Mark Hilton: Welcome everyone and thank you for calling in to today's suicide prevention cyber seminar. This event is presented by the VA Suicide Prevention Research Impact Network, or SPRINT where we highlight ongoing and high impact suicide prevention research in veterans. I'm Mark Hilton. I'm a psychologist and research group scientist at the Ann Arbor VA Medical Center and today we're lucky to be able to hear from one of the real leaders in VA suicide prevention research, Dr. Marianne Goodman. We will be talking about her work on safety planning and lethal means safety. A little background on Dr. Goodman. She is a professor at the Icahn School of Medicine at Mount Sinai in New York City and a full time VA clinical research physician at the James J. Peters VA Medical Center in the Bronx, New York City. She is currently the Associate Director of the VISN 2 MIRECC and the James J. Peters Suicide Research Program, as well as Codirector of the Transitioning Veteran and Service Member Suicide Prevention Program.

Her clinical expertise is in the treatment of dysregulated emotion including anger, aggression, and suicidal thoughts and behaviors in veterans. Her funded research is in the novel treatment, in novel treatment development and biomarkers for suicide risk, and she previously served as the President of the North American Society of the Study of Personality Disorders. With that background, I am pleased to hand it over to Dr. Goodman.

Marianne Goodman: Well, thank you so much, Mark, and to SPRINT for inviting me to speak this morning. I am really excited to share my work in this area over the past decade. In terms of my disclosures, I want to thank the VA RR&D and CSRD for funding this research, along with the New York Health Foundation, and the resources of the VSN 2 MIRECC. I have no conflicts of interest to report and just to mention that the views or opinions expressed in this talk do not represent those of the Department of Veteran Affairs or the U.S. Government.

So, I want to start out with a 10,000-foot overview on evidence-based treatment approaches that are suicide specific. And you can see on this list, it includes DBT, CBT for suicide prevention, and a collaborative assessment in management of suicidality or CAMS for short. But it also includes some briefer evidence-based treatments including safety planning and counseling about lethal means, and these last two will be the topic of what I'm going to speak about today in this cyber seminar.

So, you all know what suicide safety planning is. It's developed by Barbara Stanley and Greg Brown. It's a best practice and mandated across the VA system for high-risk veterans and upon discharge from inpatient settings.

So, what do we know about suicide safety planning? Well, lucky for us, a comprehensive PRISMA scoping review was just published in April '21 by Ferguson, et al. It included 20 quantitative papers and six qualitative papers. They did screen 565 articles to get to those 26. Interestingly, half of them

were stand alone safety planning and the other half included another intervention in addition to the safety planning. Twenty of them were in in-person format and the other six included telephone or telehealth. Fourteen of the 26 had suicide specific outcomes and three of them included groups and that will be important for this cyber seminar. Importantly, all of the outcomes for these 26 studies did show improvements in suicide spectrum across ideation and behavior, depression and hopelessness, as well as very good acceptability and feasibility.

So, I've spent the last eight years primarily focused on building new adaptations to safety planning. I'll be talking about these through the course of this book, including group settings, telehealth delivery, and interventions, safety planning interventions that involve family. You can see the different colored arrows. Those colors will continue to propagate throughout the talk, and I will talk about PRISMAs scope and reviews first and introduce you to the project.

So, starting out with group settings, our research team has been particularly interested in group formats, especially for veterans who prefer peer interventions.

So, this is a PRISMA scope and review that our group has embarked on. We wanted to ask the question what research exists on group interventions that have specific suicide outcomes, what do we know about the efficacy of these interventions, and then also do any of these interventions use suicide safety planning. Now, it's important that we restricted this review to modalities that are only group. So, if the intervention included some individual work in addition to the group, it didn't qualify, so, something like DBT where there is individual therapy in addition. We also required that suicide be openly discussed. Again, in DBT that is, the group intervention does not encourage discussion about suicide. It needed to be part of a research trial.

So, out of 1,369 articles that were screened, we ended up with ten that we included in the review. Eight of them did include skills training. Four of them with some overlap did also include reasons for living. Five of them had aspects of safety planning in this group. They did meet weekly, anywhere from eight to 20 sessions. Unfortunately, the rigor of these trials only seven of them are open label. So, three of them were not. But importantly, all ten highlighted improvements in suicide related outcomes.

So, now I'm going to talk to you about Project Life Force. This is the group intervention that we've developed. Again, the idea here is we want to keep high risk veterans alive through a group safety planning intervention. My collaborators on this are Greg Brown and Barbara Stanley, again the creators of the VA Suicide Safety Plan, and Michael Thace who runs our Philadelphia VA site.

So, the origins of this project, I was a DBT therapist for about 13 years, running a DBT program in the VA. This was a study that was funded by the Department of Defense to look at the relationship of DBT treating suicidal veterans irrespective of diagnosis. Unfortunately, this was a negative study. Both groups improved in all the outcome measures except that individuals in the DBT arm had twice as many visits as the tau arm. So, this was a little bit of a crisis for me professional since I had banked on really continuing my pathway in DBT. So, I really came to a crossroads what I was going to do next.

Around the same time, I had developed a caseload of many of the high-risk suicidal veterans in our hospital. One of my patients actually had had a very difficult day and was walking on one of the bridges in New York contemplating jumping. And he took his hands and hit it across his chest and said, "I just can't take it anymore." When he hit his hand against his chest, he realized that there was something in his front pocket. It was a button up shirt with a pocket in the front. He had unbuttoned the pocket and lo and behold there was a piece of paper. He took it out. It happened to be a safety plan. It was the shirt he wore upon discharge from the inpatient unit where he had been discharged a couple of days previously. Had taken the safety plan, stuffed it in the pocket, and completely forgotten about it. Coincidentally was wearing the same shirt a couple of days later. Unfolded the piece of paper, looked at it, and saw that, "Oh my gosh, this is crazy. I have four children. What am I doing?" Took his phone out, starting looking at pictures of his children, walked off the bridge and called me. But this incident was the particular watershed moment for me because it made me realize that if we can make suicide safety plans relevant, personalized, and accessible, that we can save veteran lives.

So, this also became the answer for me of what my next path was going to be. So, what I ended up doing was combining the best of DBT, cherry-picking out what I thought was most important, and applying it to suicide safety plan.

But before I could do that, I needed to learn a little bit more about suicide safety plans. So, we conducted a study, this was with Debbie Cayman, a colleague of mine in the VSN MIRECC, where we interviewed 20 veterans upon the creation of a safety plan and then we interviewed them one month later. What we found was there was a wide range of use. Many of the veterans said a month later, "What safety plan?" While others were using that plan several times daily. We did learn that the importance of collaborating with the clinician on the safety plans really made for increased use, and we identified both obstacles and facilitators.

The obstacles included a lack of a social network, patients felt too depressed and too much of a burden to carry out the safety plan contents alone. Those that actually had shared the plan with significant others including family, spouses, or their therapists really found that plan much more helpful, as well as actually having that plan readily accessible. Patients were putting them on

their refrigerator, in their car, at their work. But anywhere where that safety plan could be used and were needed. Also, the more individualized the plan, the more helpful it was.

So, this is Project Life Force. It basically uses these DBT skills to stress tolerance and emotional regulation. But it applies them to particular steps of the safety plan. It introduces the use of a mobile suicide safety plan app so that that app will have their safety plan so they always have it near them. It helps, it actually help patients identify those that they can call for help. Veterans have a very hard time asking for help. So, one of the things that we do in this group is we practice role playing and asking for help. Again, the idea is to develop detailed personalized and meaningful suicide safety plans. For me, the secret juice is that it's delivered in a group context for offering peer support. What I didn't appreciate at the time when I developed this treatment was that veterans are very used to being in life and death situations with each other. So, basically little units formed, and patients were coming to the intervention. They may have been too depressed for themselves, but they were coming to make sure that their, the other people in their group were okay.

So, again, Project Life Force, it's a group that teaches skills and uses psychoeducation to develop a safety plan and make that safety plan accessible. It is manualized I think at this point. The manual is over 80 pages. It's done in ten sessions and patients come in when they need to. So, when they're coming off the inpatient unit or if they've been identified with an exacerbation by their clinician, or on the high-risk list, they come in as soon as possible and they stay for ten sessions. It, they do not have to start at the beginning. It's meant to facilitate ease of entry, as well as that mandated documentation for high-risk individuals.

So, what does this treatment look like? The first session is all about identifying crisis prevention services. We have the suicide prevention coordinator come in and speak to the group. We actually have people practice calling a crisis line and send them out some homework to make that call when they're not distressed so they can make it when they are distressed.

The second session has to do with warning signs, and we teach emotional recognition skills, and really describe the cascade that gets somebody to be suicidal.

The third session is about second step in the safety plan, internal coping strategies. Here, we teach distress tolerance skills.

The fourth and fifth session have a lot to do with people, who you can ask for help either for distraction or to actually put these people on the safety plan. Here, we spend a lot of time talking about who, the pros and cons of identifying who to put on the plan, and then practicing how to actually ask

them to be on the plan. These tend to be some of the most challenging sessions to run, but actually sometimes the most rewarding.

The sixth session has to do with the clinician and the team and making sure that that clinical team, the relationship is as strong as possible, talk about any obstacles that might be there, talk about medication compliance, and we actually send these patients out with for homework to have their primary clinicians sign off on the safety plan as it has been developed.

Then the seven is the last step of the safety plan, which is making the environment safe, all about means restriction and lethal means safety.

In addition, we've added a couple additional sessions outside of the safety plan. One is we download the ritual hope box, and we go over all the other apps that are available within the VA. We particularly like the ritual hope box because patients can take pictures of their safety plan and actually upload those onto the virtual hope box. There also are some nice distress tolerance and meditation tapes that they can listen to as well.

We have a session looking at physical health management and the relationship between pain and sleep, diet and exercise, and keeping as healthy a mind as possible.

My favorite session is the ninth session, which is really about identifying reasons for living. We talk about the very small things in life that bring joy, that veterans actually compile a list during that session and then staple that on the back of their safety plan.

Then the tenth session is basically a recap and review where they go over the entire safety plan in a group together, sharing what the changes they've made together and what's worked and what's been particularly helpful.

So, we were lucky to be funded by a Spire grant from R&D where we had 45 veterans come through our pilot where we developed and really finalized the manual. A very nice satisfaction and feasibility: less than 20 percent didn't finish the treatment and every single patient that participated did update their safety plan and use it in a more frequent basis. We also had some very nice preliminary outcome measures, suicidal symptoms, depression, and hopeless, very nice decrements in this open label trial.

We did have, receive some nice press about the Project Life Force. We were featured in the VA Research Currents. But the honor that I'm most proud about is one of the patients who felt that the PLF intervention saved his life, called up his local congressman to say that he felt the VA doctors were not getting enough recognition. The local congressman contacted somebody at the Capitol Building. On June 17, 2018, a flag was flown over the U.S. Capitol and dedicated to the Project Life Force intervention. The flag was then sent back to the patient, and he actually presented the flag to me in this

wonderful ceremony and that flag now sits in my office. That to me, is the highest honor that I can receive. But I think it does speak to the power of this intervention.

We, now, have been funded by CSRD in March 2018. Three sites, Bronx and Philadelphia, VA are our recruitment sites, and Columbia University is our training and adherence site. We are, our goal is to recruit 265 patients into this trial where we randomize to either the group, which is Project Life Force or the individual suicide safety planning. This is the contemporary clinical trials, communications, our protocol paper. What we're really happy about this project is that our primary outcome is suicidal behavior. We are three and a half years into the trial.

So far, we've recruited 185 patients into the trial and what I want to tell you about now is of the 140 PLF group sessions that have been run between both sites, of those, over 60, so almost half were virtual groups. With COVID-19, we were able to quickly pivot to a telehealth version of this high-risk suicide safety group. I will be telling you about that to you shortly. We also were able to move all of our research methods so that we can conduct them remotely. We now can _____ [00:18:02] remotely and all of our assessments don't require in person people.

Okay, so let me now shift a little bit to the telehealth delivery, the suicide safety planning. Even prior to the COVID-19 pandemic, there were several barriers that made in person care difficult and these included inflexible work schedules, travel costs, and certainly at our hospital parking is a nightmare, health issues, caregiving responsibilities, and physical disabilities. Now, these barriers are especially prevalent not just in Bronx, patients in an urban setting, but particularly in rural areas where individuals have elevated risk of suicide, but also have the least access to care.

So, again, our research team conducted a telehealth and suicide specific care PRISMA scope and review. This time we asked the question what research exists on full telehealth clinical interventions with suicide specific outcomes. Again, we conducted this during the pandemic. So we were, since we were unable to see patients in person, we really wanted to know what was out there that was fully telehealth. What do we know about the efficacy of these interventions and do any of these interventions that are using telehealth use safety planning?

So, we were able to identify 212 full text articles and ended up with nine that met our inclusion criteria. Interesting, these evidence-based treatments that I talked about earlier in the cyber seminar, delivered via telehealth do not have empirical support yet. So, these nine studies that came up, none of them are evidenced based treatments at this point. Seven of the nine telehealth studies were follow-up interventions that were targeting patients for discharge from the emergency room, and they were mostly telephone and they ranged from five minutes to 40 minutes with an average about 22 minutes. Now, I do want

to give the caveat that because this was really conducted this PRISM review during the pandemic. It doesn't really capture the conversion that's been prompted by the pandemic. So, future scope and reviews will obviously have more. This really gives you the state of feel prior to the pandemic. Continuing with the results, two of the studies incorporated lethal means counseling and one of the studies did involve suicide safety planning.

Okay, so I'm going to say a little bit more about our Project Life Force Telehealth. So, now we're talking about PLFT. I want to just acknowledge the work of Shari Jager-Hyman who is my co-therapist in the PLF intervention, Sapana Patel who is going to be helping us with a qualitative study, Rebecca Rezeborsky and Sara Landis who will be helping us with an economic study, the difference between telehealth and in person group treatments for suicide.

So, we began teleworking in March 2020. Our first telehealth group was March 18, 2020. We were very able to quickly pivot, as I mentioned. At this point, we have over 60 of these telehealth group PLF sessions to date. We have learned a lot during the past year of giving these groups via telehealth. One of the most important things is that we now have a communications coordinator. So, one of our RAs is specifically tasked with making sure that everybody has the link to these group sessions, helps them get on to the group session either by telephone or patches them in. If they fall off for some reason, she is on the phone calling them to find out, but it does really require the resources of somebody to help really with this coordination piece.

Now, we tried multiple platforms. We started out with VVC. We quickly had to disband that because so many of our veterans and I would be curious to hear if this is the case elsewhere across the country, but so many of them do not have either a computer or internet access that's reliable and they're calling in by telephone. So, I would say anywhere between a half to two thirds of our group members are calling in by the phone. And VVC did not allow phone and video at the same time where WebEx does. So, this is the platform that we've been using with some success. It's been very helpful. We show the manual on the share screen. So, the patients are also emailed them and mailed the manuals, but we can also show them on the screen. We also pull up individual safety plans to make the edits to the safety plan on our share screen.

As I mentioned, we've learned a lot about how to address the barriers, particularly the issues with connectivity, but also noise and privacy. We had patients who have dialed in while on a subway, on a bus, driving their car, in a crowded room with other people. So, we really had to stress over and over again the importance kind of muting yourself and also making sure that the room is private without other individuals especially for group because you want to maintain the privacy of the other group members as well.

The assessment and management of high-risk behavior, this is still a work in progress. We used to with in person groups deliver a piece of paper that we took our CSSRS screening with several questions so we can quickly assess the suicide risk of anybody at the beginning of the group. How to do this over a virtual format has become quite a challenge because we tried actually texting people, emailing people, having them go into side rooms, stopping the group in the beginning to ask these questions, and without taking you know, 23 minutes of the group. It's still a work in progress. So, this might be, if anyone in the audience has any suggestions of what they might have been doing, if they are doing something similar, we would love to hear. As it stands right now, we're hoping people can, they know what the four questions are, and we're hoping that they can either text us or tell us upon entering the group each session. But we would love it if there are any other ideas out there.

We're also working with the VA to obtain tablets for group members who don't have smart phones. But I do want to stress that despite all these obstacles, we have been able to combine the group across the Philadelphia and New York sites, which is now making for robust numbers of veterans in the group. The really wonderful thing is that now it allows veterans who are traveling or who had to relocate because of the pandemic, they can still stay part of this group.

The other thing that's been really helpful for us is it's allowing us to expand our recruitment for this study beyond the initial Philadelphia and Bronx sites. We're trying to bring on North Port. The beautiful thing is they will also be joining the same group. So, it really does allow for a much wider net for requirements. This is something to be thinking about for future studies as well.

So, we do have the data from the first nine telehealth PLF completers. This is acceptability, appropriateness, and feasibility, which is comprised of four items on a scale from one to five. The total can be anywhere from four to 20. You can see based on these first initial completers that the scores are pretty good for feasibility and appropriateness. So, we're continuing to gather this data. We absolutely want to learn more. Initial people started out with half in person and half telehealth. Obviously, now the veterans who are coming through are 100 percent telehealth, but we really want to understand what the veterans' perspective is as we move to these telehealth directions.

This is a very basic slide, but it's really just to tell you that we are now embarking on qualitative interviews for PLF group participants who underwent the telehealth version. We will be getting a lot of information to be sharing. We are making a big effort to capture those people who didn't like format and to try to understand ways to move this forward.

I also mentioned that we will be, we received a supplement to also do an economic analysis of the in person versus the telehealth. So, hopefully, we will have those results in the next six months or so.

Okay, moving now to involving family. There is a lot of rationale to include family. We know that family systems on suicide prevention is a largely unstudied phenomenon. We know that families, in addition to being a risk factor for suicide, can also be protective through cohesion and connection and positive emotional support. And a review of clinical intervention was done by _____ [00:28:09] back 20 years ago or so. Did conclude that family is a promising target for suicide interventions.

Okay, so moving now to our PRISMA scope and review. We asked the question what research currently exists for family treatments for individuals at risk for suicide. What is the efficacy of the interventions and again do any of these family interventions involve safety planning? I just want to specify that when we talked about family treatments, we were only considering treatments for both the suicidal individual and the family member who came together to see the treatment provider. So, treatments where the family is just seeing the person separately from the suicidal individual were not included in this review.

So, out of the 180 articles reviewed, we were able to identify ten interventions that involve families with suicide specific care. Forty percent of these employed some type of cognitive behavioral therapy. Another 20 percent used attachment-based family therapy. Twenty percent used family-based crisis intervention and the other 20 percent were distinct from one another.

Interestingly, 90 percent, so almost all of the studies in family pertained to treating children, adolescents at risk for suicide, and only one targeted adult across the lifespan. So, the current state of the field is there are no sibling specific interventions. There is no family-based treatment for geriatric populations. And most of the family members that were targeted in these treatments obviously were parents or guardians with their children and adolescents. So, clearly a very large gap if you're an adult researcher wanting to do family work in this area.

So, where does the safety plan fit in? Although safety planning was integrated into some of the studies, none of the exclusively focused on a safety plan or the crisis response plan. And none of the studies specifically reviewed how family members could be involved in restricting access to lethal means, two factors that our groups is particularly enamored with.

Okay, so this intervention, it's called Safe Actions for Families to Encourage Recovery or SAFER, referring to the safer intervention for the rest of this talk. And this is a pilot RCT which we were funded by RR&D for. Really want to thank Deb Cresta, who really was instrumental in the data analysis of

this trial; Shirley, Glen, and Barbara Stanley who were consultants; and Deborah Perlick, who helped me design the therapy, as well as the initial client submission.

So, in order to develop this treatment, we conducted some qualitative interviews, 26 veterans and 19 family members. We wanted to understand the perspectives on you know, how do you involve family in veteran suicide prevention efforts, what's the family know, what do they need. In interviewing the veterans, four things really kind of emerged. One is a deep sense of isolation. They had a big family, but it's like "I have no one." Shame, deep down, part of it is shame, and really one of the big obstacles for being able to disclose. A sense of burdensomeness, "I felt like a burden. I wanted to reach out, but I didn't." And a deep sense of mistrust that family members will just flip or won't understand if they disclose some of their suicidal symptoms.

Likewise, family themes emerged. Families really identified an inability to stop their loved ones from hurting themselves. For instance, "It's hard for me to find out things that's going on with him. He keeps to himself a lot." They were very worried that if they asked questions that they would somehow trigger suicidal urges. "I just never know how he will react." They felt unsupported and very overwhelmed. "I just don't know what to do."

So, kind of in summary, veterans felt alone and afraid to reach out to family members and family members likewise didn't know how to support or react to their veteran's suicidal symptoms. These themes formed the basis for our SAFER intervention.

So, basically what we decided to do was to have a protocol that encourages discussion about suicidal symptoms and how to cope with them and doing this to the development of the veteran in a complementary family member safety plan. I'll show you that in the next slide. We use psychoeducation. We want to facilitate disclosure and really emphasize communication skills. So, basically patients and their loved ones come in separately for a joining session where we go over what the expectations are, kind of review the goals of the treatment, identify any obstacles, and really do some motivational interviewing, so we're all on the same page. Then there are four sessions where the family member and the veteran meet together to build this complementary veteran and supportive partner safety plan.

And this is what it looks like. On one side is your typical veteran plan, steps that we've all talked about. And on the other side is the, in blue, is the family member safety plan. So, just to give you an example, step one, the veteran will talk about his warning signs and the family member's step one is recognizing the warning signs in their loved one. So, if isolation and turning your phone off are some of the warning signs, you're teaching the family member what to look for in the veteran's warning signs.

Similarly, step two is using internal coping strategies and here, step two for the family member is coaching the veteran on what coping strategies to be used. So, they're constructed together. They're complementary, and they're really meant to facilitate the family member helping the veteran use that safety plan to make it as effective as possible.

So, the study included 39 veteran and support dyads. We spent a lot of time trying to figure out what the correct word would be. They're not all family members. So, just to break it down, 14 of them were romantic partners or spouses. Thirteen of them were other family members, so either a parent or a child over 18. But also, 12 of them were very close friends. So, again, it's this idea of a supportive partner. The veterans themselves were moderate risk veterans, veterans who had ideation within the last month or a lifetime suicide attempt.

Okay, and the design of the study was there were assessments done at baseline, post treatment, and three-month follow-up. Individuals were randomized either to the SAFER intervention which involved the family, or individual safety plan, which is what is current treatment. It's where the veteran would meet with one of our research staff and construct an individual safety plan.

Now, the hypotheses were we believed that the SAFER intervention would decrease ideation in the SAFER arm; that mutual coping, suicide coping and coping support for the family members would be improved in the SAFER arm. But that also those interpersonal cognitions, what I was referring to before that we came up in our qualitative study, the feeling like a burden, feeling isolated, caregivers feeling overwhelmed and burdened, we wanted to see whether the SAFER intervention would target these interpersonal cognitions greater than the individual safety plan.

So, just to kind of go over the results, here, we are comparing SAFER, which includes the family member, compared again to safety planning individually, which is what we're currently doing. The severity scale, the CSSRS, four and five include some level of intent; greater than three denotes some level of planning; and one to two are lower-level ideation. What you can see here is that veterans in the SAFER arm are showing decreases in the severity of their ideation, not zero ideation, but a decrease. This, we thought, was very, very exciting.

Moving now to this suicide related coping, here you can see what the veterans are doing to cope with their suicidal crises. Really, it is pretty much the same. In the SAFER, there are some slight improvements in the later assessment waves, but it's not a significant increase.

However, when we look at the partners here, we can see some action. So, again in the SAFER arm, there is increased confidence in coping. It slightly increases, but again, it's not significant. But what you can see in the

individual safety plan where the family members are not included, the family members would each time check in are less confident in their ability to help their loved ones. Unfortunately, we didn't see any changes in interpersonal cognitions, which was disappointing, but actually we did feel that the results were encouraging.

So, kind of in summary, what we're seeing is that keeping and bringing the family to the table, we actually do see decreases in veteran suicidal ideation. We don't need real shifts in interpersonal cognitions for change. So, again, just to kind of state that again, simply having family members come to the table to help their veterans, giving them skills and ideas what to do may be enough to move the needle for helping veteran suicide prevention.

Now, I just want to kind of make some caveats. The arms weren't matched for treatment dosage. The SAFER was four sessions with the induvial where the individual safety plan was one session. Again, these were moderate suicide risk veterans. We don't know what this intervention is like for more acute risk. We did have attrition challenges of the small end study. Really some obstacles in recruiting family members who are taking in this treatment. We weren't able to examine moderators, the gender, the suicide status of the veteran, nor the status of the partners. We are interested in seeing what a telehealth delivery of this intervention might look like. This will be our future next steps.

I just wanted to move now to another family related project, just to kind of keep it in this theme of families. We know that the VA has been very involved in lethal means safety initiatives, and these have included free firearm cable locks, and free firearm safe storage kits, as well as the Together with Veterans community intervention which is going to be rolled out as part of Suicide Prevention 2.0 efforts. If you think back on that very first slide where I showed you that evidence-based practices, one of them was CALM and CALM stands for Counseling on Access to Lethal Means. What we do know is that CALM training, so teaching providers about how to counsel others on limiting access to lethal means is very helpful. CALM training research has been conducted upon mental health providers, emerging, sorry, emergency department personnel, case managers working in geriatric care settings, and residence hall administrators in college. So, there is gaining evidence base about the utility of doing these kinds of interventions.

However, there haven't been any CALM interventions that are specifically targeted to family members. So, we are pretty excited about that. So, in collaboration with New York State Governor's Challenge Team, which I am part of, we are working with Stephanie Gambol and Rob Lane on that team, as well some people from the New York State Suicide Prevention Office, Garra Lloyd-Lester, but also Elaine Frank and Cathy Barber. They are the creators of the CALM training. They're helping us adapt this training for family members. And we're now funded by the New York Health Foundation to move this project forward.

Basically, in order to best understand what family members, need, we conducted 23 interviews. There were done in three different groups. One group was family members of veterans who, unfortunately, died by suicide with a firearm. Another group is family members of veterans where the veteran attempted suicide using a firearm. And the third group were family members who live with a veteran who have firearms in their homes. We wanted to learn what did they need, what did they know. And it's clear that they knew a lot. We were really trying to find family members who have successfully navigated safe storage with discussions with family members and they are few and far between. So, we also learned that they don't want a training in the sense of the training we go through for all our webinar and interactive trainings. Instead, they wanted to hear personalized stories of other family members who have had to grabble with similar kinds of problems and had workable solutions. So, that's what we are doing. We are writing scripts for five different scenarios involving family members. We have our design team and we've got the videographer hired. We are looking to spend the summer developing this interactive website.

I just want to let people know that this website, while it's going to be New York based and have some of the laws, storage laws around New York, we are building this interactive site so that it can be easily tweaked for other states. So, if there are people who are on different governor's challenge teams and on a subgroup working on lethal means, please reach out to us. This is going to be a resource that we want to be available nationwide.

Okay, so just to recap, really talked about various different directions, where our suicide safety planning is, group adaptations, telehealth adaptations, and adaptations that involve involving family.

I could not do this work without the help of so many talented and dedicated people. I just want to thank the individuals I worked with at the Bronx VA and VISN 2 MIRECC, several of my RAs and post docs. I want to point out Stefanie Campbell and Deb Cresta at the Center of Excellence. And the collaborating sites for the Project Life Force merit, Maureen Monahan, Michelle Gordan, and Caroline Meyer. Please, I also mentioned all of the coinvestigators earlier in the talk. So, just it's a big team. It takes a village and happy to be part of this village. Stop there and answer questions.

Moderator: Fantastic, thank you so much Marianne. We do have several pending questions here, so I'm just going to start working through those. The first question we have here: what distress tolerance skills do you teach in session three?

Marianne Goodman: So, I, because as I mentioned, I spent many, many, many years doing DBT, the stress tolerance. So, we really kind of pick up many of those. So, we teach literally distraction and self-soothing and crisis management. So, we actually have the patients tell us what they do for distraction, tell us. And we literally

give examples, and we share within the group. Then we actually send them out to actually try different, different skills that they've learned about from the others in the group.

The self-soothing is actually hard for a lot of veterans. The self-soothing often has been done through alcohol and drugs. We try to, we try to really talk about healthy self-soothing, so meditation, relaxation. Here we will bring in some of the resources that are available and some of the mobile apps as well.

Moderator: Great, thank you. The next question here: as a member of my state's governor's project, we've been discussing that safety planning is not necessarily done with fidelity from clinician tactician. Can you talk to how you address efficacy and fidelity of safety planning? Is there a specific training that VA or SMVF clinicians should complete in order to ensure that they are creating quality safety plans with their clients, perhaps it is CAMS.

Marianne Goodman: So, whoever asked that question, you are right on target. I think the quality of the safety plans makes a tremendous difference. Part of our program, our research project is we are grading safety plans, because I do think sometimes, they are filled out very, very quickly. Sometimes you have clinicians that spend 20, 30 minutes on them. This group, they spend close to nine and a half hours building a safety plan. So, obviously the more you put into it, the more you are going to get out. So really, the quality does make a difference. Greg Brown is helping us with the grading. There are publications on, I think it's Garra has one, but Greg also has another one for the actual how do you go through and look at them and score how each step is filled out.

There are trainings. I know that as a VA clinician, we do have to, we do have to attend safety planning online trainings and there is that available as well.

I do think that the more we, when we talk to different providers about safety planning, they just felt it was just another requirement that they had to do to check the box. I think if we can really instill in providers that this can be a lifesaving. It's really valuable. It's evidence based. And have the patients speak about the power of the safety planning, I think clinicians will be more motivated to do justice to the intervention.

I will say what makes the group intervention with safety planning so helpful is that often patients don't have a lot of skills. So, they don't know what coping strategies that they want to employ when they're feeling overwhelmed. So, by teaching them those skills that they can then use on the safety plan, I think the marriage of trying DBT emotional regulation skills, distress tolerance skills, with safety planning is sort of where the money is.

Moderator: Great, thank you. The next question here: is the PLF manual available for ordering? This would be a very helpful resource to incorporate at _____ [00:48:54]

Marianne Goodman: So, thank you for that question. So, when I presented that Project Life Force in previous conferences, normally people would come up to me afterwards and ask me for the manual because I think it really speaks to clinicians. Because it's manualized, it's fun to run. The patients do a lot of the work so the clinician just kind of has to steer the direction of things. It's a little bit more challenging because the telehealth because you have got to monitor all the different facets. But because I have to prove its efficiency, which is why we are involved in this CSRD merit right now, once I can prove that it's more effective than treatment as usual, then I think we can move to the dissemination and publication phase. But in order to kind of get ready for that phase , I am having, if there are individual sites that want to sort of see what this is like so we can kind of learn a little bit ahead of time, it's one thing to come, one thing that comes out of my hospital, but it's something different when it's not in the creator's environment. So, we are looking for partners to kind of team up with. So please, here is my email. Please reach out to me. We can think about this, or you know, it had different people from inpatient units say they want to adapt this for the patients who are hospitalized. I would love to kind of talk and see where other people think this could go. Open for future collaborations.

Moderator: Great, thank you. Next question here: Since Barbara Stanley participated in this research project, do you think that creating safety plans with family or significant support person will become the standard for individuals who are not veterans? Is this going to become a best practice?

Marianne Goodman: So, you know, we were very excited. It was a pilot study, so it's a small. While it was randomized clinical trial, it's still 39 so it's really considered on the small side. I think, what I didn't tell you is it took us 350 people that we had to approach in order to get the 39 veterans to participate. This is a very hard treatment. Veterans don't want to include their family. Family members don't want to be bothered and burdened anymore. I think that family interventions are an important part of the arsenal. I just don't know that it's going to be for everybody. Most of the veterans, what would happen is we would approach prospective veterans for both this study, the family study, and the Project Life Force study, and they all wanted the Project Life Force. They much prefer talking to other veterans than talking to their family. "Veterans understand me. My family doesn't. "So, in my mind, I'm sort of thinking of this as a sequence. Maybe people do this from the peer intervention to get that safety plan ready to go and then they share that with a family member once it's sort of robust and used.

The sessions where we talk about involving family in the PLF, they're really spirited discussions and lots of people their families just don't understand them. So, I think it's going to be a little bit more work. This, SAFER was the first entre into family treatments. I think we still need much more refinement. I think four sessions still might be too long. Maybe we can thin it down. We have to really look at is the family member one of the triggers for suicidal

urges and impulses, in which case you might need different intervention. So, I think it's the beginning. I think we've opened Pandora's box about the importance of family, but I still think there is a lot more work to be done until we call it the be all, end all.

Moderator: Great, thank you. The next question here: I like how you start your project with PRISMA scope and review. Can you tell us more about how that works?

Marianne Goodman: So, Sara Selden who is my lab manager love scope and reviews. You can see her name is attached to every one of these. So, basically, she has formed a relationship with the librarian at Icahn School of Mount Sinai. Basically, the librarians know how to do this. They, you meet with the librarian, you come up with the search terms for the articles that you are hoping to find, and you end up with like thousands upon thousands. So, you know, some of these have 4,000, 5,000. And you actually have to go through all the abstracts to see if they're relevant. So, if you put in family and suicide, it could be, have nothing to do with what we're looking for. So, it requires two people to review all the various abstracts. So, a lot of our research staff has been involved in this, student volunteers. It's a wonderful way to involve others in this work. They look through all the different abstracts and they identify the ones that they think are pertinent. Both people have to agree. If one says yes and one says no, it has to go to a third person who arbitrates. So that once all those abstracts are looked at, they then pull full articles. So, you want to somewhere be in the range of you know, between ten and 30, 40 articles. Then all of those articles are read line by line and they constitute what the review is.

What's nice about this is these are comprehensive. You know, you can put some restrictions on it, only English speaking. You don't want to have to be, it has to be a research study versus just a clinical presentation. You can include abstracts and conference proceedings or not. So, there are some ways that you can kind of direct the course of this, but what you end up getting is a very wide net of kind of all the information that's out there. I do think that these PRISMA scope and reviews is now kind of the established way to do review papers on a particular topic.

Moderator: Great, thank you. The next question here: do you have any instances where the discovery of past childhood trauma played a role and that impacted the veteran's openness to include the family?

Marianne Goodman: You know, that's a really important question. One of my post docs, Rob Lane, is really going to be focusing on disclosure and disclosing of suicidal symptoms either, you know, either disclosure to therapists or to family or to friends, and what are some of the factors that are involved in that. I assume that mistrust and not being able to you know, if something terrible happened to you in the past and you weren't able to share that, I'm sure that has to shape future disclosures. So, I'm sure we'll be having much more information about that. Many, many of our veterans, especially the ones that

are high risk have histories of abuse in childhood. So, I do think this is a pertinent factor and something that we need to be thinking about. But one of the areas that we want to go in in the future is to kind of help facilitate these disclosures. You know, how do make it safe, how do you override some of these past hurts including childhood trauma if that is one of them, you know, to make it so that your disclosure is done in a safe and effective way. I am aware of peer interventions where you can practice the disclosure, but this is a whole new area that I think is going to have some exciting developments.

Moderator: Great, thank you. I just have one comment before we move onto the next question from one of our participants. Dr. Heather Kelly is here from the House Veterans Affairs Committees: loving all of the content, especially interested in this family LMS training. Congresswoman Underwood has legislation that will mandate VA trained caregivers, as well as all VA staff including VVA, all contract providers in LMS.

Marianne Goodman: Well, thank you. I have to say I love this family lethal means safety. It's, I think it's an untapped resource and I just want to say one thing. The reason why the New York Health Foundation funded this, the funder told us the story, they said that for prostate exams, usually I don't talk about prostate exams, but they, when you advertise directly to men, they don't get the prostate exam. When you advertise the importance of prostate exams to the spouse, they get their spouse to go get the prostate exams. So, they just said that there is such value in involving family members, it's really an untapped resource and we've got to, the VA will have to do a better job in figuring out how to involve them and really take control, help them manage the situation more effectively and give them tools and skills. So, thrilled that the audience agrees with me on this, and we are excited to move this project forward and really want it out as much as possible. It's really fun to have so many people excited about this including funders and other governor's challenge teams, and the creators of CALM themselves. They said that they've been thinking that this was really important approach. Anyway, we're hoping to launch where we wanted it for the fall, but you know, definitely by Veterans Day is our goal.

Moderator: Great, fantastic. We've got about one minute left, so I'm just going to follow-up on the comment you made there. We've gotten a lot of questions: how do you refer someone to Project Life Force?

Marianne Goodman: Oh, okay, email me. We will figure this out. I don't know how we can do it if we're not, well, we'll have to think about this because I definitely want to move in a telehealth direction. So, if there are people, we'll find a way. It might require some, because it's research, and I sort of have to have, there are issues about credentialing and different hospitals, but let's if we can get enough of an interest, then we can go talk to the appropriate people on how to make this happen.

Moderator: Sounds great. We are at the top of the hour here, so we are going to wrap things up. We do still have several pending questions here that I can pass along to Dr. Goodman, or her contact information is on the screen here. I want to thank everyone for joining us today. Dr. Goodman, thank you so much for taking your time to prepare and present today. We really do appreciate it.

[End of audio]