NOVEL APPROACHES FOR HIGH-RISK SUICIDAL VETERANS

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PRESENTATION AIMS

1. **Participants will be able to describe the scope of Veteran suicide and identify pertinent risk factors pertaining to substance abuse.**

2. **Participants will learn about novel group and family suicide safety planning clinical interventions being developed for use with high risk suicidal Veterans.**

Q & A

Question: What percentage of Veterans do you think are currently living in the US?

Answer: Of all living US citizens, 7.3 percent have served in the military at some point in their lives (SAMSHA).

Q & A

Question: How many Veterans kill themselves every day?

Answer: 20

However, 14 of the 20 Veterans who kill themselves per day do not seek services at VA facilities (Dept. of Veterans Affairs, 2016).


How to Grow Jobs By Fareed Zakaria / Higgs-teria! / Chipotle's Secret
TIME
ONE A DAY
Every day, one U.S. soldier commits suicide. Why the military can't defeat its most insidious enemy
BY MARK THOMPSON & NANCY GIBBS

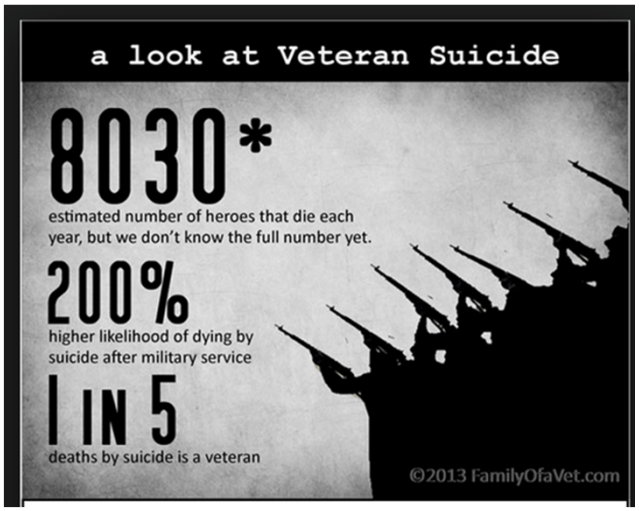
a look at Veteran Suicide
8030*
estimated number of heroes that die each year, but we don't know the full number yet.
200%
higher likelihood of dying by suicide after military service
1 IN 5
deaths by suicide is a veteran
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Table 3. Age-Adjusted Hazard Ratios of Suicide During FY 1999 to FY 2006 in All VHA Patients Treated in FY 1999 Who Were Alive at the Start of FY 2000

Characteristic	Hazard Ratio (95% Confidence Interval)	
	Male	Female
Any psychiatric diagnosis	2.50 (2.38-2.64)	5.18 (4.08-6.58)
Any substance abuse or dependence	2.27 (2.11-2.45)	6.62 (4.72-9.29)
Alcohol abuse or dependence	2.28 (2.12-2.45)	6.04 (4.14-8.82)
Drug abuse or dependence	2.09 (1.90-2.31)	5.33 (3.58-7.94)
Bipolar disorder	2.98 (2.73-3.25)	6.33 (4.69-8.54)
Depression	2.61 (2.47-2.75)	5.20 (4.01-6.75)
Other anxiety	2.10 (1.94-2.28)	3.48 (2.52-4.81)
Posttraumatic stress disorder	1.84 (1.70-1.98)	3.50 (2.51-4.86)
Schizophrenia	2.10 (1.93-2.28)	6.08 (4.35-8.48)

Abbreviations: FY, fiscal year; VHA, Veterans Health Administration.

(Ilgen et al., 2010)

Characteristic	All suicide mortality FY06-11		Suicide rate per 100 000 person-years	Suicide mortality among males FY06–11		Male suicide rate per 100 000 person-years	Suicide mortality among females FY06–11		Female suicide rate per 100 000 person-years
	n	%		n	%		n	%	
Overall	9087	100.0	34.7	8796	100.0	36.9	291	100.0	12.4
Any SUD	1573	17.3	75.6	1524	17.3	76.1	49	16.8	63.4
Alcohol use disorder	1259	13.9	76.2	1231	14.0	76.9	28	9.6	54.0
Cocaine use disorder	231	2.5	49.3	222	2.5	49.3	9	3.1	48.0
Cannabis use disorder	246	2.7	77.4	239	2.7	78.9	7	2.4	47.3
Opioid use disorder	177	1.9	86.9	168	1.9	86.4	9	3.1	98.6
Amphetamine or other psychostimulant use disorder	64	0.7	95.0	61	0.7	96.5	3	1.0	72.4
Sedative, hypnotic or anxiolytic use disorder	66	0.7	171.4	62	0.7	174.1	4	1.4	138.7

Bohnert, K. M. (2017)

Observation	Clinical Implication
The sizable risk of suicide among women with a current opioid use disorder is especially noteworthy.	Clinicians need to be aware of this when treating such patients.
There is a potentially confounding role of comorbid psychiatric illness in SUD–suicide associations.	Assessment and treatment of comorbid psychiatric conditions may be important in lowering the risk of suicide among individuals with co-occurring SUDs and other psychopathology.
Suicide Methods	It is important to develop strategies to prevent intentional poisoning, as well as increasing firearm safety in these patients.
Co-Diagnoses	The presence of co-occurring psychiatric diagnoses often reflects a combination of symptoms and distress/impairment. Also, these cases require cross-sectional treatment.

EFFECT OF TRAUMA

- **Combat exposure also increased the likelihood for suicide and substance use among veterans.**
- **Past violence increased the likelihood of suicide ideation and attempt among individuals seeking SUD treatment when controlling for demographic factors and depressive symptoms in a national sample (Ilgen et al., 2010).**

FEMALES IN SERVICE

- **Problematic substance use is prevalent in the military.**
- **In addition, 32% of women reported binge drinking, 8% heavy weekly drinking, and 7% alcohol related problems (Jacobson et al., 2008).**
- **Further, a 2005 survey of 1,200 Army soldiers found that women engaged in unsafe drinking at a rate nearly twice that of men (9.1% vs. 5.1%; Lande et al., 2007).**

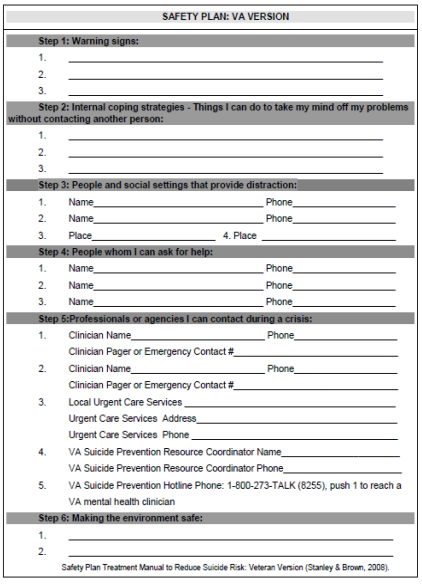
FUTURE DIRECTIONS

- **Longitudinal data on suicidal thoughts, nonfatal suicide attempts, and suicide mortality**
- **Improved identification of diagnosis**
- **More data on female Veterans**
- **Better treatments for suicidal Veterans with SUDs**

SUICIDE SAFETY PLAN (SSP)

- **The Suicide Safety Plan (SSP) is a written, prioritized list of coping strategies and resources for reducing suicide risk.**
- **It is a prevention tool, developed collaboratively by patient and clinician (Stanley & Brown, 2008).**
- **In 2008, the VA mandated that clinicians oversee the construction of an individualized SSP for every patient who is identified at "high risk" for suicide.**
- **The patient takes the SSP home for his/her use at the onset of (or during) a suicidal crises.**

SUICIDE SAFETY PLANNING



SAFETY PLAN: VA VERSION

Step 1: Warning signs:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Place_____ 4. Place _____

Step 4: People whom I can ask for help:

1. Name_____ Phone_____
2. Name_____ Phone_____
3. Name_____ Phone_____

Step 5:Professionals or agencies I can contact during a crisis:

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Local Urgent Care Services _____
   Urgent Care Services Address_____
   Urgent Care Services Phone _____
4. VA Suicide Prevention Resource Coordinator Name_____
   VA Suicide Prevention Resource Coordinator Phone_____
5. VA Suicide Prevention Hotline Phone: 1-800-273-TALK (8255), push 1 to reach a VA mental health clinician

Step 6: Making the environment safe:

1. _____
2. _____

Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

(Stanley & Brown, 2008)

The Safety Plan Steps:

- **Step 1 – Warning signs.**
- **Step 2 – Internal coping strategies.**
- **Step 3 – People and social setting that provide distraction.**
- **Step 4 - People whom I can ask for help.**
- **Step 5 – Professionals or agencies I can contact during a crisis.**
- **Step 6 – Making the environment safe.**

SUICIDE SAFETY PLAN (SSP) STEPS

The SSP instructs an individual to:

1. **Recognize personal warning signs of suicide;**
2. **Use internal coping strategies;**
3. **Engage social contacts that can offer support and serve as distraction from suicidal thought;**
4. **Contact family members or friends who may help resolve a crisis;**
5. **Provide contact information for VA professionals to help plus introduction to the VA Crisis Line; and**
6. **Establish means restriction, or specify steps for how to make the immediate environment more safe (Stanley & Brown, 2012).**

VA USE OF THE SSP

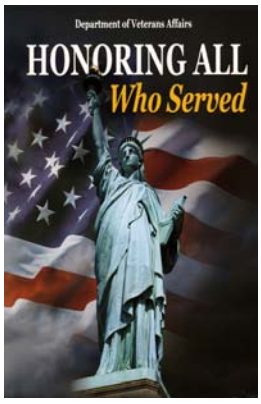
- **While the SSP is a vital component of the VA's coordinated effort at suicide prevention, to our knowledge, there are currently no recommended guidelines or mechanisms for refinement of the SSP beyond its initial development.**
- **Additionally, there are no recommended guidelines for involving family members or friends in the implementation of, or use of, the SSP.**

NOVEL INTERVENTIONS

To address these critical gaps, our clinical research group has developed two novel interventions:

1. **PLF - Project Life Force**
2. **SAFER - Safe Actions for Families to Encourage Recovery**

Please Note: **These interventions are adjunctive to standard outpatient mental health care at the James J. Peters VA Medical Center.**



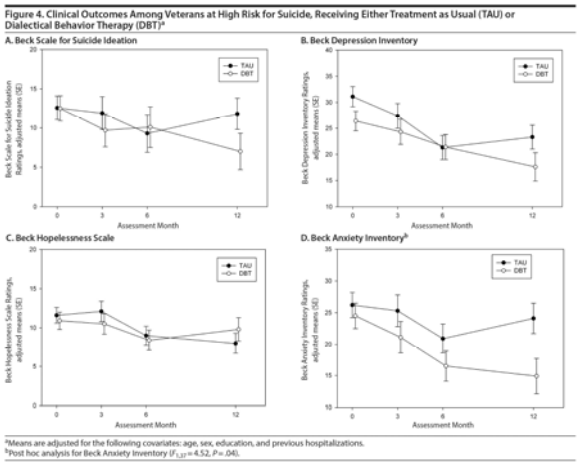
"PROJECT LIFE FORCE"

SUICIDE SAFETY PLANNING GROUP

INTERVENTION FOR HIGH RISK SUICIDAL VETERANS

DIALECTICAL BEHAVIOR THERAPY (DBT) TRIAL IN SUICIDAL VETERANS
(GOODMAN ET. AL, 2016)

RCT:
6 month DBT vs. TAU in 93 high-risk suicidal Veterans: **Negative study**.
Both groups improved in all outcome measures



QUALITATIVE STUDY OF SUICIDE SAFETY PLAN (SSP) USE (KAYMAN ET AL., 2015)

20 Veterans interviewed after SSP construction and 1 month later

Findings notable for:

Wide range of use (none to several times daily)

Importance of clinician collaboration

Barriers/obstacles to use

PLF aims to address these concerns

Problems/obstacles:

Lack of social network

Social withdrawal/depression

Avoidant style of coping

Burden too great to carry out plan alone

→

PLF incorporates:
1) Teaching of distress tolerance and emotion regulation skills applied to individual steps of the SSP,
2) Introduces use of a mobile SSP Application,
3) Helps Veterans identify individuals they can call for help, and practice asking for help,
4) Aims to develop detailed, personalized and meaningful SSPs,
5) Delivered in a group context offering support.

Facilitators of use of the plan:

Sharing of plan with significant others

Mobile formats of the plan

Individualized plans

PROJECT LIFE FORCE: SKILLS + SAFETY PLANNING IN A GROUP CONTEXT

Project Life Force Session Outline

	Session Focus	Skill Covered
1	Introduction, psychoeducation about suicide, SSP step #5 - crisis numbers, meet local SPC	Crisis Management Skills Urge Restriction
2	SSP step #1 - Identification of Warning Signs	Emotion, Thought or Behavior Recognition skills
3	SSP step #2 - Internal Coping Strategies	Distraction Skills
4	SSP step #3 - Identifying people to help distract	Making Friends Skills
5	SSP step #4 - Sharing SSP with Family	Interpersonal Skills/Practicing Asking for Help
6	SSP step #5 - Professional Contacts	Skills to Maximize Treatment Efficacy & Adherence
6	SSP step #6 - Making the Environment Safe	Means Restriction, Psychoeducation About Methods
7	Improving Access to the SSP	Use of Safety Planning Mobile Apps and Virtual Hope Box
8	Physical Health Management	Decreasing Vulnerability to Negative Emotion
9	Building a Meaningful Life	Building Meaning and Reasons for Living
10	Recap/Review	

1) PLF=manualized, weekly 90-minute group treatment lasting 10 weeks.

2) Each session of PLF corresponds to a step of the safety plan and teaches skills to maximize the use of that particular step of the plan.

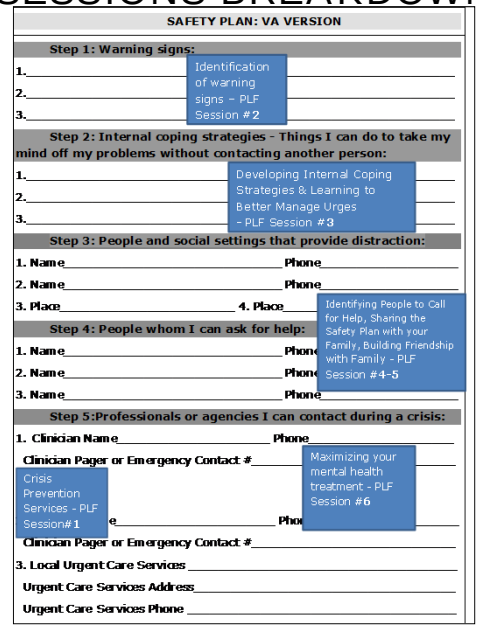
3) PLF is augmented with education pertaining to suicide risk, means restriction and suicide prevention mobile applications.

4) A manual with 47 pages of session handouts has been developed & tested.

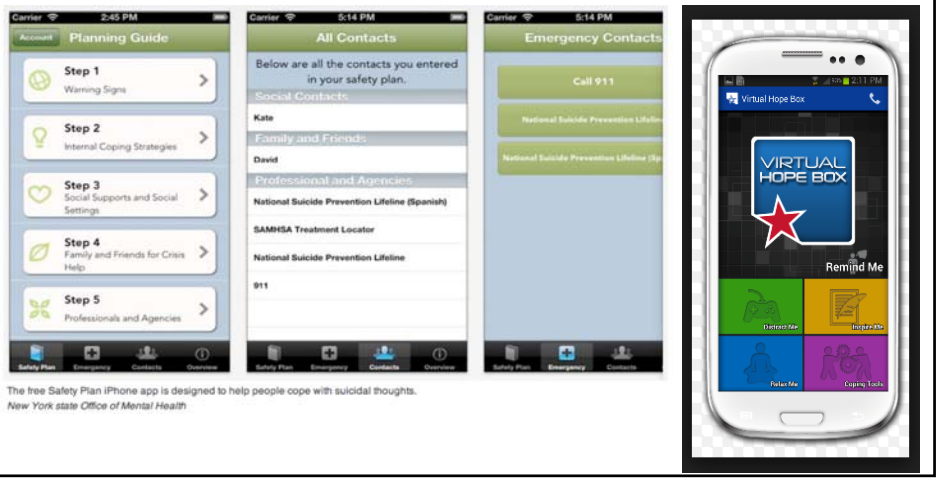
5) Designed to meet VA mandated monitoring and permit immediate access.

**PLF is one of the only manualized outpatient *group treatments* for suicidal individuals.

PROJECT LIFE FORCE: SESSIONS BREAKDOWN



NY OFFICE OF MENTAL HEALTH SUICIDE SAFETY PLAN MOBILE APP & VIRTUAL HOPE BOX



The free Safety Plan iPhone app is designed to help people cope with suicidal thoughts.
New York state Office of Mental Health

PLF = SAFETY PLANNING IN A GROUP FORMAT

PLF is **one of the only** manualized outpatient group treatments for individuals at high risk for suicide.

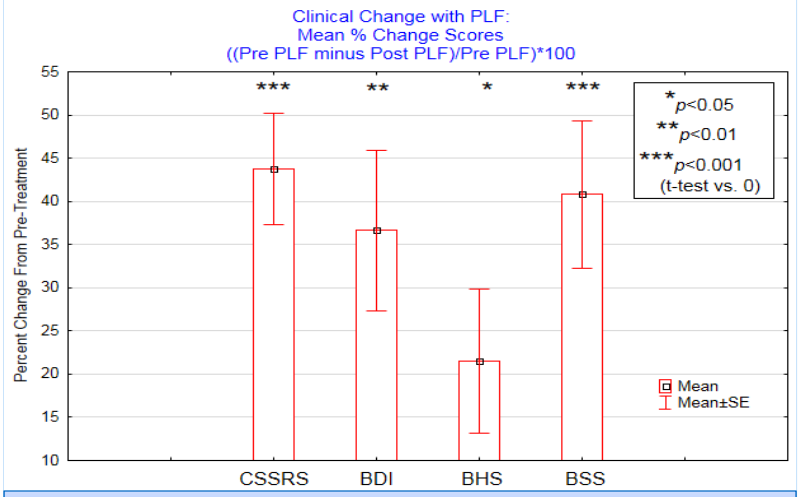
This is surprising given that groups:

1. Diminish social isolation and increasing social support/social connectedness, a protective factor against suicide;
2. It's cost effectiveness and maximizing staff time;
3. The peer movement among those who have experienced suicidal crises is strong and growing; and
4. Veterans and military service members are familiar with working as a unit, with team approach to problems.

OPEN-LABEL PILOT

- **Test feasibility and tolerability of intervention on 50 Veterans.**
- **Initial effectiveness in depression, suicidal symptoms, hopelessness, and community integration (exploratory).**
- **Feedback on each session from patient and PLF therapist.**
- **Plus post-intervention feedback from treating clinician(s).**

PRE/POST PLF OUTCOME MEASURES (FIRST 20 VETERANS- SPIRE)



CSSRS= Columbia Suicide Severity Rating Scale, BDI= Beck Depression Inventory BHS= Beck Hopelessness Scale BSS= Beck Suicide Ideation Scale

QUALITATIVE FEEDBACK ON PLF: HOPE/IMPROVED DEPRESSIVE AND SUICIDAL FEELINGS

- "I wake up wanting to live now." (PLF04)
- "Hanging up my safety plan and making it visible was reinforced in PLF. Seeing it daily is a positive reminder that help is out there." (PLF05)
- "PLF has had profound effects on my will to live, the most in the past 4 years. I now have a reason to get out of bed in the morning and can last through the week until the next PLF meeting." (PLF013)
- "It was most helpful to hear other veteran's stories, feedback and perspectives. It made me realize I was not the only one struggling with this." (PLF01, PLF07)

QUALITATIVE FEEDBACK ON PLF: INCREASED CONNECTION & SENSE OF BELONGINGNESS/LESSENED LONELINESS

- "The program led me to call friends I haven't spoken to in a while and become more open to starting new friendships, especially with other group members." (PLF15)
- "I got to listen to the stories of my brothers. It opened up sympathy and empathy in my heart because I could relate so much. I thought I was a misfit even though you hear about people struggling with suicide. To actually connect with my brothers in this fight was powerful. It's another battle we are facing." (PLF11)
- "The group helped me get over my embarrassment of struggling with mental illness- I 'came out' to some of my family members as having these struggles as a result of talking with the group members." (PLF08)

QUALITATIVE FEEDBACK ON PLF: MORE EFFECTIVE USE OF SAFETY PLAN

- "I learned about the Crisis Line, and used the text feature." (PLF01, PLF02)
- "Virtual hope box app was a favorite." (PLF02, PLF04, PLF11)
- "Going through each step in depth makes it a living document, instead of just filling it out on the fly and never using it. Knowing warning signs, when a bad feeling was coming and knowing which distractions are available to get me through, that was huge." (PLF02)
- "I put the safety plan on my phone." (PLF04)
- "Actually calling people on my plan." (PLF15, PLF16, PLF18)

Study Assessments, Schedule and Purpose

Domain	Measure	Description	Source	Study Contact (Month)	Study Purpose
Suicidal Behavior and Ideation	Columbia Suicide Severity Rating Scale–current & since last visit version	Interim history of suicide related behaviors; severity of ideation; intensity of ideation subscales	Interview	0, 3, 6,12	Primary Outcome;
Suicidal Ideation and Behavior	Suicidal behavior, Suicidal intention	Identification of suicidal ideation and behavior in medical record	Chart abstraction	12	Primary Outcome
Suicide	Death by suicide	Death by suicide	Death Certificates NVDRS	12	Primary Outcome
Depression	Beck Depression Scale	Depression	Self-Report	0, 3, 6,12	Secondary Outcome
Hopelessness	Beck Hopelessness Scale	Hopelessness Positive and Negative Beliefs about the future	Self-Report	0, 3, 6,12	Secondary Outcome
Mental Health Services	Self-report log based on the Modified Cornell Services Index MCSI	Use of mental health services, SOC contacts determined from medical record	Log maintained by subject & research staff	3, 6,12	Secondary Outcome
Safety Plan	Brief Survey of Safety Plan Utilization	Subject self-report of using the safety plan prior to baseline assessment or during follow-up and which components were used	Self-report	0, 3, 6,12	Secondary Outcome
Suicide-Related Coping	Suicide-Related Coping Measure	Report of coping behaviors identified on the SPI and confidence in managing suicidal feelings.	Self-report	0, 3, 6,12	Secondary Outcome
Group Cohesion	Group Psychotherapy Process Measure	Group Process Outcomes	Self-report	1,5,10 (weeks)	Mediator
Demographic and Medical History Information	Demographic Information and History of Psychiatric, Substance Use, Medical Information	MSRC Common Data Elements	Interview	0,3	Descriptive
Diagnosis	Mini-International Psychiatric Interview	Axis I diagnosis	Interview	0	Descriptive

Methodology Merit

Special Design Features:

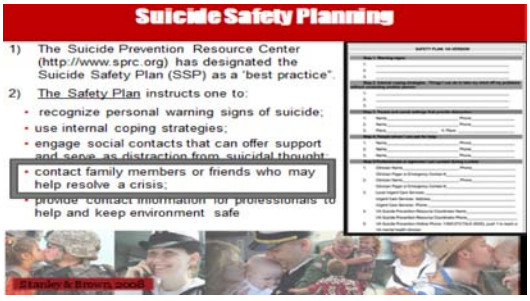
1) Multi-site RCT, n=265 suicidal Veterans
2) Co-investigators Drs. Brown and Stanley are creators of the VA suicide safety plan
3) Rigorous multi-method assessment of suicidal behaviors with follow-up out to 1 year.
4) Assessment training and adherence monitoring performed by 3rd site.
5) Examining impact on suicide safety planning quality
6) Explore "group cohesion" as mediator

SAFE ACTIONS FOR FAMILIES TO ENCOURAGE RECOVERY

SAFER RCT

PROTOCOL SUMMARY

SAFER is a novel, 4-session manualized intervention. Through the use of psychoeducation, disclosure and development/revision of both the Veteran and a complementary family member safety plan, SAFER provides the tools and structure to support family involvement in suicide safety planning for Veterans at moderate risk for suicide.



RATIONALE FOR FAMILY INVOLVEMENT

Our research team conducted a qualitative study (*n* = 26 Veterans, 19 family members) interviewing suicidal Veterans and their family members which revealed a gap in current suicide prevention research.

Veteran themes

1) **Isolation**: "I have a big family but it's like I have none",
2) **Shame:** "Deep down a part of it is shame"
3) **Perceived burden:** "I felt like a burden, I wanted to reach out but didn't"
4) **Mistrust:** "They'll flip out or won't understand"

Family themes

1) **Perceived inability to stop their loved on from hurting themselves:** "it's hard for me to find out things that's going on with him; he keeps it to himself a lot"
2) **Fear of triggering urges**, "I never know how he'll react"
3) **Feeling unsupported**, "There's no real support" and
4) **Feeling overwhelmed,** "I didn't know what to do"

Multiple perceptions that may prevent successful communication about suicide between patients and families were identified based on the themes stated above. Overall, while Veterans felt alone and afraid to reach out to family members, family members also did not know how to support or react to their Veterans suicidality.

This data served as the basis for the SAFER intervention.

SAFER INTERVENTION

SAFER is a novel, manualized, weekly, 90-minute, individual joining + 4-session family-based treatment.

Session #	Focus
Individual Joining	Introductions, assess Veteran and family interaction around suicide, review individual concerns, motivation. Clarify intervention goals, ensure commitment
1	Psychoeducation about suicide; risk assessment Teaching of communication skills
2	Review of barriers to Safety Planning and family involvement. Review Veteran Safety Plan. Homework: Veterans and family members construct a list of "reasons for living" to share in the next session
3	Construction of family member's safety plan. Practice using communication skills to facilitate use of Veteran and family member plans Review Reasons for Living for Veteran and family member
4	Review of Safety Plan use for both Veteran and family member; address implementation problems

ELIGIBILITY - VETERAN

Inclusion Criteria:

1. Moderate risk for suicide, defined as:
   - evidence of current (within the past week) suicidal ideation, plan or intent on the Columbia Suicide Severity Rating Scale (C-SSRS),
   - Scoring < 4 on the C-SSRS Behavior Scale, and without history of suicide attempt in the last three months.
2. Inclusion criteria also include the availability of a consenting, qualifying family member or partner.

Exclusion criteria:

1. **Alcohol or drug abuse or dependence defined by Patient Health Questionnaire (PHQ; Spitzer, Kroenke, Williams, et al., 1999).**
2. For romantic couples, “severe” intimate-partner violence as defined by the revised 20-item Conflict Tactics Scale Short Form (CTS2S) (Straus & Douglas, 2004);
3. Medical condition or life event (e.g., ongoing or pending legal action in another state) that would compromise participation
4. Participation in another family-based psychosocial intervention trial six months prior to study;
5. Limited English proficiency.

ELIGIBILITY - CAREGIVER

Inclusion Criteria:

Family members/friends must meet at least three (two for nonrelatives) of five criteria established by (Pollak & Perlick, 1991):

1. Spouse, co-habiting significant other or parent;
2. More frequent contact than any other caregiver
3. Helps to support the Veteran
4. Contacted by treatment staff for emergencies;
5. Involvement in the patient’s treatment.

Exclusion criteria:

1. **Alcohol or drug abuse or dependence defined by Patient Health Questionnaire (PHQ; Spitzer, Kroenke, Williams, et al., 1999).**
2. For romantic couples, “severe” intimate-partner violence as defined by the revised 20-item Conflict Tactics Scale Short Form (CTS2S) (Straus & Douglas, 2004);
3. Medical condition or life event (e.g., ongoing or pending legal action in another state) that would compromise participation
4. Participation in another family-based psychosocial intervention trial six months prior to study;
5. Limited English proficiency.

SCREENER: ALCOHOL & DRUG USE

C25.	Do you ever drink alcohol (including beer or wine)?	**NO**	**YES**
If you checked "NO" go to question D27.			
C26.	**Have any of the following happened to you more than once in the last 6 months?**	**NO**	**YES**
a.	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health		
b.	You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities		
c.	You missed or were late for work, school, or other activities because you were drinking or hung over		
d.	You had a problem getting along with other people while you were drinking		
e.	You drove a car after having several drinks or after drinking too much		

CODE: Alcohol Abuse if any of #C26a-e is "YES."

Alcohol Abuse: Yes or No

C27 a)	Did you use any of these in the past 6 month? Check all that apply.		
alcohol		hallucinogens (e.g mushrooms, acid)	
marijuana		stimulants (e.g. crystal meth., speed)	
heroin		prescription pain killers	
cocaine		nicotine (e.g. cigarettes, dip)	
something else (specify)			

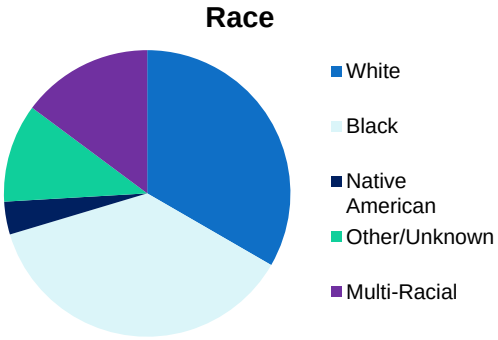
C28.	If you checked off any problems on this questionnaire, how difficult have these problems been for you to do your work, take care of things at home, or get along with other people?		
Not difficult at all	**Somewhat difficult**	**Very Difficult**	**Extremely difficult**

RECRUITMENT TO DATE

Since the start of the study recruitment has been exceedingly strong.

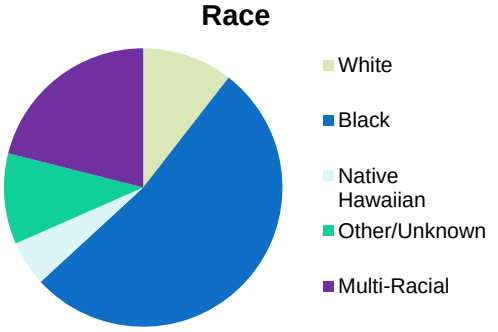
- The research staff has consented a total of 52 Veterans and family members (31 Veterans and 21 family members).
- Out of the consented participants 38 individuals have completed baselines and 16 dyads have been randomized.
- Out of those who have been randomized 20 individuals have completed posts and 9 individuals have additionally completed post three month follow up assessments.

DEMOGRAPHICS VETERANS - CONSENTED



- Age Range: 35-84
- Gender: 2 Females, 29 Males
- Hispanic: 12/31

DEMOGRAPHICS CAREGIVERS- CONSENTED



- Age Range: 24-66
- Gender: 12 Females, 9 Males
- Hispanic: 8/21

ASSESSMENT PACKET - VETERAN

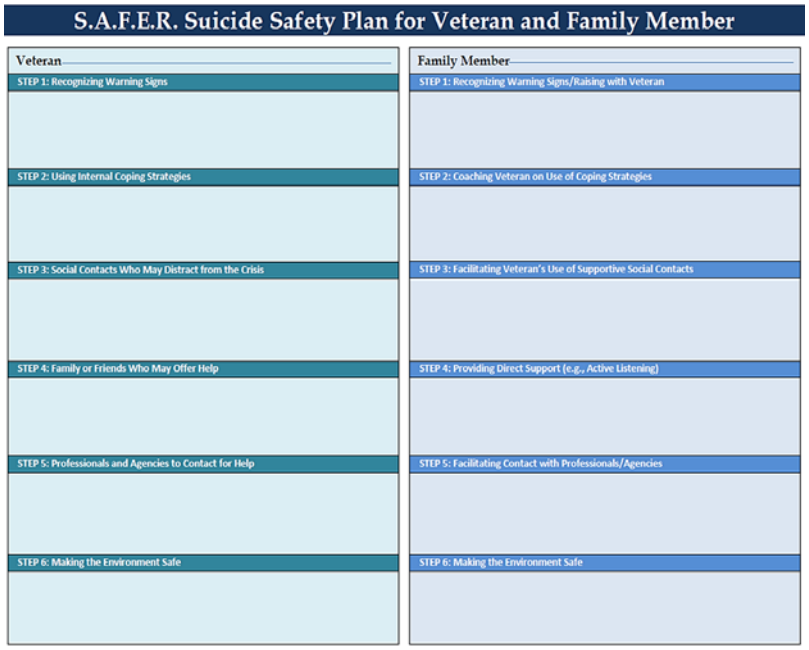
Screener
Suicide History Intake
C-SSRS
Mini Neuropsychiatric Interview
PHQ – Alcohol & Drug Use
Montreal Cognitive Assessment (MoCA)
Zanarini for BPD
Conflict Tactics Scale (couples only)

MODULE A: Suicidal Intent
Beck Scale of Suicide Ideation
MODULE B: Suicidal Cognitions/Coping
Beck Hopelessness Index
Suicide-related Coping Measure
Ways of Coping – Avoidance
Devaluation of Consumers Scale
Secrecy & Withdrawal
Interpersonal Needs Questionnaire
Self-harm and Suicide Disclosure Scale
Family Quality Reaction Scale
PROMIS Emotional Support – Short Form
MODULE C: Mental Health/Health Behavior
Beck Depression Inventory
PROMIS Pain Interference – Short Form
SF-8
Insomnia Severity Index
LEC-5
MODULE D: Communication & Support
Family Assessment Device
Perceived Criticism
Couples Assessment of Relationship Elements

ASSESSMENT PACKET - CAREGIVER

Screener
Mini Neuropsychiatric Interview
Montreal Cognitive Assessment (MoCA)
PHQ – Alcohol & Drug Use
Conflict Tactics Scale (couples only)

MODULE A: Burden/Health
Caregiver Burden Inventory
Beck Depression Inventory
SF-8
Insomnia Severity Index
LEC-5
MODULE B: Stress & Coping
Suicide-related Coping Measure – Family Counterpart
Devaluation of Consumers' Families Scale
Ways of Coping - Avoidance
Family Empowerment Scale
PROMIS Emotional Support – Short Form
MODULE C: Communication & Support
Family Assessment Device
Perceived Criticism Scale
Couples Assessment of Relationship Elements


S.A.F.E.R. Suicide Safety Plan for Veteran and Family Member

Veteran	Family Member
STEP 1: Recognizing Warning Signs	STEP 1: Recognizing Warning Signs/Raising with Veteran
STEP 2: Using Internal Coping Strategies	STEP 2: Coaching Veteran on Use of Coping Strategies
STEP 3: Social Contacts Who May Distract from the Crisis	STEP 3: Facilitating Veteran's Use of Supportive Social Contacts
STEP 4: Family or Friends Who May Offer Help	STEP 4: Providing Direct Support (e.g., Active Listening)
STEP 5: Professionals and Agencies to Contact for Help	STEP 5: Facilitating Contact with Professionals/Agencies
STEP 6: Making the Environment Safe	STEP 6: Making the Environment Safe

QUALITATIVE FEEDBACK

Veteran

- **"Having someone to reach out with such as Dr. Goodman."**
- **"We need more doctors, like Dr. XX, that listen instead of constantly speaking."**
- **"SAFER helped me keep my SSP constantly in my head and helped me go to my safety zones."**

Caregiver

- **"Knowing that we are not alone."**
- **"To have a plan that is useful."**
- **"Reaching out to others that are going through what my husband is going through is helpful."**
- **"I liked best finding different ways to help my husband."**

THANK YOU!

ANY QUESTIONS?