Involving Concerned Significant Others in Firearms Safety: Development and Testing of a New Intervention

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Disclaimer and Funding Acknowledgement

This presentation does not represent the views of the Department of Veterans Affairs, the United States Government, or other affiliates.

This work was supported by the VA Suicide Prevention Research Impact Network (SPRINT), HSR&D/CSR&D Consortium of Research and the VA Office of Mental Health and Suicide Prevention (OMSHP). The VA Rocky Mountain MIRECC provided infrastructure resources.

Firearms and Veteran Suicide

- Firearms are used in 69% of Veteran suicides (U.S. Department of Veteran Affairs, 2022)
- Unsecure firearm storage practices are associated with increased suicide risk (Anestis et al., 2017, Dempsey et al., 2019)
- Firearm interventions target high-risk populations
  - May fail to reach at-risk individuals who go undetected (Slovak et al., 2019)
- Intervening well in advanced of a suicidal crisis may be critical for preventing self-injury or death by firearm

Lethal Means Safety & Concerned Significant Others (CSOs)

- Veterans may be more open to discussions with a concerned significant other (CSO; e.g., family, friends, spouse) than a clinician (Monteith et al., 2020)

- Veterans desire for CSOs to be involved in their suicide prevention care, including firearms storage (DeBeer et al., 2019; DeBeer et al., under review)

Study Aims

- Objective 1
  - Develop a CSO-involved firearm safety intervention to increase secure storage among Veterans far in advance of a suicidal crisis.

- Objective 2
  - Refine the intervention and understand optimal conditions for implementation using a successive cohort design based on Veteran, CSO, therapist, and expert feedback (*n* = 10 Veteran-CSO dyads)

Intervention Design and Components

- Single, brief 90-minute virtual session
- Veteran and CSO, and therapist discussion based on 4 components

CSO INVOLVEMENT

Instruct the CSO on how to:

- identify warning signs for suicide risk
- Support the Veteran's mental health
- Create a collaborative safe storage plan
- Help enact the safe storage plan

SAFE STORAGE

- Describe safe firearm storage practices
  Troubleshoot barriers to safe storage

PSYCHOEDUCATION

- Describe the VA rationale
- Describe common mental health symptoms in Veterans and suicide warning signs

CRISIS SITUATION

- Provide guidance on when and how to reach out for VA mental health services.
- Perform a role play of a crisis scenario

Methods

- Develop manual
- Receive feedback from stakeholder board
- 10 Veteran-CSO dyads enrolled (*n* = 20)
- 8 dyads completed the intervention (*n* = 16)
- 6 dyads completed the intervention and follow-up (n = 12)
- Study design included pre/post-intervention assessments and a 1-month follow-up assessment.

Veteran Demographics (n = 8)

- 51.25 years old (SD = 16.74)
- 60% Male, 100% White; 0% Hispanic or Latino
- All had at least some college
- 5 (63%) married, 1 (13%) single, 1 (13%) cohabitating and 1 (13%) divorced
- 1 (13%) employed full-time, 3 (38%) employed part-time, 1 (13%) not employed yet seeking employment, and 3 (38%) retired from workforce
- 1 (13%) identified as a student

Veteran Military History

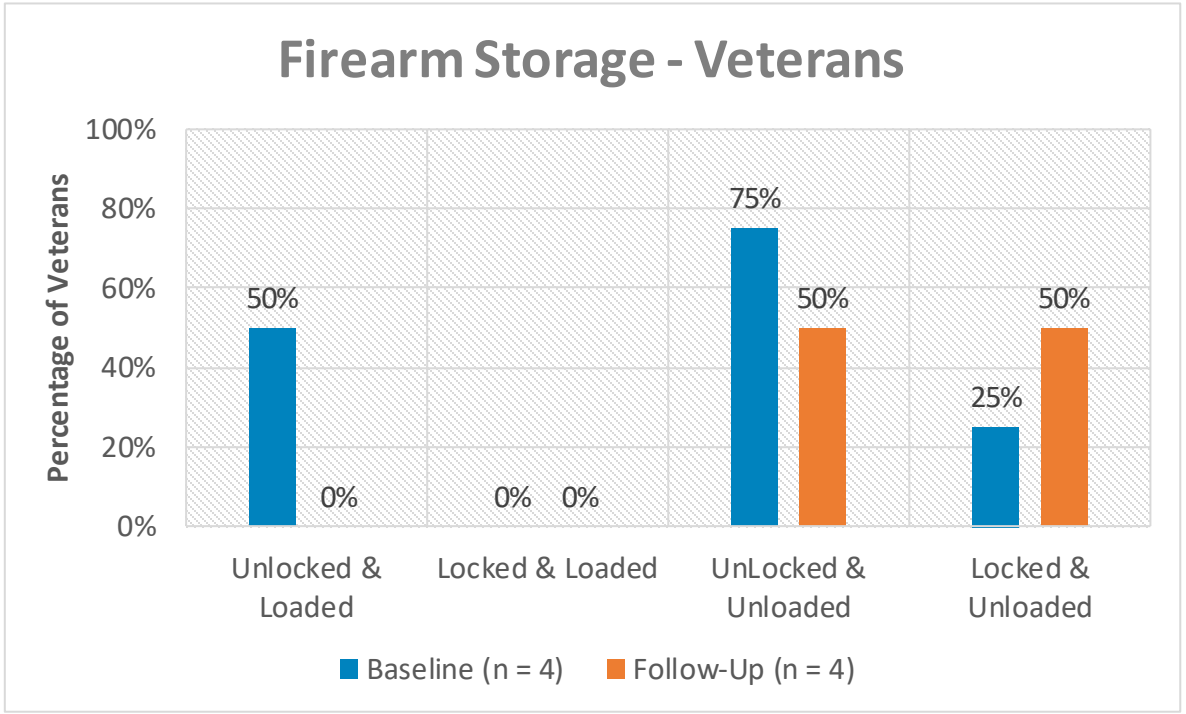
- Majority served in Army (n = 5), followed by Air Force (n = 3), Marine Corps (n = 3), and Coast Guard (n = 1)*
- Average Service Length – Active Duty: 10.28 years (SD = 7.42)
- Average Service Length – Reserve: 1.13 years (SD = 2.47)
- Years since separation – Active Duty: 24.13 (SD = 17.85)
- Years since separation – Reserve: 25.50 (SD = 30.41)
- Majority served during Post-9/11 (n = 4), followed by Vietnam (n = 2), Desert Storm/Desert Shield (n = 1), and Other (n = 1)*
- Majority served as NCOs (n = 4), followed by Enlisted (n = 3) and as an Officer (n = 1)

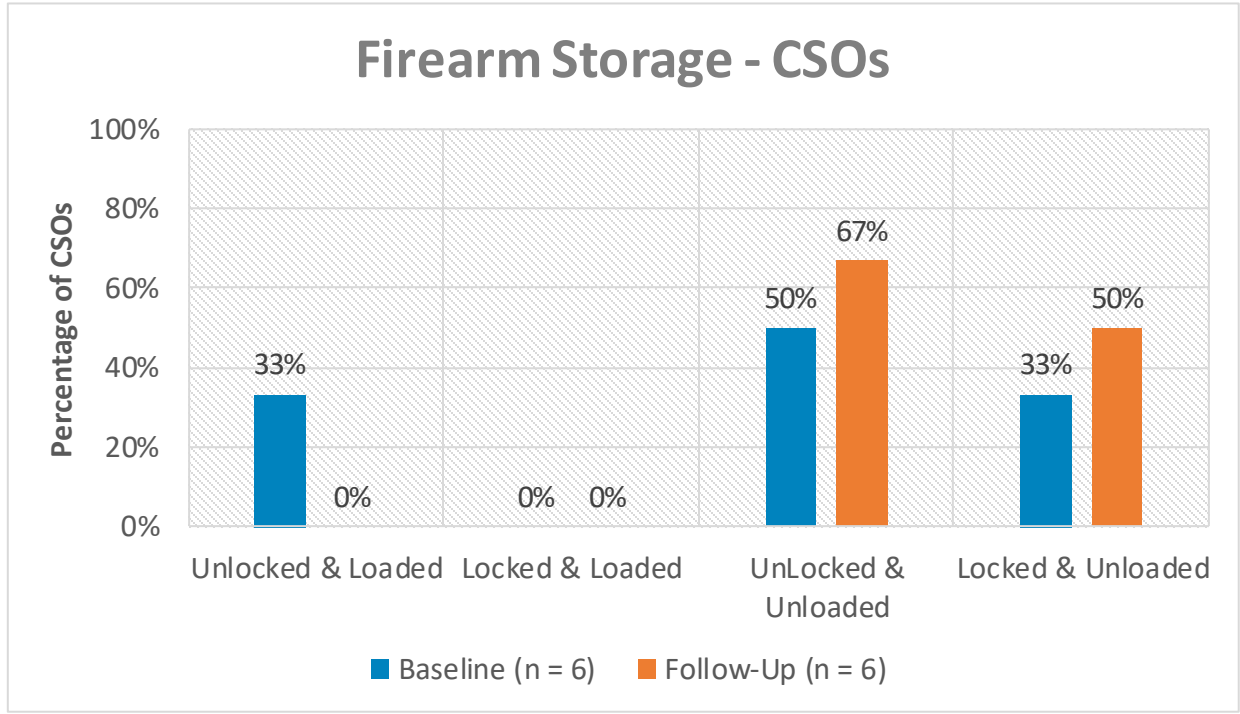
*categories not mutually exclusive.

CSO Demographics (n = 8)

- 51.13 years old (SD = 13.88)
- 75% were Female, 88% White, 13% Asian; 13% Hispanic or Latino
- 7 (90%) had at least some college, 1 (10%) had a high school diploma
- 7 (90%) married, and 1 (10%) divorced
- 3 (38%) employed full-time, 2 (25%) employed part-time, and 3 (38%) retired from workforce
- None identified as a student
- 7 (88%) were the Veteran's spouse, and 1 (13%) was a family member

Firearm Storage at Pre-Intervention & Follow-Up

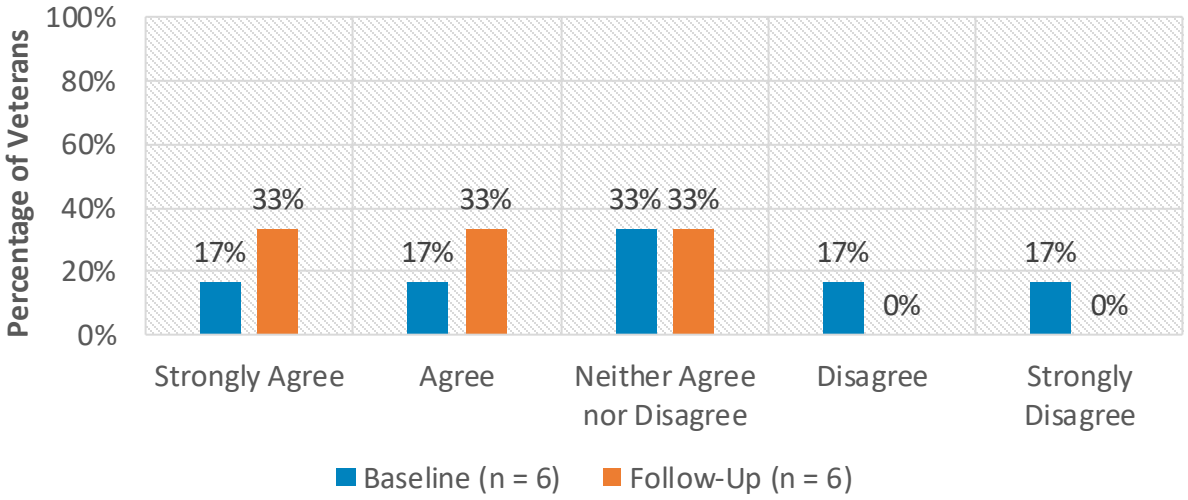




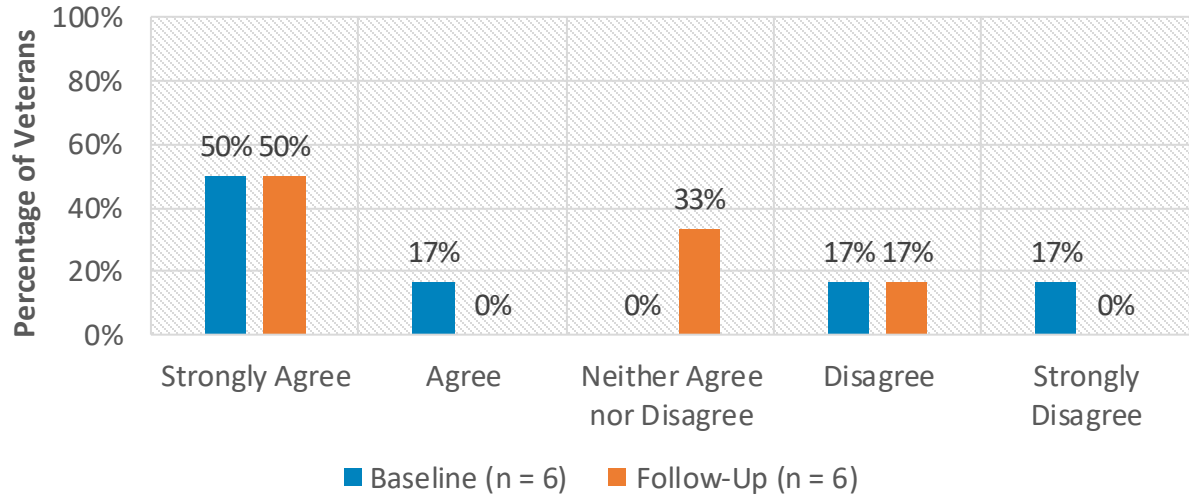
Note. Categories of firearm storage are not mutually exclusive.

Veteran Attitudes on Firearm Storage at Pre-Intervention and Follow-Up

Guns should be stored locked and unloaded with the ammunitions stored separately when they are not in use.



If a gun owner has to take the time to unlock or load their gun, it's no good for self-protection.



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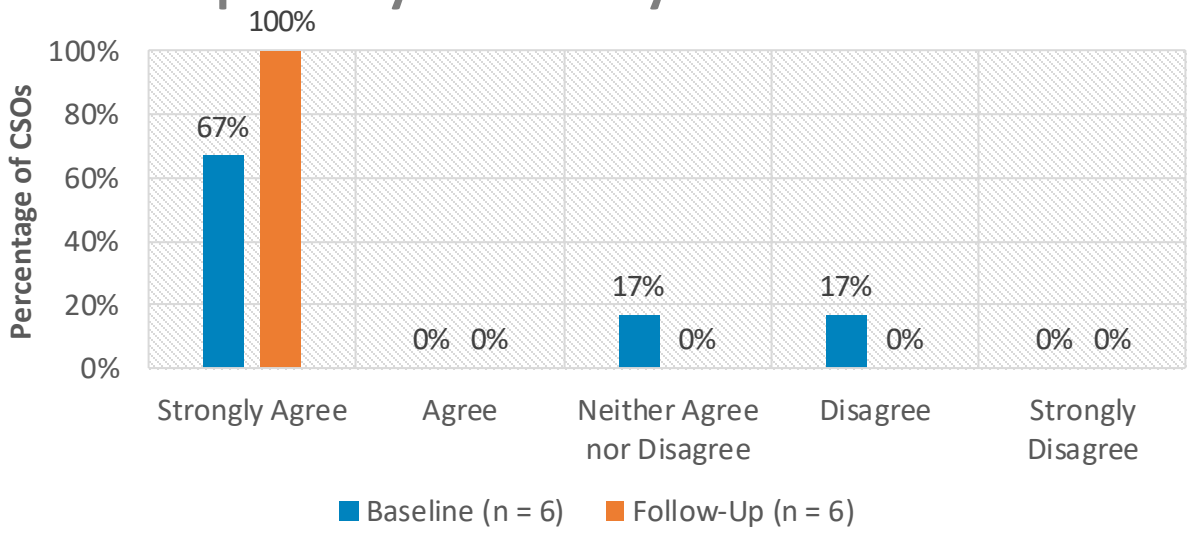

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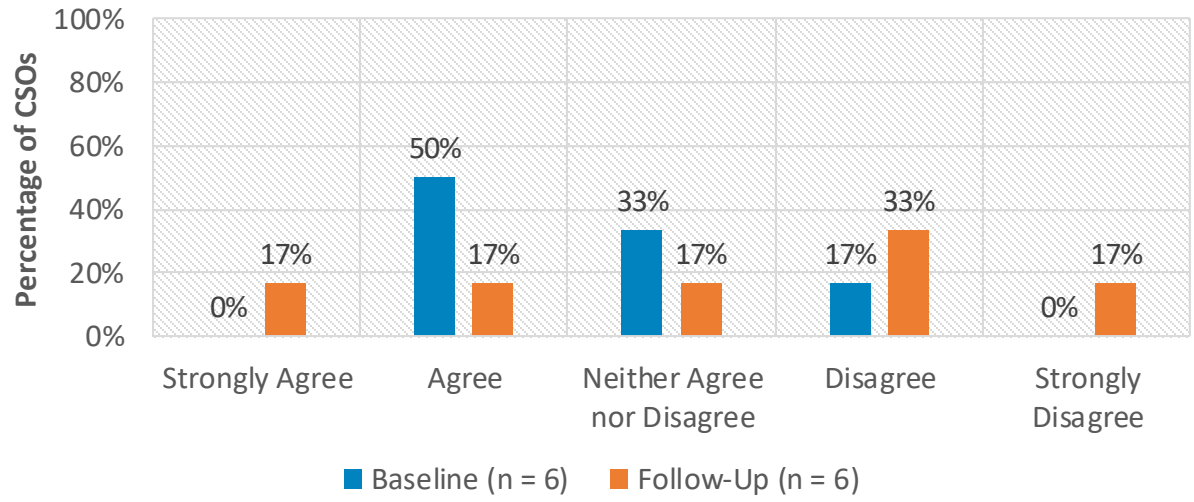
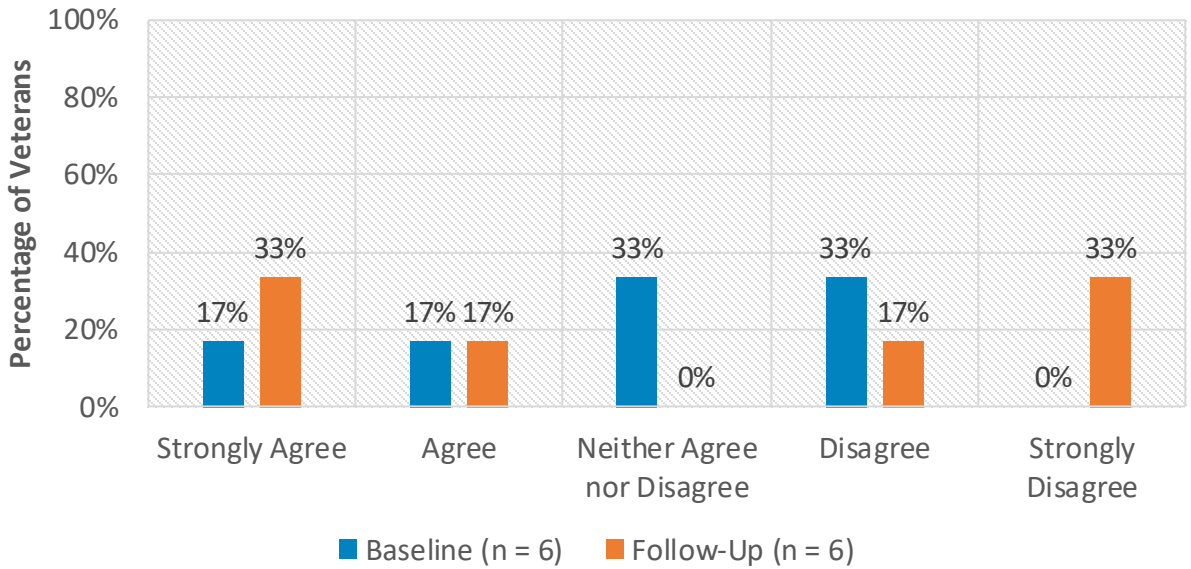
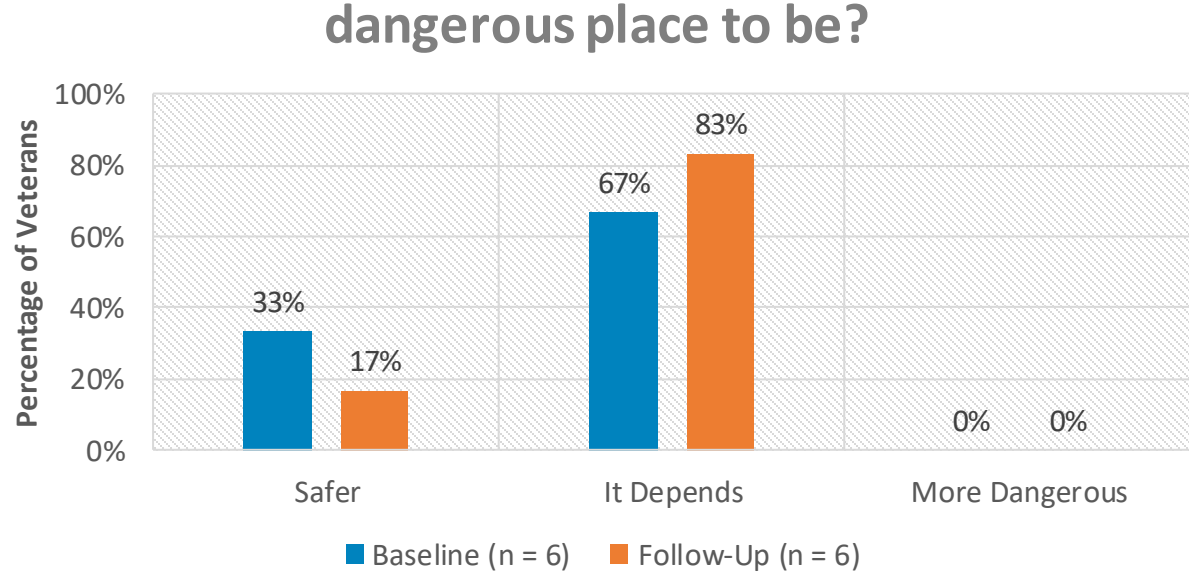


Veteran Attitudes on Firearms and Suicide Risk at Pre-Intervention and Follow-Up





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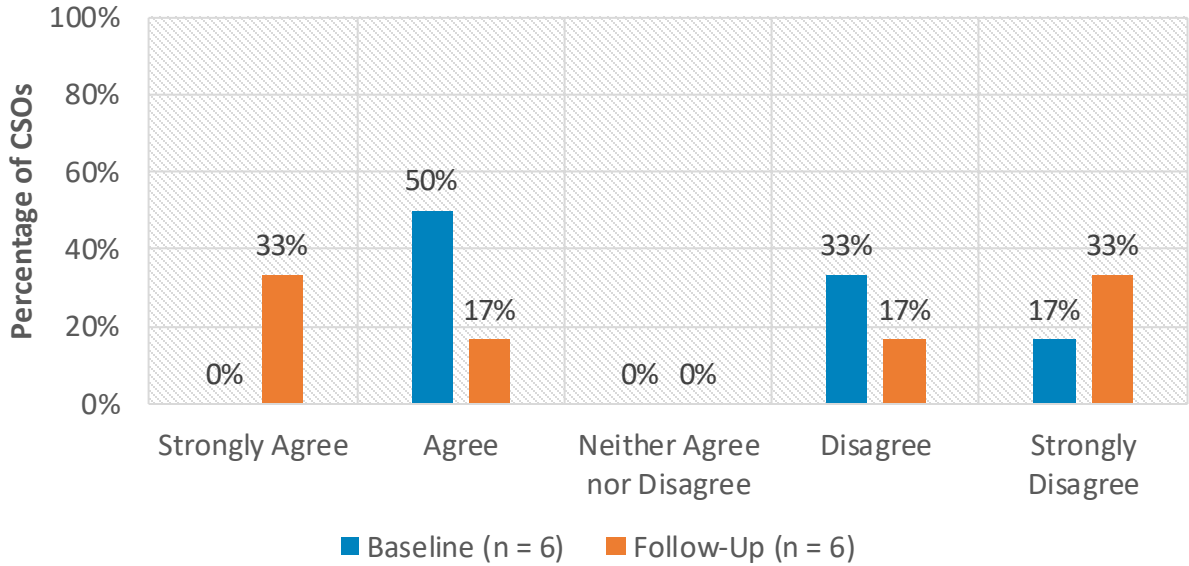
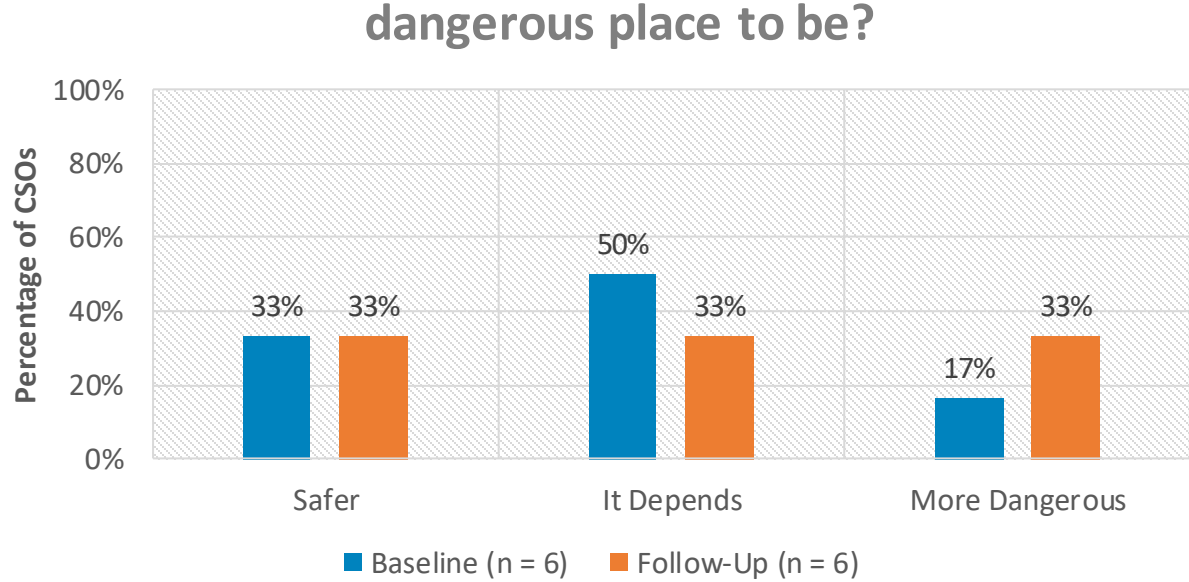
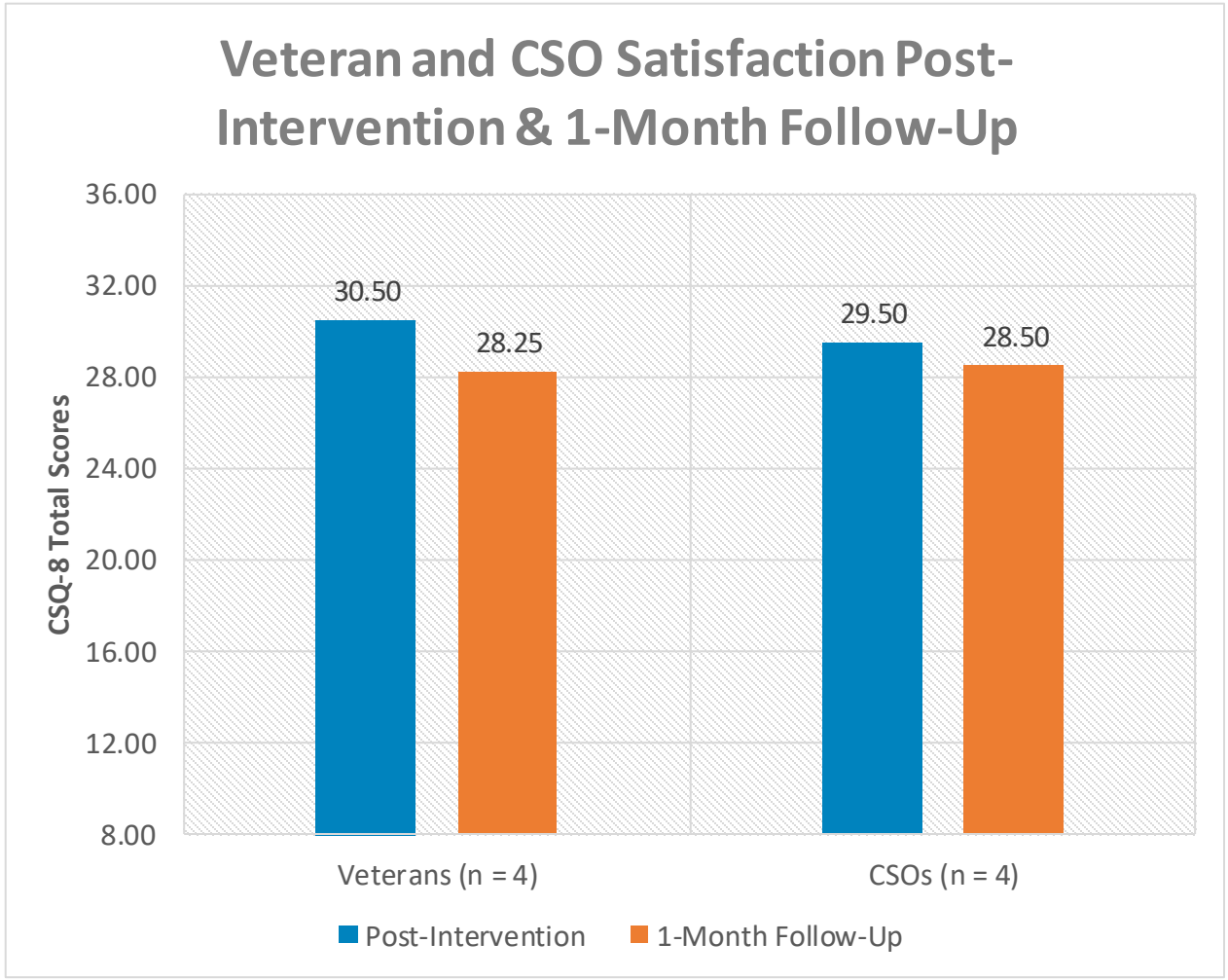




Satisfaction with Intervention at Post-Intervention & Follow-Up



Lessons Learned

- Veterans and CSOs identified additional unsafe situations
  - Children having access to firearms
  - Adult children with mental health symptoms having access to firearms
  - Broadened intervention to reflect these scenarios
- Received feedback from Veteran panel, experts, and therapist
- Recruitment is challenging
  - In an unrelated study learned Veterans have weak social networks
- CSOs want an intervention to obtain this information without the Veteran present

Conclusions

- Intervention increased safer firearm storage practices and increases in positive attitudes towards safe firearm storage in Veterans and CSOs
- Intervention is acceptable and feasible.
- Veteran and CSO attitudes toward safe storage conflicted, intervention was able to increase communication

Next Steps

- Funded by VA OMHSP
- Additional pilot data are being gathered to assess the feasibility and acceptability of the intervention in an addition 30 Veteran-CSO dyads.

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“Keep it short and simple”: The development of a brief, motivational interviewing-based firearm storage intervention for primary care

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Disclosures

- Views expressed in this presentation are my own and do not represent the official policy or position of the U.S. Department of Veterans Affairs or the U.S. government.
- Funding:
  - HSR&D Suicide Prevention Research Innovation NeTwork (SPRINT) Planning Award
  - VISN1 Career Development Award (CDA)
- No conflicts of interest

The Problem:

- Veterans are dying by suicide at alarming rates
- Firearms account for **70%** of Veteran suicides
- Nearly half of suicides happen within 10 min of initial urge

(2022 National Veteran Suicide Prevention Annual Report; Simonetti, et al., 2018)

Possible solution: Lethal Means Safety (LMS)

- LMS is evidence-based clinical intervention to reduce suicide risk
- Aims to increase time to access lethal means to ride out the urge
- Recommended clinical strategy by DoD/VHA
- Not being widely implemented

(Yip, 2012; 2022 National Veteran Suicide Prevention Annual Report; Simonetti, et al., 2022)

Possible solution: Motivational interviewing (MI)

- MI is an **evidence-based**, **patient centered** clinical approach to navigate ambivalence & promote behavior change
- It has supported **brief** interventions, including those in **primary care**
- MI is a core competency of PC providers

(Miller, 2013; Lundahl, et al., 2013)

The context: Primary Care

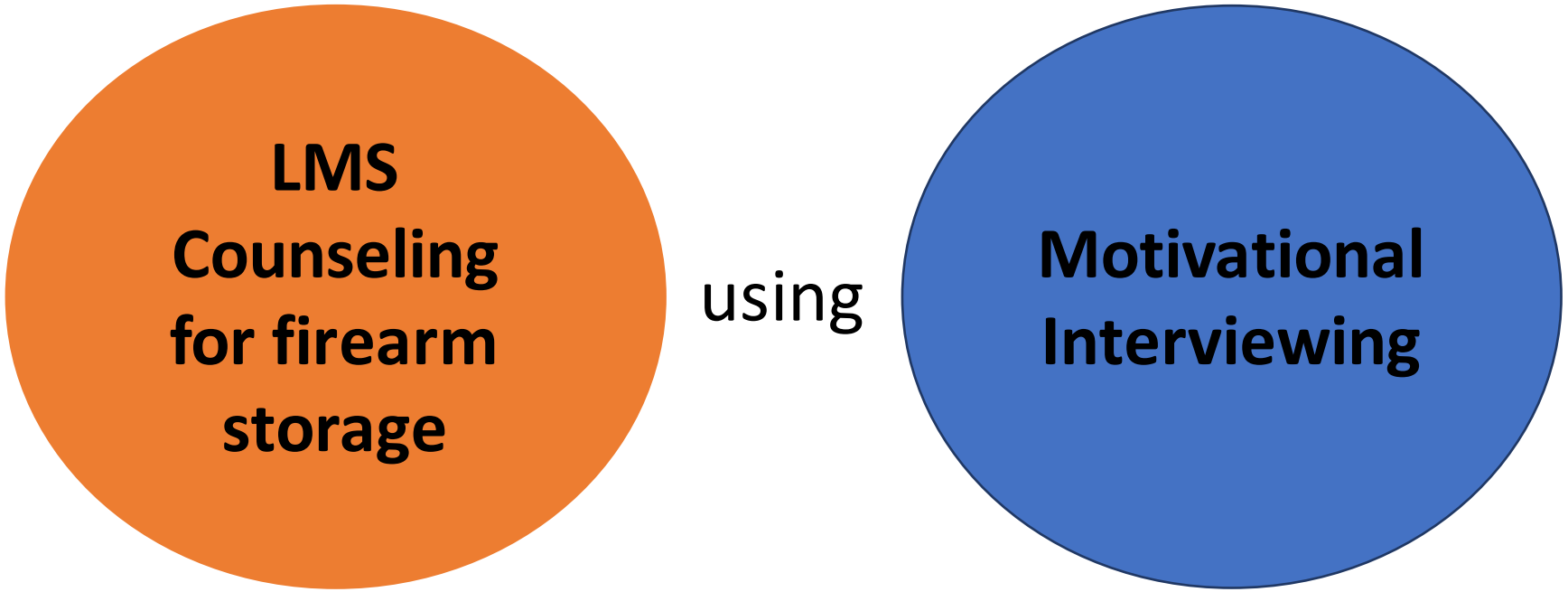
- **Primary Care** is most likely to see Veterans prior to suicide
- **BUT…there are limited resources to support Primary Care** clinicians in providing LMS

(Ahmedani, et al., 2019)

The challenge:

LMS Counseling for firearm storage

The challenge:



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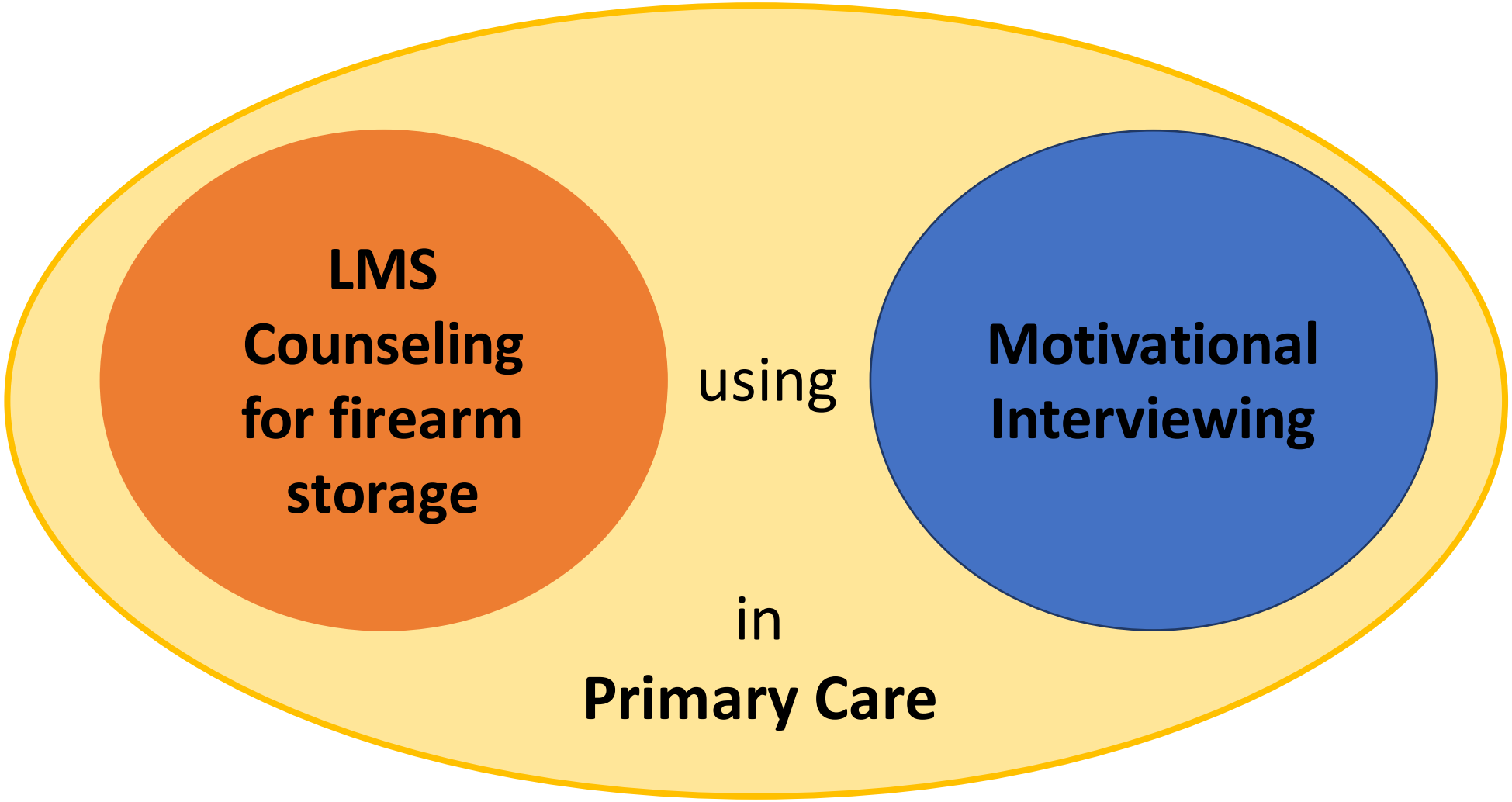

What did we hear from Primary Care?

- Interviewed 32 PC stakeholders from VA Conn, VA Maine, CRH
- Used rapid content analysis to analyze data and extract themes

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"If someone says they own a firearm…then what?"

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"I need something to help me remember."

"NOT another clinical reminder!"

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"This is important."

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"I need something to help me remember."

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Introducing RA(M)P!

- Focused on firearm storage
- Administered in ~5-8 min
- Tool guides **Assess** and **Plan**

Raise the subject

Assess current storage

(M)otivate change

Plan next steps

Raise the subject → **Assess** current firearm storage → **(M)otivate** change → **Plan** next steps

1. **Provide context** for talking about firearms and/or **explain the rationale** for lethal means safety
2. **Ask permission** to spend a few minutes talking about firearm storage

(Dobscha, et al., 2021)

Raise the subject → **Assess** current firearm storage → (M)otivate change → Plan next steps

1. **Orient Veteran to "the tool"**
2. **Assess current firearm storage**
3. **Summarize and explain rationale for LMS**

Firearm Storage Options	Less secure → → → → → → → → → More secure				
Where is it stored? (Location)	**Easily accessible** (e.g. carrying, bedside table)	**Moderately accessible or visible** (e.g. across room)	**Not easily accessible or visible** (e.g. attic, basement)	**Difficult to access, not visible** (e.g. shelf in garage cabinet)	**None in house** (e.g. given to a trusted adult)
How is it stored? (Method)	**Unsecured**	**Secured with external locking device** (e.g. gunlock)	**Secured in a locked container** (e.g. safe or lock box)	**Secured in a locked container, with an external locking device** (e.g. gunlock in lock box)	**Secured in a locked container; trusted adult is the only person with access**
What is it stored with? (Ammunition)	**Firearm loaded**	**Firearm unloaded, ammunition stored with firearm**	**Firearm unloaded, ammunition stored away from firearm**	**Firearm unloaded, ammunition locked away from firearm**	**Firearm unloaded, no ammunition in house**

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Raise the subject → **Assess** current firearm storage → **(M)otivate** change → **Plan** next steps

NOTE: If Veteran is on board, skip this step and go straight to Plan.

1. **Assess Veteran's motivations for current firearm storage**
2. **Reflect** Veteran's value

   Optional: Share information
3. **Explore other ways** to support the value while storing the firearm more securely

Raise the subject → **Assess** current firearm storage → **(M)otivate** change → **Plan** next steps

1. Invite Veteran's **ideas to improve** firearm security
2. Identify **next steps**
3. **Troubleshoot** barriers
4. **Summarize** and reinforce commitment

Firearm Storage Options

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Limitations & Challenges

- Validity of storage outcomes with respect to suicide risk
- Determining who should get intervention
- Generalizability
- Primary Care is overburdened
- Setting up for sustainable change

Next Steps:

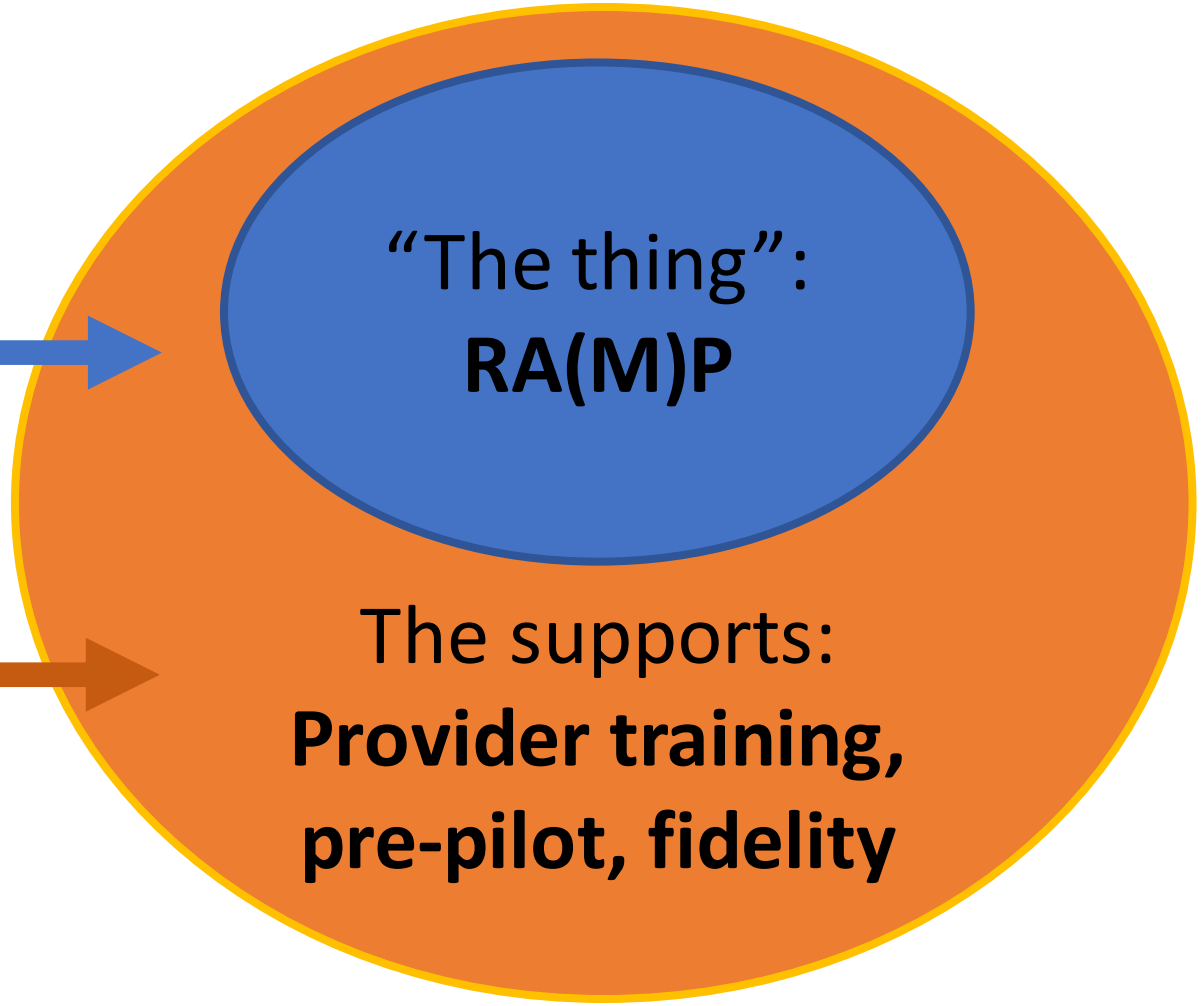
Where we've been
(SPRINT)

"The thing":
RA(M)P

Next Steps:

Where we've been
(SPRINT)

Where we are now
(VISN1 CDA)

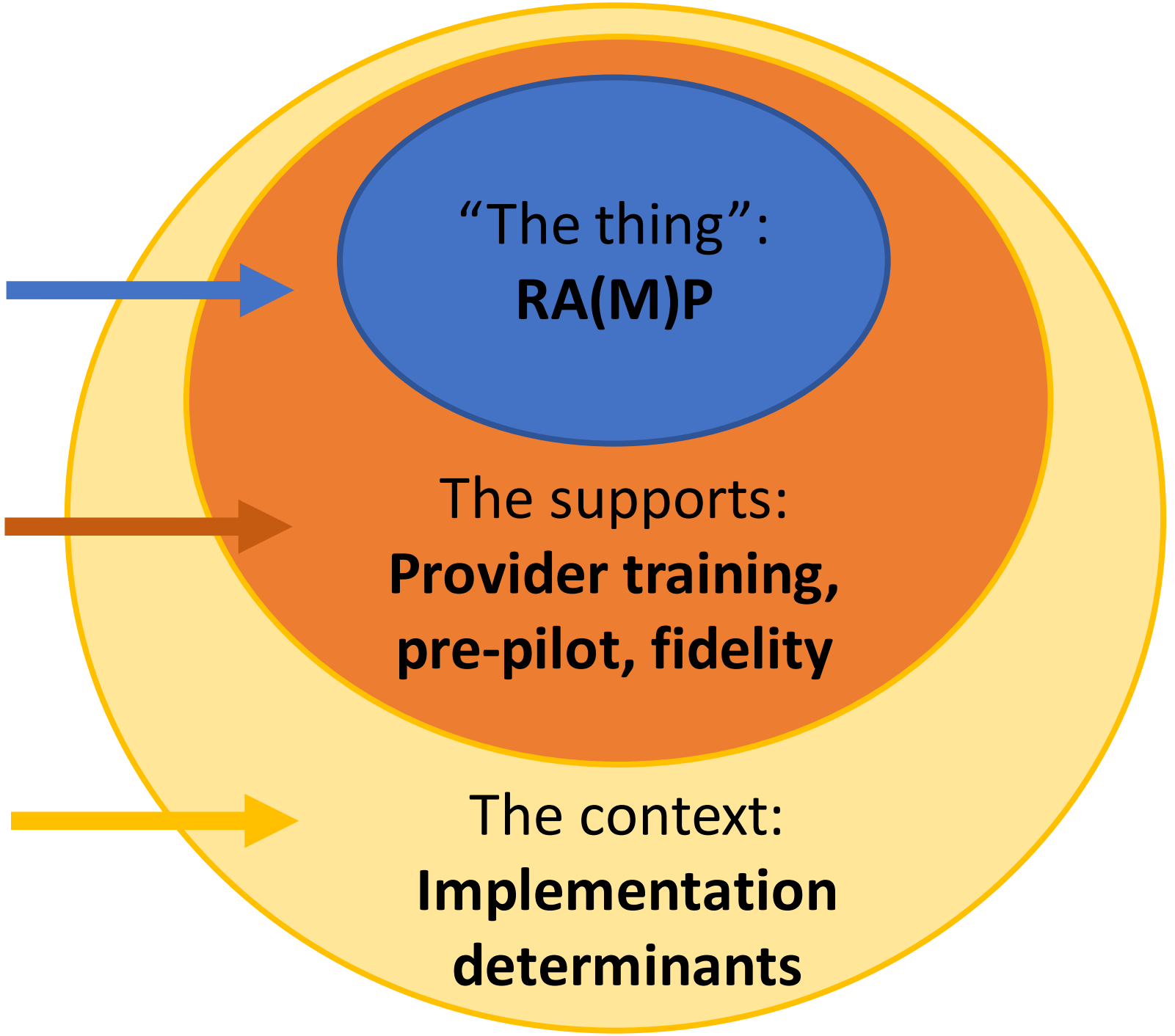


Next Steps:

Where we've been
(SPRINT)

Where we are now
(VISN1 CDA)

Where we're going
(HSR&D CDA2???)

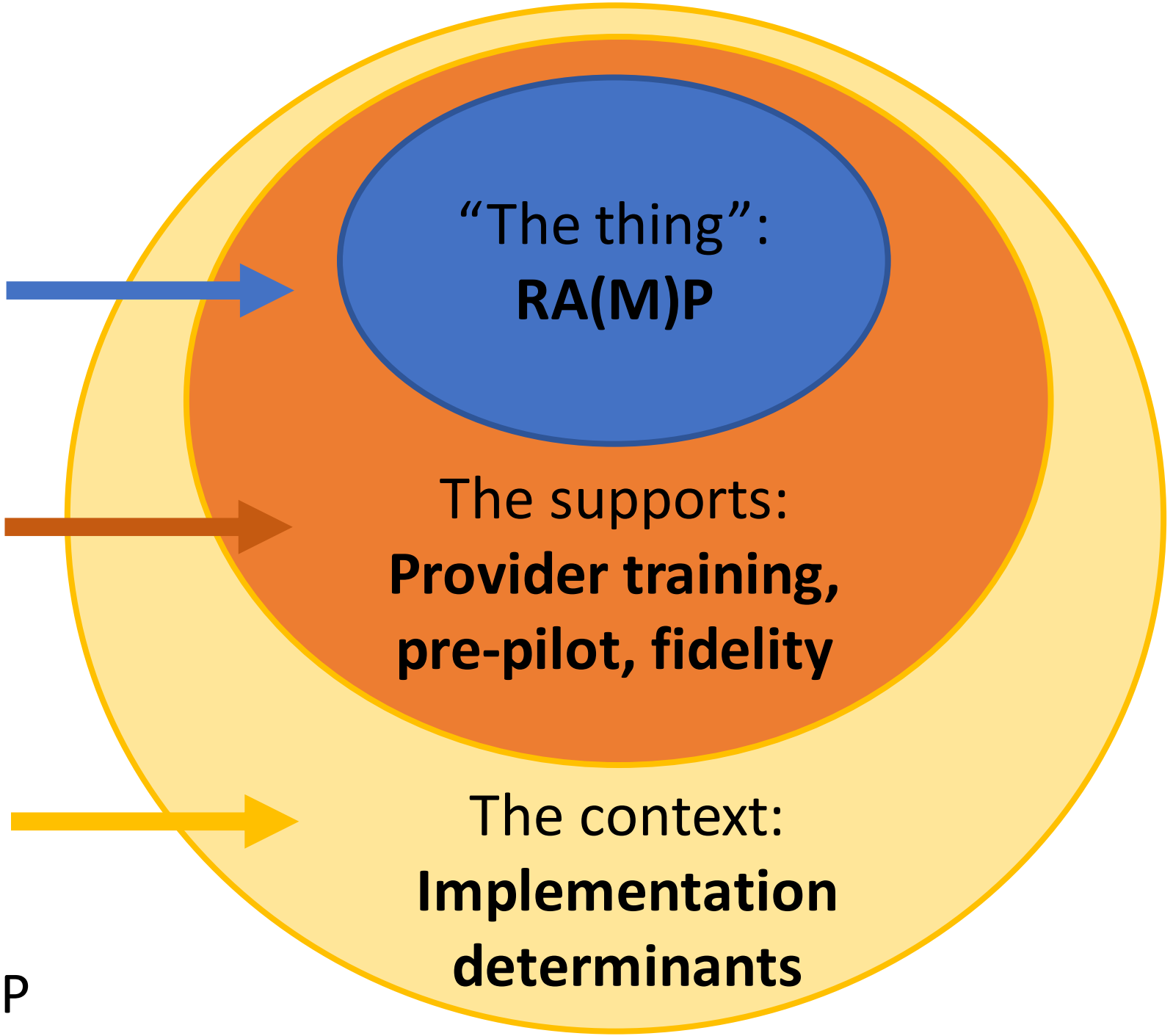


Next Steps:

Where we've been
(SPRINT)

Where we are now
(VISN1 CDA)

Where we're going
(HSR&D CDA2???)
Discussing operations collaboration with OMHSP



Thank you!

SPRINT

Suicide Prevention
Suzanne Decker, PhD
Jessie Casella, LCSW

Suicide Prevention Veteran's Engagement Group; VISN 1 Veteran Engagement Board

Motivational Interviewing
Noel Quinn, PhD
Steve Martino, PhD

PC and PCMHI
Kirsten Wilkins, MD
Jeffrey Kravetz, MD
Providers

Firearm Injury Prevention
Joe Simonetti, MD
Steve Dobscha, MD

Implementation Science
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SPRINT PLANNING AWARD CYBERSEMINAR: PROJECT LIFE FORCE- RURAL VETERANS (PLF-RV)

SUICIDE-SPECIFIC SAFETY PLANNING TELEHEALTH GROUP INTERVENTION FOR RURAL VETERANS AND VETERANS WHO DO NOT SEEK VA CARE:

PILOT IMPLEMENTATION

Marianne Goodman MD
Acting Director, VISN 2 MIRECC
Director of the James J. Peters VA Medical Center
Suicide Prevention Clinical and Research Program

Suicide Specific Evidence Based Treatment (EBTs)

10,000 foot view

Evidence Based Treatments

- Dialectical Behavior Therapy (DBT)*
- CBT-SP
- Collaborative Assessment and Management of Suicidality (CAMS)

Brief EBTs

- Safety Planning**
- Counseling About Lethal Means (CALM)*

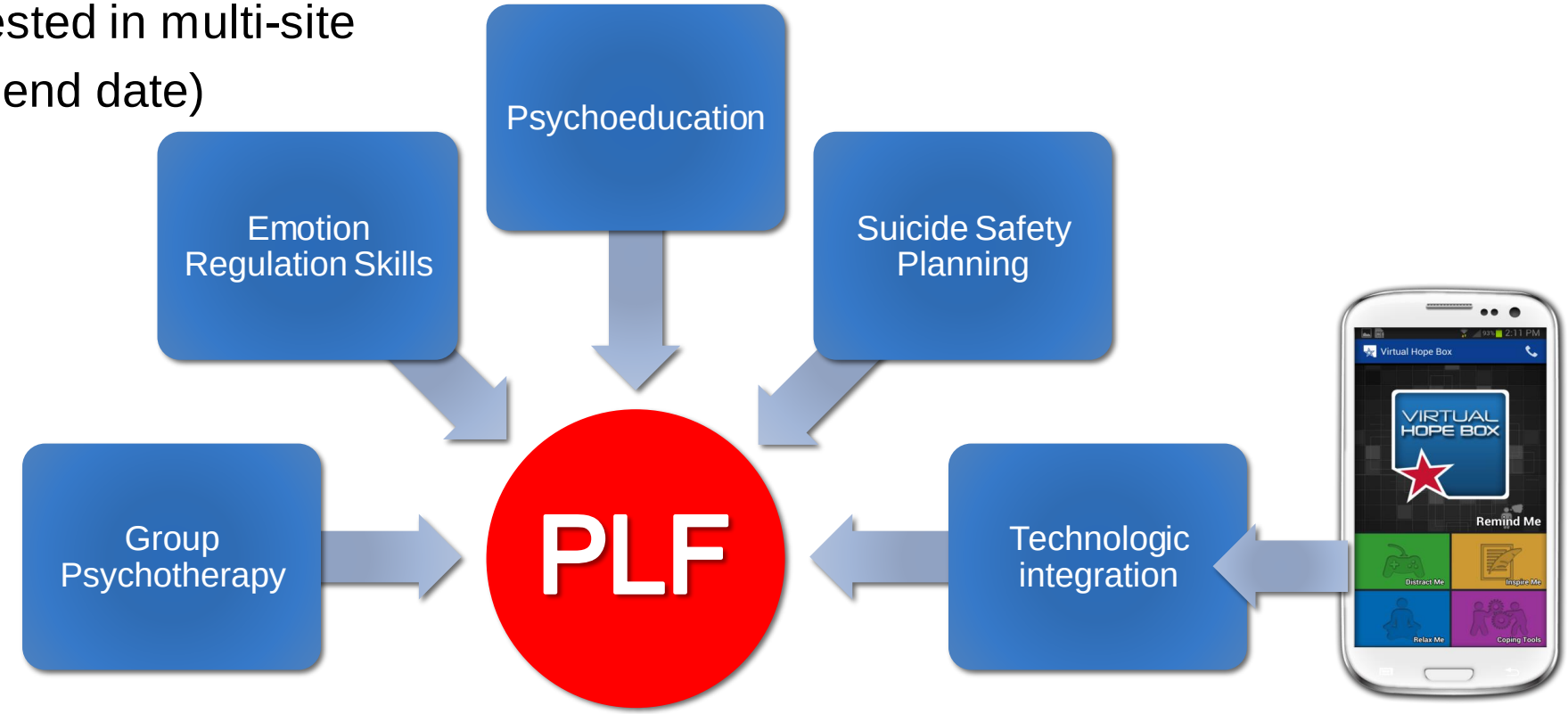
*Focus of today's presentation.

My VA Career Goal:
Add "Project Life Force" (PLF) to this list

The Intervention: Project Life Force (PLF)

- manualized, 90-minute **group therapy** for 10 sessions, lasting 3 months
- Combines **psychoeducation** and **emotion regulation skills** with **suicide safety planning** development and implementation.
- RR&D, CSRD and SPRINT funded since 2016
- Currently being tested in multi-site

  RCT (*est. 12/23 end date)



"PROJECT LIFE FORCE" Group Suicide Safety Planning & Skills Intervention

PLF Session 2: Emotion Recognition Skills

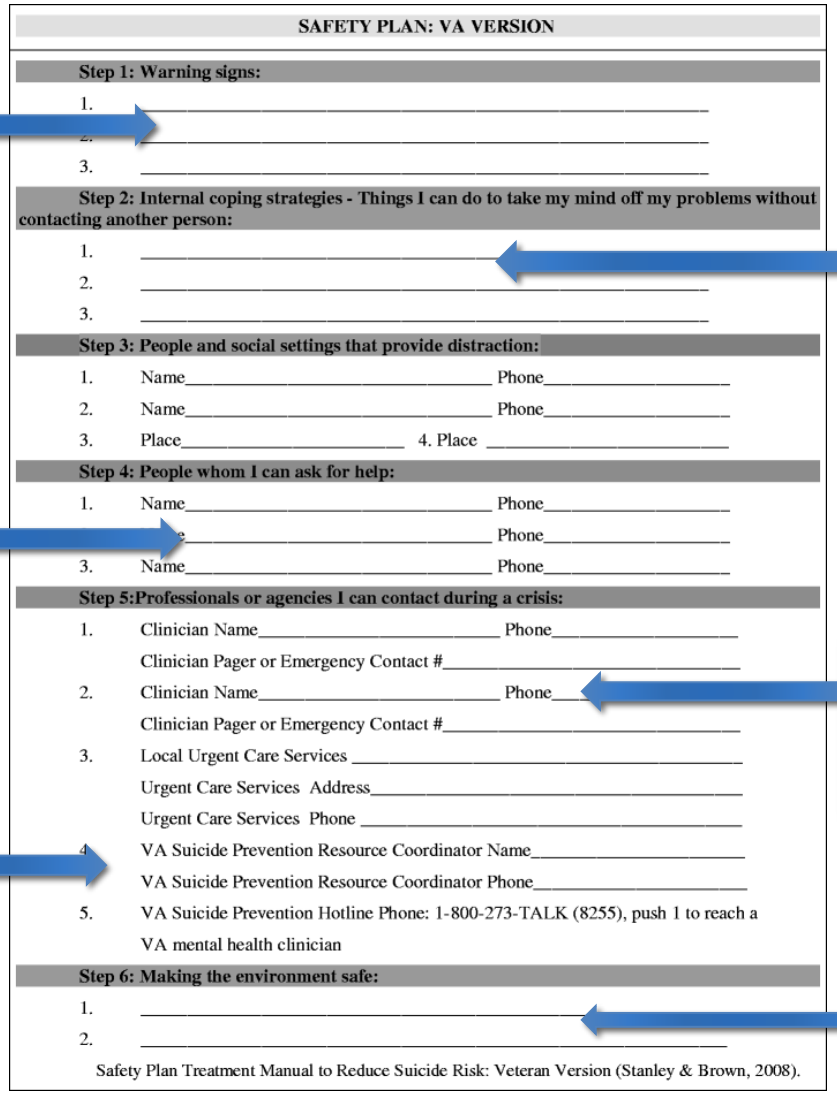
PLF Session 3: Distress Tolerance Skills

PLF Session 4 5: Interpersonal Communication Skills with Family

PLF Session 6: Interpersonal Communication Skills with Clinical Team

PLF Session 1: Crisis Prevention Services

PLF Session 7: Means Restriction



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. _____ 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. _____

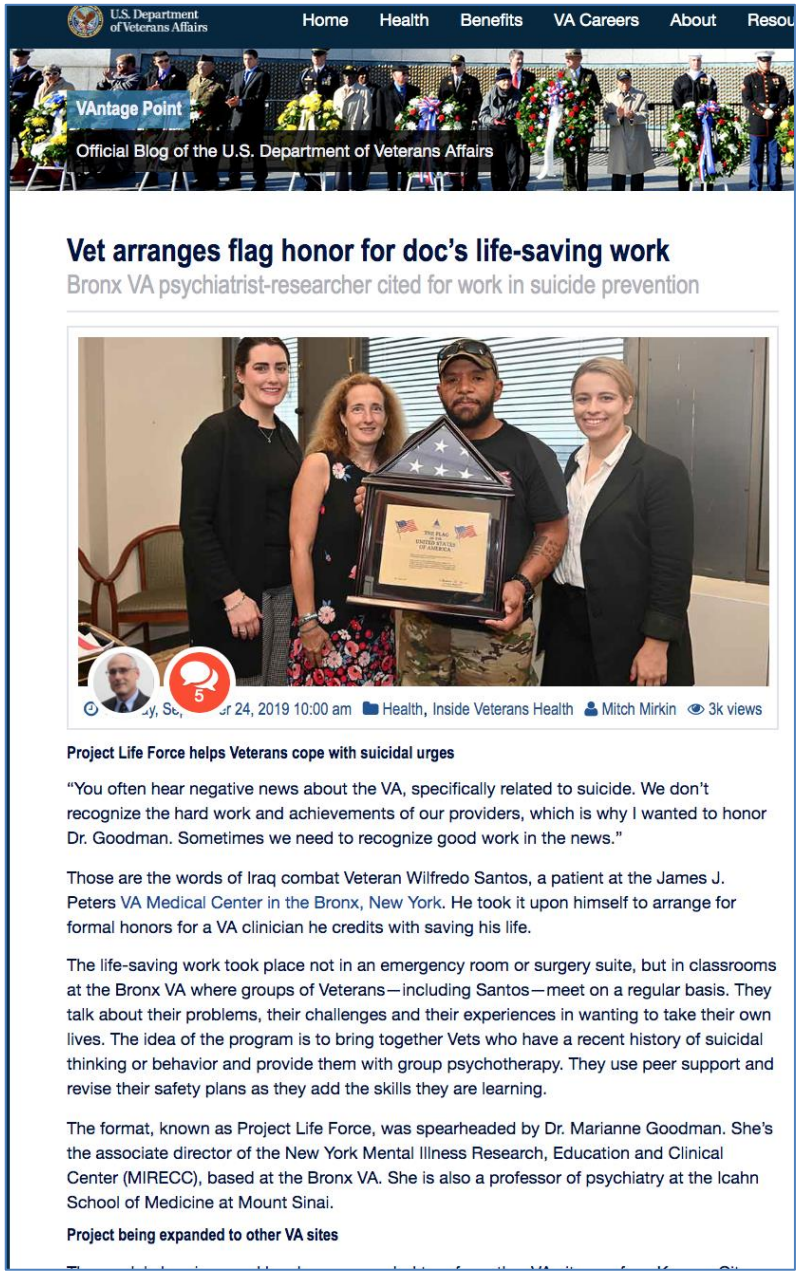
Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version (Stanley & Brown, 2008).

Project Life Force Sessions

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

	Project Life Force Session Outline	
Session	**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**
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 Positive Life**	**Building Positive Emotion**
10	**Recap/Review**	

PLF in the News



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VAntage Point
Official Blog of the U.S. Department of Veterans Affairs

Vet arranges flag honor for doc's life-saving work

Bronx VA psychiatrist-researcher cited for work in suicide prevention

r 24, 2019 10:00 am | Health, Inside Veterans Health | Mitch Mirkin | 3k views

Project Life Force helps Veterans cope with suicidal urges

"You often hear negative news about the VA, specifically related to suicide. We don't recognize the hard work and achievements of our providers, which is why I wanted to honor Dr. Goodman. Sometimes we need to recognize good work in the news."

Those are the words of Iraq combat Veteran Wilfredo Santos, a patient at the James J. Peters VA Medical Center in the Bronx, New York. He took it upon himself to arrange for formal honors for a VA clinician he credits with saving his life.

The life-saving work took place not in an emergency room or surgery suite, but in classrooms at the Bronx VA where groups of Veterans—including Santos—meet on a regular basis. They talk about their problems, their challenges and their experiences in wanting to take their own lives. The idea of the program is to bring together Vets who have a recent history of suicidal thinking or behavior and provide them with group psychotherapy. They use peer support and revise their safety plans as they add the skills they are learning.

The format, known as Project Life Force, was spearheaded by Dr. Marianne Goodman. She's the associate director of the New York Mental Illness Research, Education and Clinical Center (MIRECC), based at the Bronx VA. She is also a professor of psychiatry at the Icahn School of Medicine at Mount Sinai.

Project being expanded to other VA sites

VA RESEARCH CURRENTS
Research News from the U.S. Department of Veterans Affairs

Jesse Brown (center) and Chris Murray (second from right) are part of a suicide-prevention group led by Drs. Marianne Goodman (third from right) and Kalpana Nidhi Kapil-Pair (left) at the Bronx VA Medical Center. *(Photo by Yang Zhao)*

They've got each other's backs

Researchers help Vets at risk of suicide build mutual support network

A video was developed by the VA Public Affairs Office in honor of **VA Research Week, May 2022**.

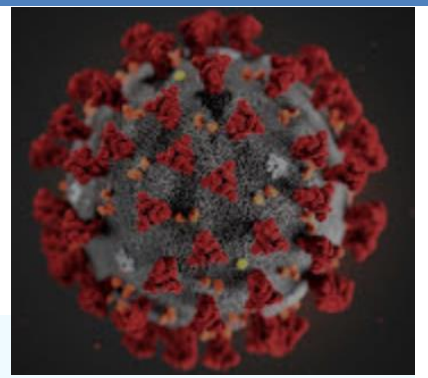
PLF is <u>one of 5</u> VA research projects that will be featured nationally.

The video captures the emotional angst of suicidal veterans and introduces PLF; a novel way to intervene that leverages "unit mentality", peer support, and learning how to ask for help while building a robust safety plan.

vimeolink: https://vimeo.com/user35552848/review/689851330/0d75920567

PLF-Telehealth

*Adaptation due to COVID-19



- Study was never placed on hold!
- All study procedures moved online
- PLF suicide safety planning groups all now conducted over telehealth (n=>150 to date)
  - Philadelphia and Bronx Veterans now in the same group & co-led by Bronx and Philadelphia PLF therapists
  - This has led us to expand our recruitment to other states/sites

Project Life Force – Rural Veteran (PLF-RV):

bringing suicide "specific-treatment" to communities where its needed most

- Can we expand PLF (telehealth) outside of urban settings to rural communities?
- Can we target a region where suicide specific treatment is lacking? High gun ownership rates? High suicide rates? Limited access to mental health care? Can we engage community partners to collaborate with us?
- Funded 2022 **SPRINT** pilot to bring PLF-telehealth to rural Arkansas, (Baxter County) with assistance from co-I Angie Waliski PhD

SPRINT Planning Award: Project Life Force – Rural Veteran (PLF-RV)

- **Two specific aims** allowed us to implement and evaluate the PLF-RV project and identify strategies for expansion into other rural counties.
- **Aim 1**: Assess feasibility, acceptability, and preliminary effectiveness of PLF-RV for Baxter County Veterans
- **Aim 2**: Identify contextual factors impacting implementation of PLF-RV, using a multi-stakeholder process evaluation.

Study Barriers- Identifying Willing Community Partners

We encountered barriers with our first identified community partner: DAV-30 helped us **understand the biases** present in rural Arkansas communities:

- toward government agencies and especially the VA,
- particularly in reference to individual freedoms and gun laws when suicidal
- negative feelings pertaining to telehealth delivery,
- “outsiders” from elsewhere.

- Solution: identified an alternative community partner,
- ”We are the 22” (WAT-22). This is an organization of Veterans who provide crisis care to suicidal Veterans. They were excited to partner with us to extend their mission.

1994 - Pace Thick & Chunky Salsa - Switch Brands (NEW YORK CITY?!?!) Commercial

Watch

Results- Qualitative Interviews of Stakeholders

Qualitative Interviews of PLF-RV Community Stakeholders (n=10) how best to reach and engage Veterans in rural Arkansas that are currently disconnected from the VA.

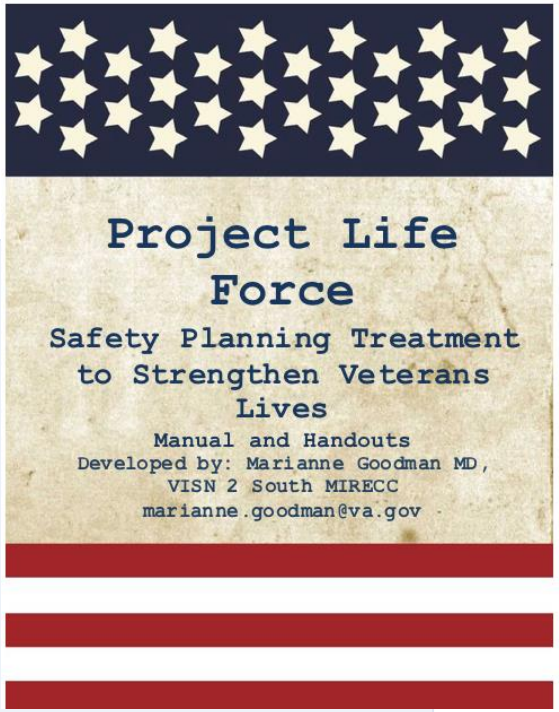
Community stakeholders emphasized:

- 1) the importance of **including Veterans in outreach efforts** to engage and introduce PLF-RV (given the local distrust with the government and especially the VA);
- 2) **involve individuals with lived experience** in the group as a local ally to facilitate program retention and connection to local community resources, often needed to survive.

Furthermore, WAT-22 group participants: viewed the PLF intervention easy to integrate as the next step after gatekeeper/crisis response visits that would offer a resource for continuous care.

- Suggestions from community stakeholders **led to the partnership with WAT-22** in the recruitment of the first PLF-RV group and ultimate participation in HSRD grant application.

PLF-RV Participant Results



SPRINT PLF-RV results:

PLF RV participants (n=3) Included current WAT-22 responders from rural Baxter county with histories of serious firearm suicide attempts (n=2) and all with current mental health concerns and recent suicidal ideation.

- Attendance was excellent, averaging 8.5 of 10 sessions.

PLF-RV participant Qualitative Interviews revealed that PLF-RV:

1) **was acceptable and easy to access** via phone or video,
2) helped participants **disclose their suicidal thoughts** and feelings knowing that others were experiencing the same,
3) facilitated learning skills (i.e. distraction and exercise) to help themselves and help other Veterans,
4) reminded one to “reboot and take a step back" in moments of crisis,
5) helped recognize the importance of storing guns safely despite being in a pro-gun culture
6) taught them to use the safety plan and share it with others.

Next Steps:

- Feedback and suggestions from community stakeholders and PLF-RV group participants informed our decision to develop a peer component to **PLF, and new intervention for rural community work: PLF – Peer enhancement (PLF-PE).**

- HSRD pilot grant was submitted to develop and test PLF-PE
- Thrilled that SPRINT investigator Paul Pfeiffer PhD joining us, along with original pilot investigators: Drs. Sapana Patel and Angie Waliski (and her Empowering Veterans Team).
- Special thanks to WAT-22 leadership for partnering with us for the SPRINT pilot and next steps

Acknowledgements:

JJPVA Suicide Research Team:

Kyra Hammerling-Potts, BS

Lakshmi Chennapragada, MA

Chana Silver, BA

Madison Strause, BA

Suicide Implementation expertise:

Sapana Patel, PhD

Little Rock VA collaborators:

Angie Waliski, PhD, Michael Knox, PhD,

Telehealth expert: Bradford Felker, MD

WAT-22 leadership: Glenn Holt, Sam Sellers

CSRD Merit: PLF Randomized Control Trial & Protocol Paper- estimated end date 12/23

CSRD funded Merit (3/18)

- Recruitment sites:

Bronx, Northport, Waco and Philadelphia VAs
Columbia University: training adherence monitoring

- Goal: 265 patients

Randomized to PLF vs. TAU, followed for 1 year (n=205 randomized to date)

- Primary outcome= suicidal behavior

Contemporary Clinical Trials Communications 17 (2020) 100520

Contents lists available at ScienceDirect

Contemporary Clinical Trials Communications

journal homepage: http://www.elsevier.com/locate/conctc

Research paper

Group ("Project Life Force") versus individual suicide safety planning: A randomized clinical trial

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ARTICLE INFO

Keywords:
Suicide
Treatment
Group
Safety plan
Depression
Veteran

ABSTRACT

One in five suicide deaths is a Veteran and in spite of enhanced suicide prevention services in the Veterans Health Administration (VHA), twenty Veterans die by suicide each day. One component of the VHA's coordinated effort to treat high-risk suicidal Veterans, and diminish suicide risk, is the use of the safety plan. The current study aims to examine a novel intervention integrating skills training and social support with safety planning for Veterans at high-risk for suicide, "Project Life Force" (PLF). A randomized clinical trial (RCT) will be conducted examining if Veterans who are at high-risk for suicide will benefit from the novel group intervention, PLF, compared to Veterans who receive treatment as usual (TAU). We plan to randomize 265 Veterans over the course of the study. The primary outcome variable is the incidence of suicidal behavior, during follow-up, established using a rigorous, multi-method assessment. Secondary outcomes include depression, hopelessness, suicide coping and treatment utilization. Exploratory analyses include safety plan quality and belongingness for those in both arms as well as group cohesion for those in the PLF intervention. Strengths and limitations of this protocol are discussed.

1. Introduction

In the United States, Veterans have a significantly higher suicide risk relative to the general population [1]. Veterans account for about 20% of suicide deaths and, despite the Veterans Health Administration's (VHA) provision of enhanced suicide prevention services, an estimated 20 Veterans die by suicide each day [2]. This highlights an urgent need to develop additional, empirically validated, interventions for suicidal Veterans.

One component of the VHA's efforts to diminish suicide risk is the Safety Planning Intervention (SPI) [3]. Considered best practice, the SPI is developed collaboratively with the patient and therapist and involves identification of: personal warning signs of suicide; internal coping strategies; social contacts or settings offering support and distraction from suicidal thoughts; contact information for VHA professionals, the crisis line and emergency services; and specific steps for how to make the immediate environment safer [3]. The patient takes the safety plan home for their use during a suicidal crisis. Safety planning is based on the idea that suicide risk fluctuates over time, aims to prevent suicidal crises from escalating, as well as presenting individuals from acting on their suicidal urges [3].

Stanley and colleagues (2018) recently administered the SPI in emergency departments to Veterans with suicidal behavior [4]. Participants who completed the SPI, and received at least two structured follow-up phone calls, were half as likely to exhibit suicidal behavior [4]. They were also more than twice as likely to attend at least one mental health appointment than usual care [4]. Therefore, the SPI may be an efficacious intervention.

To further explore the utility of the SPI, 20 Veterans participated in semi-structured longitudinal interviews and expressed that creating the

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https://doi.org/10.1016/j.conctc.2020.100520
Received 6 May 2019; Received in revised form 20 December 2019; Accepted 4 January 2020
Available online 10 January 2020