of Suicide Prevention Treatment

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Presenter

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Disclosures

- Dr. Justin Baker has no relevant financial or non-financial relationships to disclose relating to the content of this activity;

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Learning Objectives

At the conclusion of this activity, participants will be able to:

1. Describe evidence-based psychotherapies that effectively reduce suicidal thoughts and behaviors, with particular emphasis on suicide-focused cognitive behavioral approaches.

2. Evaluate innovative delivery models (e.g., telehealth, group-based treatment) designed to increase the reach and accessibility of suicide prevention interventions while maintaining clinical effectiveness.

3. Apply scalable training and implementation strategies, including web-based clinician training frameworks, to support dissemination and fidelity of suicide prevention treatments across diverse practice settings.

Suicide is a major public health crisis

700,000

People die each year

(World Health Organization, 2024)

30%

Increase in suicides in the US since 2000

(Curtin et al., 2023)

11 mins

One death every 11 minutes

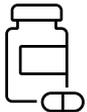(Centers for Disease Control and Prevention, 2024)

Effective Suicide Prevention Treatments

- What does the literature tell us?

  Cognitive Behavioral Therapies (CBTs) and Problem-Solving therapies led to largest reductions in suicidal thoughts and behaviors (Fox et al., 2017)

  Treatments that directly target suicidal ideation and suicide attempts led to largest reductions in suicidal ideation. (van Ballegooijen et al., 2025)
  - ✓ Only two specific types of therapy (DBT and suicide focused CBTs) led to a reduction in <u>Suicide Attempts</u>

  CBTs with a Narrative Assessment significantly reduce risk of suicide attempts compared to controls, whereas CBTs without a narrative assessment do not. (Janssen et al., 2025)

Polling Question 1: Barriers to Access

- Which barrier do you believe most limits access to evidence-based suicide prevention treatment in your clinical setting?
    A. Limited Clinician availability/staffing shortages
    B. Treatment length or intensity of current EBPs
    C. Difficulty engaging in high-risk patients consistently
    D. Lack of scalable training or implementation supports

What is a narrative assessment?

- "The narrative assessment is a suicide risk assessment approach used in brief cognitive behavioral therapy (BCBT) that uses storytelling to assess suicide risk while fostering therapeutic alliance. This is contrasted with a more traditional suicide risk assessment approach that uses a set of standardized or templated questions to assess risk." (Baker, 2025)

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Brief Cognitive Behavioral Therapy

- 12-session treatment, delivered weekly, typically in an outpatient setting
- Three phased treatment approach
  - I: Emotion Regulation
  - II: Cognitive Restructuring/Flexibility
  - III: Relapse Prevention

Phase	Behavior	Emotion	Cognition	Physical
Phase One				
Crisis response plan	X	X	X	X
Means restriction counseling	X			
Sleep stimulus control				X
Relaxation skills training	X	X		X
Mindfulness skills training	X	X	X	
Reasons for living list/survival kit		X	X	
Phase Two				
ABC Worksheet			X	
Challenging Questions Worksheet			X	
Problematic Patterns of Thinking Worksheet			X	
Activity planning	X			
Coping cards	X		X	
Phase Three				
Relapse prevention task	X	X	X	X

(Baker, 2025)

BCBT Treatment Outcome Studies

Study	Design	Tx	# of Sessions	Comparison Condition	Setting	Sample	Follow-Up	Findings
Rudd et al. (2015) N=152	RCT	BCBT	12	TAU	Outpatient	Military, 87% male, 27 y	24 mos	Attempts: 60% rel. risk reduction
Sinyor et al. (2020) N=24	RCT	BCBT	10	TAU	Outpatient	Youths, 29% male, 18 y	12 mos	Attempts: 100% rel. risk reduction
Baker et al. (2024) N=96	RCT	BCBT	12	PCT	Telehealth	Adults, 33% male, 32 y	12 mos	Attempts: 41% rel. rate reduction
Diefenbach et al. (2024) N=200	RCT	BCBT	4	TAU	Inpatient	Adults, 41% male, 33 y	6 mos	Attempts: 60% rel. risk reduction
Bryan et al. (2025)	RCT	BCBT	12	PCT	Outpatient & Telehealth	Mil & vets, 73% male, 33 y	24 mos	Attempts: 75% rel. risk & rate reduction

Increasing Reach and Access of BCBT

- Telehealth BCBT

- Group BCBT

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Polling Question 2: Telehealth Comfort Level

- How confident do you feel providing suicide-focused treatment (e.g., BCBT) via telehealth?

    A. Very confident

    B. Somewhat confident

    C. Not very confident

    D. I have not provided suicide-focused treatment via telehealth

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Telehealth BCBT

Telehealth BCBT

- People in BCBT made fewer suicide attempts than those in PCT

- BCBT: 11 people made 36 attempts, 0.70 (0.0-8.0) attempts per person

- PCT: 12 people made 56 attempts, 1.4 (0.0-10.0) attempts per person

- BCBT had **41% reduced risk for suicide attempts** compared to PCT (HR, 0.59; 85% CI, 0.36-0.96); *p* = .03).
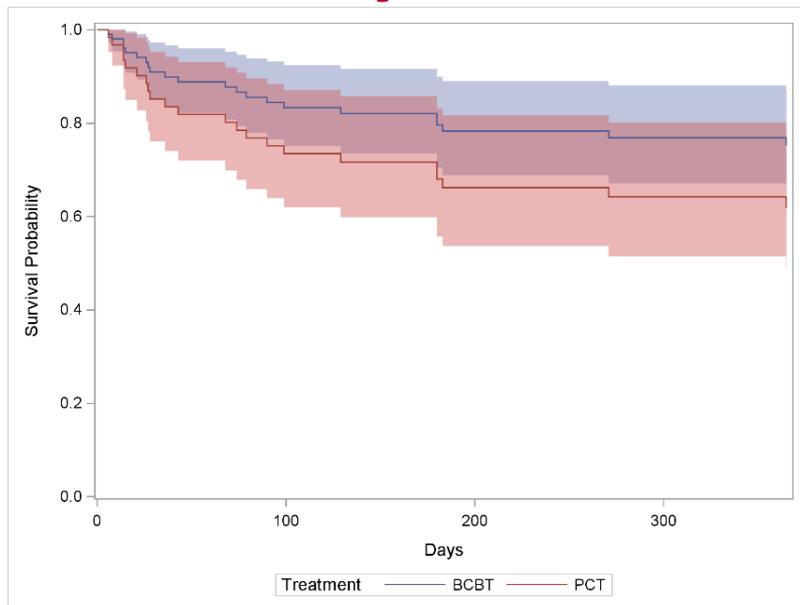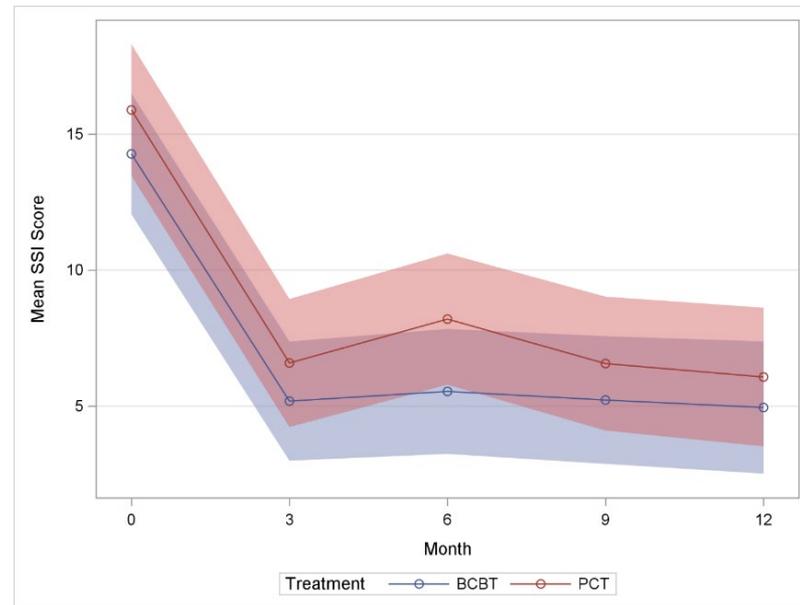
Baker, et al. (2024)

PCT-present centered therapy

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14

Telehealth BCBT

Suicide Attempt-Free Probability

Severity of Suicidal Ideation

(Baker et al., 2024)

15

Group BCBT

STUDY PROTOCOL   **Open Access**

Check for updates

Group brief cognitive behavioral therapy for suicide prevention compared to dialectal behavior therapy skills group for military service members: a study protocol of a randomized controlled trial

Justin C. Baker[1*], Shawna Grover[2], Laura H. Gunn[3], Cindy Charles[3], Heather Rikli[3], Michael J. Franks[2], Lauren R. Khazem[1], Sean Williams[1], Ennio Ammendola[1], Cherita Washington[3], Marquita Bennette[2], Austin Starkey[1,4], Kelly Schnecke[1], Shannon Cain[3], Craig J. Bryan[1] and Robert J. Cramer[3]

Structure of Group BCBT

Phase I	Phase II	Phase III
Emotion Regulation	**Cognitive Flexibility**	**Relapse Prevention**

Phase I — Emotion Regulation

Session 0
Intake
Narrative Risk Assessment
Crisis Response Plan
Means Safety Counseling

Sessions 1-5
Treatment Plan
Sleep Disturbance
Relaxation / Mindfulness
Reasons for Living
Survival Kit

Phase II — Cognitive Flexibility

Sessions 6-10
ABC Worksheets
Challenging Questions
Patterns of Problem Thinking
Activity Planning
Coping Cards

Phase III — Relapse Prevention

**Sessions 11-12**
Relapse Prevention Task

Group BCBT Trial Design

- 4-year, 2-arm non-inferiority design.
- Phase III randomized controlled trial of G-BCBT compared to a Dialectical Behavior Therapy (DBT) skills group.
- We will recruit a total of 68 active-duty personnel per arm.
- G-BCBT is a new adaptation of the existing BCBT protocol administered in a group format.
- **Hypothesis: G-BCBT will be at least as equally effective as DBT skills.**

Figure 3. Recruitment and Randomization Steps

Recruitment & Screening → Computer Randomization → Group BCBT / DBT Skills Group
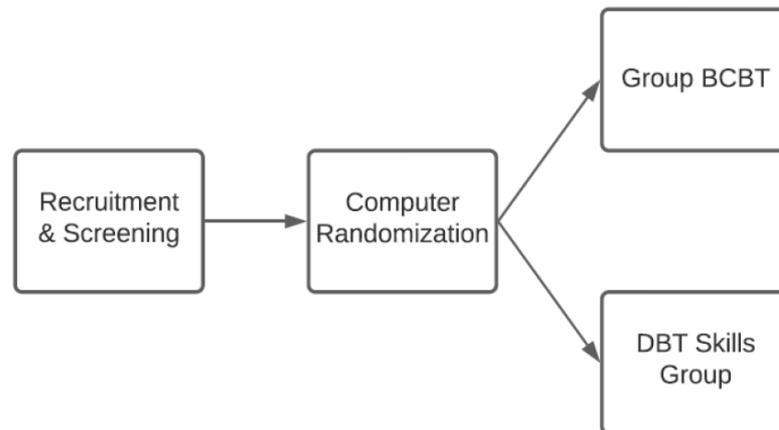
(Baker et al., 2023)

Group BCBT Proposed Outcomes

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Primary outcome*:

1. <u>Reductions in suicidal ideation</u> at 6-month follow-up

Secondary outcomes*:

1. <u>Reductions in suicide attempt frequency</u> at post-treatment, 3-, and 6-month follow-up

2. <u>Reductions in psychological distress</u>: symptoms of depression, anxiety, post-traumatic stress, sleep difficulties, and suicidal beliefs

3. <u>Improved self-regulatory skills</u>: Coping self-efficacy, behavioral control, and emotion regulation skills

*All outcomes assumed to be no worse between treatment groups.

Military & hospital benefits:

1. Supports VA/DoD 2019 Suicide Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide

2. Meets recommendations in the 2023 Suicide Prevention and Response Independent Review Committee report...

Polling Question 3: Group-Based Treatment Adoption

- If evidence shows Group BCBT (G-BCBT) is non-inferior to DBT Skills Group, how likely would you be to consider implementing it?

    A. Very likely

    B. Somewhat likely

    C. Unlikely

    D. Not sure—would need more training/support

Study Timeline: Finalizing Data Collection

1 Aug 22 to 31 Jan 23
Planning phase

①

26 June 2023 forward
Recruit patients from ATC, SARP, inpatient discharge, etc.

③

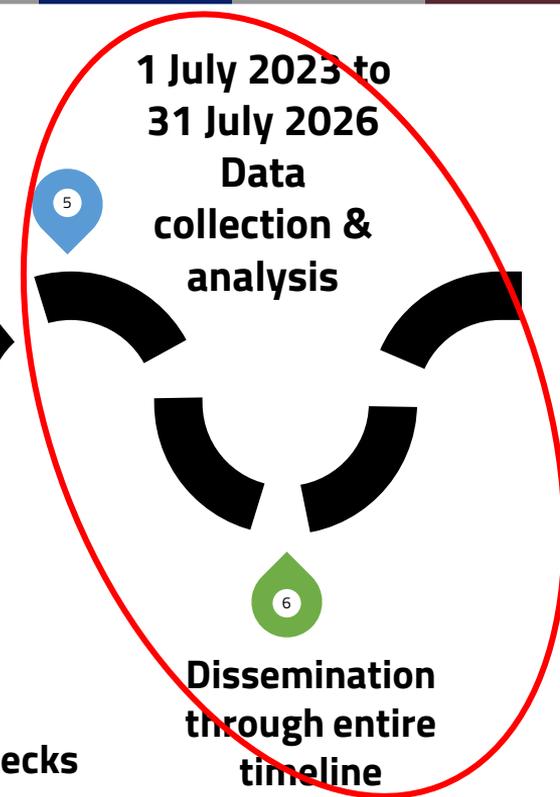**1 July 2023 to 31 July 2026**
Data collection & analysis

⑤

②

1 Feb 23 to 23 June 23
Complete staff onboarding
& re-advertise study to NMCP staff

④

1 July 2023 to 15 Aug 25
Run groups & fidelity checks

⑥

Dissemination through entire timeline

NMCP- Navy Medical Center Portsmouth
ATC-Access to Care
SARP- Substance Abuse Rehabilitation Program

Increasing Reach and Access of Training

- www.BCBTweb.org

- www.CRP-web.org

Benefits of Web-based Training

- Web-Based trainings for mental health interventions associated with increased knowledge and skill
- Found to be comparable to face-to-face workshops
- Easily accessible and disseminated
- Providers can reference training videos multiple times as needed
- Web-based trainings can be updated in accordance with latest research and clinical practice guidelines

Polling Question 4: Web-based Training Adoption

- When considering web-based training platforms for suicide-focused treatments (e.g., BCBTweb and CRPweb), what do you see as the MOST valuable advantage for clinicians?

  A. On-demand access that allows providers to learn at their own pace

  B. Reduced need for in-person workshops and travel

  C. Ability to review training videos repeatedly to reinforce skills

  D. Built-in fidelity and competency assessments that support implementation

Specific Aims

- Develop a web-based training program for improved dissemination of BCBT and Crisis Response Planning (CRP).

- Assess practitioner reaction/satisfaction and learning/knowledge gain.

- Compare reaction/satisfaction, learning, and subsequent behavior/fidelity of providers who complete BCBT*web* to a control group of providers who attend a live workshop (in-person or virtual) using the same training materials.

User Centered Iterative Design

(freepik.com, n.d.)

- Five Strategic Phases
  - Inception
  - Iteration
  - Release
  - Production
  - Launch
- Four Assessment Outcomes
  - Reaction
  - Learning
  - Behavior/Mastery of Knowledge
  - Results/Cost analysis

Project Timeline

Table 1. Proposed Project Timeline	Year 1		Year 2		Year 3		Year 4	
Month:	1-6	7-12	13-18	19-24	25-30	31-36	37-42	43-48
Activity:								
Regulatory approvals								
Hire and train staff								
Phase 1: Inception								
Suicide treatment summit								
Publish summit results of updated BCBT manual								
Map project requirements and assign project timeline priorities								
Final components of BCBT								
Phase 2: Iteration (Alpha-Testing Phase)								
BCBT*web* development (Aim 1)								
Alpha testing and revisions (Aim 2)								
Phase 3: Release (Beta-Testing Phase)								
Beta testing and revisions (Aim 2)								
Phase 4: Production (Comparison Study)								
Comparison study (Aim 3)								
Phase 5: Launch BCBT*web*								
Finalize data and reports								
Evaluation:								
Reaction								
Computer usability satisfaction questionnaires								
Web-based training-specific reaction evaluation								
Demographics								
Learning								
Pre- and post-module tests								
Behavior								
Fidelity scales with standardized patient								
Results								
Cost Analyses								

(Baker, 2025)

Data Analysis

Alpha testing: Mixed-methods approach

Qualitative: Content analysis of interviews with providers using deductive-inductive coding.

Quantitative: ISM Computer Usability Satisfaction Questionnaire (ICUSQ)

Beta testing:

ICUSQ, reaction/satisfaction scores

Frequency counts, number of providers completing each module and total number of modules completed.

Paired samples t-test will be calculated from pre- and post-test scores to measure learning (acquired knowledge) during the training.

Data Analysis

- Comparison testing
  - Mixed linear model regression examining group (BCBTweb vs. BCBT in-person) by time-point (pre- to post-training) main effects and interactions on reaction, learning, and behavior.

(stock.adobe.com, n.d.)

Data Analysis

(stock.adobe.com, n.d.)

- Provider Behavior
  - Standardized Patients
  - Objective Structured Clinical Exams
    - ✓ 3 role plays per provider
    - ✓ Recorded sessions scored for fidelity to BCBT or CRP

Website Launch

- Primary outcome of this study is development and launch of BCBT*web*.
  - Site maintenance
  - Commercialization
- Additional evaluation metrics
  - # of registered providers
  - # of providers completing each module
  - # of total modules completed
  - # of per capita providers by state
  - # of providers by type of provider
  - Provider reaction/satisfaction of module characteristics
  - Knowledge gained for each module

Key Takeaways

- **Suicide-focused psychotherapies work.**
  - Brief, suicide-specific cognitive behavioral interventions—particularly BCBT with a narrative assessment—demonstrate consistent reductions in suicidal ideation and suicide attempts across diverse populations and settings.
- **Increasing reach requires rethinking delivery—not lowering standards.**
  - Telehealth and group-based adaptations of BCBT can meaningfully expand access to care while maintaining clinical effectiveness and treatment fidelity.
- **Scalable training is essential to closing the research-to-practice gap.**
  - Web-based clinician training platforms offer a feasible, effective strategy for disseminating evidence-based suicide prevention treatments at scale.
- **Implementation drives impact.**
  - Integrating evidence-based treatments with accessible delivery models and fidelity-focused training represents a critical pathway to improving suicide prevention outcomes within healthcare systems.

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Questions?

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