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).
ONE A DAY

Every day, one U.S. soldier commits suicide. Why the military can't defeat its most lethal enemy

BY MARK THOMPSON & NANCY RAPES

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

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Hazard Ratio (95% Confidence Interval)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Any psychiatric diagnosis</td>
<td>2.50 (2.38-2.64)</td>
</tr>
<tr>
<td>Any substance abuse or dependence</td>
<td>2.27 (2.11-2.45)</td>
</tr>
<tr>
<td>Alcohol abuse or dependence</td>
<td>2.28 (2.12-2.45)</td>
</tr>
<tr>
<td>Drug abuse or dependence</td>
<td>2.09 (1.90-2.31)</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>2.98 (2.73-3.25)</td>
</tr>
<tr>
<td>Depression</td>
<td>2.61 (2.47-2.75)</td>
</tr>
<tr>
<td>Other anxiety</td>
<td>2.10 (1.94-2.28)</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>1.84 (1.70-1.98)</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>2.10 (1.93-2.28)</td>
</tr>
</tbody>
</table>

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

(Ilgen et al., 2010)

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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

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.

(Stanley & Brown, 2008)
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

Facilitators of use of the plan:
- Sharing of plan with significant others
- Mobile formats of the plan
- Individualized plans

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.
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: Skills + Safety Planning in a Group Context

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

### Project Life Force: Sessions Breakdown

#### Step 1: Warning Signs
1. **Identification of warning signs** - SSP Session #2

#### Step 3: Internal coping strategies - Things I can do to take my mind off my problems without contacting another person:

#### Step 4: People and social settings that provide distraction:

#### Step 4: People whom I can ask for help:

#### Step 3: Professionals or agencies I can contact during a crisis:

1. **Clinician Name:**
2. **Clinician Phone:**
3. **Crisis Prevention Services:**
4. **PLF Session #:**
5. **Emergency Contact Name:**
6. **Emergency Contact Phone:**

### Project Life Force: Sessions Breakdown (VA Version)

#### Step 1: Warning Signs
1. **Identification of warning signs**

#### Step 2: Identifying people to help distract

#### Step 3: Distraction Skills

#### Step 4: Making friends skills

#### Step 5: Sharing SSP with Family

#### Step 6: Professional Contacts

#### Step 7: Making the environment safe

#### Step 8: Use of Safety Planning Mobile Apps and Virtual Hope Box

#### Step 9: Decreasing vulnerability to negative emotion

#### Step 10: Building meaning and reasons for living

**PLF is one of the only manualized outpatient group treatments for suicidal individuals.**
NY OFFICE OF MENTAL HEALTH
SUICIDE SAFETY PLAN MOBILE APP &
VIRTUAL HOPE BOX

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

<table>
<thead>
<tr>
<th>Domain</th>
<th>Measure</th>
<th>Description</th>
<th>Source</th>
<th>Study Count (Month)</th>
<th>Study Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Behavior and ideation</td>
<td>Columbia Suicide Severity Rating Scale-current &amp; clinical vs visit ratings</td>
<td>interferes history of suicide related behaviors; severity of ideation; intensity of ideation subacute</td>
<td>Interview</td>
<td>0, 3, 6, 12</td>
<td>Primary Outcome</td>
</tr>
<tr>
<td>Suicide Behavior and ideation</td>
<td>Suicide behavior, suicidal ideation</td>
<td>Identification of suicidal ideation and behavior in medical record</td>
<td>Chart abstraction</td>
<td>12</td>
<td>Primary Outcome</td>
</tr>
<tr>
<td>Suicide</td>
<td>Death by suicide</td>
<td>Death by suicide</td>
<td>Death Certificate</td>
<td>12</td>
<td>Primary Outcome</td>
</tr>
<tr>
<td>Depression</td>
<td>Total Depression Scale</td>
<td>Depression</td>
<td>Self-report</td>
<td>0, 3, 6, 12</td>
<td>Secondary Outcome</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>Hopelessness Rating Scale</td>
<td>Positive and Negative Beliefs about the future</td>
<td>Self-report</td>
<td>0, 3, 6, 12</td>
<td>Secondary Outcome</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>Mental Health Services Log</td>
<td>Use of mental health services, SOC contacts determined from medical record</td>
<td>Log maintained by subject &amp; research staff</td>
<td>3, 6, 12</td>
<td>Secondary Outcome</td>
</tr>
<tr>
<td>Safety Plan</td>
<td>Brief Survey of Safety Plan</td>
<td>Subject self-report of using the safety plan prior to baseline assessment or follow-up.</td>
<td>Self-report</td>
<td>0, 3, 6, 12</td>
<td>Secondary Outcome</td>
</tr>
<tr>
<td>Suicide-Related Coping</td>
<td>Suicide-Related Coping Measure</td>
<td>Suicide-related Coping Measure identified on the SPI and confidence in managing suicidal feelings.</td>
<td>Self-report</td>
<td>0, 3, 6, 12</td>
<td>Secondary Outcome</td>
</tr>
<tr>
<td>Group Cohesion</td>
<td>Group Psychotherapy Process Measures</td>
<td>Group process outcomes and process measures identified on the SPI and confidence in managing suicidal feelings.</td>
<td>Self-report</td>
<td>1, 6, 12</td>
<td>Mediator</td>
</tr>
<tr>
<td>Demographic and Medical History Information</td>
<td>Demographic Information and History of Psychiatric, Social, Medical Information</td>
<td>MSRC Common Data Elements</td>
<td>Interview</td>
<td>0.3</td>
<td>Description</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Multi-dimensional Psychiatric Interview</td>
<td>Initial diagnosis</td>
<td>Interview</td>
<td>0</td>
<td>Description</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Session #</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Joining</td>
<td>Introductions, assess Veteran and family interaction around suicide, review individual concerns, motivation. Clarify intervention goals, ensure commitment</td>
</tr>
<tr>
<td>1</td>
<td>Psychoeducation about suicide; risk assessment Teaching of communication skills</td>
</tr>
<tr>
<td>2</td>
<td>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</td>
</tr>
<tr>
<td>3</td>
<td>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</td>
</tr>
<tr>
<td>4</td>
<td>Review of Safety Plan use for both Veteran and family member; address implementation problems</td>
</tr>
</tbody>
</table>
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;

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)?

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>

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?

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>

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 months? Check all that apply.

<table>
<thead>
<tr>
<th></th>
<th>Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>alcohol</td>
<td>Hallucinogens (e.g. mushrooms, acid)</td>
</tr>
<tr>
<td>marijuana</td>
<td>Stimulants (e.g. crystal meth, speed)</td>
</tr>
<tr>
<td>heroin</td>
<td>Prescription pain killers</td>
</tr>
<tr>
<td>cocaine</td>
<td>Nicotine (e.g. cigarettes, dip)</td>
</tr>
<tr>
<td>something else (specify)</td>
<td></td>
</tr>
</tbody>
</table>

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?

<table>
<thead>
<tr>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very Difficult</th>
<th>Extremely difficult</th>
</tr>
</thead>
</table>

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

- Race:
  - White
  - Black
  - Native American
  - Other/Unknown
  - Multi-Racial

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

DEMOGRAPHICS CAREGIVERS- CONSENTED

- Race:
  - White
  - Black
  - Native Hawaiian
  - Other/Unknown
  - Multi-Racial

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

#### MODULE A: Suicidal Intent
- Beck Scale of Suicide Ideation
- Suicide-related Coping Measure
- Devaluation of Consumers Scale
- Secrecy & Withdrawal
- Interpersonal Needs Questionnaire
- Self-harm and Suicide Disclosure Scale
- Family Quality Reaction Scale
- PROMIS Emotional Support – Short Form
- Suicide History Intake

#### MODULE B: Suicidal Cognitions/Coping
- Beck Hopelessness Index
- Ways of Coping – Avoidance
- PROMIS Pain Interference – Short Form
- SF-8
- Insomnia Severity Index
- LEC-5

#### MODULE C: Mental Health/Health Behavior
- Beck Depression Inventory
- PROMIS Pain Interference – Short Form
- SF-8
- Insomnia Severity Index
- LEC-5
- Montreal Cognitive Assessment (MoCA)
- Zanarini for BPD
- Conflict Tactics Scale (couples only)

#### MODULE D: Communication & Support
- Family Assessment Device
- Perceived Criticism
- Couples Assessment of Relationship Elements

### ASSESSMENT PACKET - CAREGIVER

#### 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
- 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

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