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SUPERCEDE TREATMENT MANUAL FOR VA COMMUNITY CARE

Suicide Prevention Intensive Case Management and Coordination in VA Community Care

VHA Patient Safety Center of Inquiry – Suicide Prevention Collaborative

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Death By Suicide in Veteran Populations

More than 6,146 Veterans die by suicide every year (U. S. Department of Veterans Affairs [VA], 2022a). Further, Veterans are at higher risk for suicide when compared to civilian populations (VA, 2018b, 2022a). Veterans comprise 14% of the deaths by suicide, but only account for 8% of the general population (VA, 2018b). VA has worked to implement a multicomponent strategy to address suicide risk among Veterans (DeBeer et al., 2023; O'Hanlon et al., 2016; Shulkin, 2016). Notably, 60.3% of Veterans who died by suicide in 2020 had not recently engaged with VA (VA, 2022a), which highlights the need for a public health approach to Veteran suicide prevention (Carroll et al., 2020). At a national level, the VA National Center for Patient Safety and VA Office of Mental Health and Suicide Prevention have created and implemented new suicide prevention programs to reduce Veteran death by suicide (VA, 2018a). The national initiative, Community-Based Interventions for Suicide Prevention (CBI-SP), aims to reach Veterans at risk for suicide who are either engaged or not engaged in VA care by facilitating community agency collaborations. The CBI-SP encourages community-based suicide prevention coalitions to identify and conduct suicide risk screening for Veterans and their family members, improve care transitions, and facilitate community-wide safety planning and lethal means safety.

In addition, Veterans Health Administration (VHA) and the Substance Abuse and Mental Health Services Administration (SAMHSA, 2022) created the Governor's Challenge to Prevent Suicide Among Service Members, Veterans, and their Families (Eagan, 2019; VA, 2018a, 2019). Together with Veterans is another initiative to prevent Veteran suicide in rural communities (Monteith et al., 2020), and the Staff Sergeant Parker Gordon Fox suicide prevention grants are awarded to community organizations to partner with the VA in Veteran suicide prevention (VA, 2022b). The Veterans Crisis Line was also established as a tool to connect Veterans who call the line in crisis with VHA if needed (VA, 2023). Lastly, VHA established Community Engagement Partnership Coordinators (CEPCs) to support and build community coalitions for Veteran suicide prevention (SAMHSA, 2022). There is an urgent need to expand care and improve care coordination for Veterans receiving care at VA and in the community to stem this crisis.

VA and Department of Defense [DoD] suicide prevention guidelines encourage providers to utilize community resources to enhance care for Veterans enrolled within VA and DoD health care systems (VA/DoD, 2019). However, no guidance exists on coordinating suicide prevention services for Veterans who use VA Community Care. The intent of SUPERCEDE, **SU**icide **PR**evention intensive **C**as**E** management and coor**D**ination in Community Car**E**, is to provide evidence-based and best practice strategies in suicide prevention for Veterans who use VA Community Care.

Purpose and Intent of SUPERCEDE

In June of 2019, the VA implemented the MISSION Act with the goal of increasing access to health care for Veterans experiencing certain circumstances that decrease access (e.g., lengthy appointment wait times, unavailability of services at local VA; Library of Congress, 2018). However, the implementation of this legislation may not facilitate access for all types of services. **Specifically, the MISSION Act decreases Veterans' connection to high-quality suicide prevention practices embedded within the VA integrated behavioral health system.**

VA provides world-class mental health and suicide prevention care embedded within the integrated behavioral health system (VA, 2018a). The system facilitates enterprise-wide monitoring of suicide risk using multi-component strategies (e.g., regular suicide risk screening, predictive analytics) across various settings (e.g., primary care, specialty care). Moreover, once risk is detected, VA refers Veterans to integrated behavioral health for follow-up. Thus, the program components combine to provide a strong safety net. Compared to other guidelines for suicide prevention in health care settings, such as the Centers for Disease Control (CDC; Stone et al., 2017) and Zero Suicide (CDC, 2010; National Council for Behavioral Health, 2015), the VA program (VA, 2018a, 2018b) has implemented far more components. Of 36 identified suicide prevention program components, VA has implemented 35, whereas CDC recommended 25 of those components, DoD recommended 28, and Zero Suicide 24 (DeBeer et al., 2023; see Table 1; Lemle, 2018). Indeed, the National Strategy for Suicide Prevention (VA, 2018a) noted the advancements of the evidence-based VA program and indicated it as a model for other medical systems (Suicide Prevention Resource Center and SPAN USA, 2010). On many metrics, including suicide prevention and behavioral health, VA outperforms services available within the community (Lemle, 2018; Price et al., 2018; Tanielian et al., 2014; Watkins et al., 2016; Weeks & West, 2019).

Veterans who receive care in both VA and community settings (i.e., dual-users) are at risk for fragmented, poorly coordinated care across care settings, which may contribute to reduced access, adverse outcomes, increased costs of care, and suicide (Gaglioti et al., 2014; Lemle, 2018; McDonald et al., 2007; Peterson et al., 2018). Community health care systems are significantly less equipped to recognize and respond to Veterans who are at-risk for suicide and in need of mental health services (Lemle, 2018). For example, if a Veteran at-risk for suicide receives primary care in the community, they may not be screened for suicide risk, nor will their medical record data be fed back into the VA's predictive suicide risk analytic model (e.g., REACH VET; Libbon et al., 2019). Additionally, compared to civilian users, dual users may have experienced combat trauma and military sexual trauma, which community health care systems may not have the cultural competence to adequately treat. These concerns, which existed prior to the Mission Act, were apparent with the Veteran's Choice Program, which resulted in shortages of community mental health providers, insufficient community provider networks, and scheduling issues with the subcontractors, further decreasing access to and delaying care (Cunningham, 2009; Mattocks, et al., 2017). **Of utmost importance, formal standardized processes must be developed to help community providers who identify a Veteran at increased risk for suicide to transition the Veteran back to VA care.** This is notable, as care transitions are a point of increased risk for suicide, particularly following acute care (Libbon et al., 2019). **The current system does not allow VA and community systems to rapidly communicate, monitor, and respond to Veteran suicide prevention needs, and ultimately may not facilitate access to high quality behavioral health and suicide prevention services.** In sum, the national change to VA health care processes as a result of the Mission Act may disconnect Veterans at high risk for suicide from VA health care, and consequently, may increase their risk for death by suicide.

To address this serious gap in care, members of this team propose developing a suicide prevention intensive case management (ICM) intervention to increase access to high quality mental health services for Veterans who are at risk for suicide. **This intervention aims to ensure Veterans at risk for suicide who are referred out to the community for physical health care services receive timely access to specialty mental health care.**

TARGET POPULATION

SUPERCEDE targets Veterans who are at-risk for suicide and are sent into VA community care. "At-risk for suicide" means the Veteran reports experiencing current suicidal ideation or has a past suicide

attempt. Veterans are also eligible if they have severe mental health symptoms and several risk factors for suicide (e.g., impulsivity, substance use, risky behavior). The Therapeutic Risk Management -Risk Stratification Table can be used as a guide to assess a Veteran's risk for suicide: high acute, intermediate acute, or low acute risk (see Appendix 2-B). The Veteran may be deemed at low, intermediate, or high chronic risk, or low or intermediate acute risk of suicide (Bryan et al., 2014a; VA, 2019). If a SUPERCEDE candidate is at high acute risk or imminent risk for suicide, emergency services will be coordinated immediately. This program serves Veterans who are sent into community care, who are low, intermediate, or high chronic risk, or low or intermediate acute risk, and who are not actively engaged in VA mental health treatment (i.e., no more than 1 mental health session per month).

WHO SHOULD ADMINISTER SUPERCEDE?

SUPERCEDE should be administered by a VA-licensed mental health practitioner or a mental health practitioner practicing under the supervision of a licensed clinician. Examples of these mental health practitioners include psychologists, psychiatrists, licensed social workers, licensed professional counselors, and mental health nurse practitioners.

DEVELOPMENT OF SUPERCEDE

SUPERCEDE is based on an adaptation of practices drawn from the existing literature on suicide prevention and intensive case management: (a) the Zero Suicide Model (Zero Suicide, 2019); (b) VA/DoD Suicide Prevention Guidelines (VA/DoD, 2019); (c) empirical literature on cognitive-behavioral interventions for suicide prevention (Bryan & Rudd, 2018; Rudd et al., 2015); and (d) VA integrated case management. The Zero Suicide Model has provided guidance regarding care transitions (Nash et al., 2012). This guidance consists of a "pathway to care," which refers to developing methods in which an individual is connected to care and has support and follow-up to ensure care continuity. Also, community care coordination between VA and other systems is integrated into case management.

Brief Cognitive Behavioral Therapy for Suicide Prevention

Although dozens of therapeutic approaches addressing suicide attempts exist, very few treatments have demonstrated efficacy preventing suicide attempts (Rudd et al., 2015). Cognitive behavioral therapy (CBT) is the evidence-based psychotherapy regarded as the gold standard treatment across diagnoses (Brown et al., 2005a; Bryan & Rudd., 2018; Patsiokas & Clum, 1985; Slee et al., 2008). Therefore, this manual utilizes a cognitive behavioral framework focusing on brief cognitive behavioral therapy (BCBT) for suicide prevention, which has proven effective in preventing suicide attempts (Bryan & Rudd, 2018; Rudd et al., 2015).

CBT, which was originally developed to treat depression, has become an evidence-based approach that has been applied to many different patient populations (Gaudiano, 2008). CBT focuses on the association between thoughts, emotions, and behavior and then intervenes by changing thoughts and behaviors (Beck, 1970). CBT has been applied to suicide prevention by Brown and colleagues (2005) who developed a 10-session, one-on-one outpatient cognitive therapy framework. CBT for suicide prevention focuses on modifying core beliefs of the self, the world, and the future through cognitive restructuring, particularly related to suicidal thoughts. A randomized clinical trial examining the efficacy of CBT treatment in comparison to usual care for suicide prevention indicated that individuals who received CBT were significantly less likely to attempt suicide during the follow-up period than patients who received usual care (e.g., 24% in CBT versus 42% in usual care). However, for levels of depression, hopelessness, and suicidal ideation, few differences existed between patients in CBT and usual care. Moreover, patients were significantly more likely to stay engaged in treatment if they received cognitive

therapy, but throughout the 18-month follow-up, treatment groups did not differ in their likelihood of being hospitalized (Brown et al., 2005a).

The results from Brown and colleagues' (2005a) clinical trial served as a milestone in developing brief cognitive behavioral therapy for suicide prevention. Researchers were able to show that short-term treatments could be as effective as lengthier cognitive behavioral protocols (Rudd et al., 1995). Meta-analytic findings from Tarrier and colleagues (2008) have also found that long-term CBT is no more or less effective than BCBT.

Therefore, Rudd and colleagues (Bryan & Rudd, 2018; Rudd et al., 2015) developed brief CBT or BCBT, which has been found efficacious in preventing suicide, as it not only addresses the distorted cognitions associated with the patient's suicidal ideation, but also in preventing suicide attempts (Rudd et al., 2015). A randomized controlled trial of BCBT for suicide prevention was conducted with strong results (Rudd et al., 2015). This trial showed that BCBT reduced the risk for suicide attempts at the conclusion of treatment and at 24-month follow-up (Rudd et al., 2015). BCBT for suicide prevention spans 12 sessions and involves altering cognitions that contribute to suicide risk, identifying reasons for living, and developing skills to prevent future suicidal behavior (Kauth et al., 2011). This brief therapy includes between session practice of skills learned during therapy sessions. Notably, studies showed these interventions reduced suicide attempts, but not deaths by suicide. Conducting a trial to assess methods to reduce deaths by suicide, rather than suicide attempts, would be difficult. The trial would need a robust sample size to detect any effects given that death by suicide is an infrequent behavior.

Zero Suicide Model

According to Sisti and Joffe (2018), the Zero Suicide Model, adopted by health systems from all over the world, "serves as a laudable aspiration for society." The framework is based on the realization that suicidal individuals often fall through the cracks in a fragmented health care system. The model's core components include a focus on prevention, assessment, screening, and training, and its goals are to: (a) improve health outcomes for patients at risk for suicide, and (b) transform behavioral health care systems to improve patient safety. The Zero Suicide concept is derived from the 2012 National Strategy for Suicide Prevention and is a priority of the National Action Alliance for Suicide Prevention (Action Alliance), the Suicide Prevention Resource Center (SPRC), SAMHSA, and VA (Zero Suicide, 2019).

Crisis Response Planning

Crisis Response Planning (CRP) is an intervention created collaboratively by the provider and Veteran that assists the Veteran in identifying his or her unique personal warning signs of an emotional crisis, practicing self-management coping skills, and specifying sources of social support (Bryan et al., 2017a). Prior to the collaborative planning, the clinician prompts the Veteran to share the most recent story of a prior suicidal crisis or suicide attempt. Next, the clinician invites the Veteran to collaboratively create (a crisis response plan as a solution to a potential future crisis situation. The crisis response plan consists of five components, or six components if the Veteran agrees to means restriction counseling (Bryan & Rudd, 2018; see Chapter 7). In crisis response planning, the Veteran identifies the following: (a) warning signs of an emotional crisis; (b) internal coping strategies; (c) sources of social support in their personal life; (d) professionals or social services who could provide assistance during a crisis; (d) environmental safety (e.g., means restriction); (e) reasons for living. The Veteran is instructed to write their individualized plan for each step on an index card. Crisis response planning has demonstrated efficacy in reducing suicidal ideation and attempts (Bryan et al., 2017b) and reducing negative emotional states (Bryan, 2017a).

Intensive Case Management

Case management focuses on building a collaborative relationship between the therapist and the client to facilitate assessment, evaluation, care coordination, and advocacy on behalf of the client (Case Management Society of America, 2017). The intent of case management is to provide intervention and resources that address individual needs (Case Management Society of America, 2017). Intensive case management, or ICM, has several advantages. First, case management assists in coordination of care, which increases access to care. Communication is reduced to a single point of contact. Additionally, ICM provides resources addressing social determinants of health that the Veteran may not have had previously. These positive impacts radiate beyond direct benefits to the Veteran, but also to their family, care providers, and the health care system. ICM allows the case manager to provide streamlined and enhanced care to meet the Veteran's needs.

ICM may be a particularly relevant, yet understudied and underutilized, suicide prevention intervention. Indeed, case management interventions are effective in preventing reattempts due to the additional interventions received around social adjustment (Park et al., 2015). Addressing social adjustment and social support is backed by the interpersonal theory of suicide (Joiner, 2005), which has found that having healthy, supportive social relationships is protective against suicide. Further, Baumeister and Leary (1995) assert that an individual's innate need to belong to caring and supportive relationships is so strong that if thwarted, can lead to suicidal ideation (You et al., 2011). Therefore, SUPERCEDE's version of ICM involves the assigning a case manager who ensures the Veteran establishes a continuity of holistic care and health care needs by connecting them to providers and services both within VA and in VA community care.

SUPERCEDE also focuses on community care coordination. At times, community agencies may cancel consults or appointments, schedule appointments with the incorrect specialty providers, or not know how to refer the Veteran back into VA care. The Veteran may also experience duplications in care. The SUPERCEDE provider assists in streamlining community care the Veteran is receiving to improve treatment outcomes.

Summary

While there are several community-based suicide prevention programs (i.e., Zero Suicide Model, Veteran's Crisis Line, Mayor's and Governor's Challenge), gaps remain regarding care for Veterans who are at-risk for suicide, use VA Community Care and are disengaged from VA mental health care. The highest percentage of suicide deaths among Veterans are from those who are disconnected from VA services (VA, 2022a). Thus, VA must provide solutions to ensure that at-risk Veterans are receiving the care they need when they receive VA Community Care. SUPERCEDE aims to address this significant need by implementing a combination of BCBT for suicide prevention adapted from Bryan & Rudd (2018), and intensive case management. This provides Veterans with the tools necessary to manage suicidal ideation as well as interventions to ensure they are connected to the appropriate psychosocial resources in their communities.

CHAPTER 2: OVERVIEW OF SUPERCEDE PROGRAM FLOW AND PREPARATION FOR PROGRAM IMPLEMENTATION

Overview of Program Flow

SUPERCEDE is a program designed for Veterans who are at risk for suicide and receive community care but are disengaged from mental health treatment. The program is intended to address psychosocial challenges, as well as community care coordination issues. The intervention is modular and intended to address the Veteran's specific needs, particularly those that reduce suicide risk (e.g., help with unemployment, access to mental health care, food insecurity, financial and benefit resources, etc.). The Veteran's needs are continually assessed throughout the program. As needs are identified, the clinician connects the Veteran with therapy and resources to address those needs. Suicide risk is assessed at every visit, consistent with VA suicide prevention practices (DeBeer, et al., 2023; VA, 2018a, 2019). Thus, an appropriate response can be made to address this risk, consistent with VA policies and procedures.

Figure 2-1. *SUPERCEDE Program Flow*

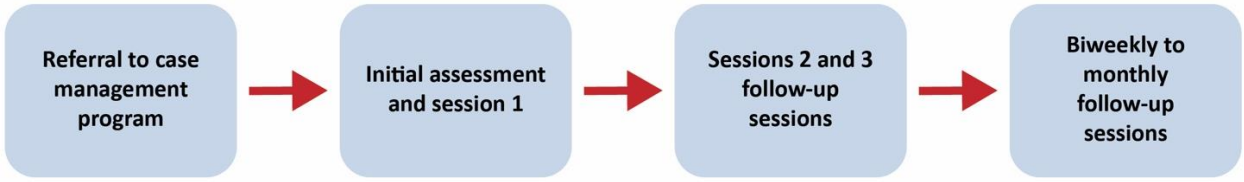


Figure 2-1 outlines the flow of the SUPERCEDE program. The first step is to assess the Veteran's eligibility for the SUPERCEDE intervention. Session 1 of SUPERCEDE consists of therapy, a crisis response plan (CRP), if necessary, and intensive case management (ICM). Goals of the session are to: (a) assess the Veteran's current mental health symptoms, suicidal ideation, and whether the Veteran has an existing safety plan or CRP; (b) determine current mental and physical health treatments in both VA and the community, the need for additional treatment, and the need for coordination of community care; (c) understand the Veteran's psychosocial needs. The clinician gathers contact information for the Veteran's community providers and VA providers.

Suicide risk is assessed at every SUPERCEDE session using the suicide risk assessment provided in this manual (see **Appendix 2**). Depending on the outcome of the suicide risk assessment, the clinician will work with the Veteran to create a safety plan or crisis response plan. If the Veteran has an existing safety plan or CRP, the clinician will review it with the Veteran. Safety plans or crisis response plans are reviewed between the clinician and the Veteran at all sessions. At times, Veterans may not recall having a safety plan or CRP, especially if the plan was created several years before. Thus, if the Veteran indicates no prior CRP or safety plan, review the Veteran's chart to see if one exists. If the Veteran has an existing CRP or safety plan, review it with the Veteran.

The clinician administers the assessment of needs to determine psychosocial needs. Following the assessment of needs, the clinician provides the Veteran with referrals to community organizations based on needs (e.g., unemployment services, etc.). Additionally, the clinician tells the Veteran to reach out to the clinician if additional resources are needed, or other needs arise. The clinician instructs the Veteran to reach out to the Veterans Crisis Line in case of a crisis situation. Refer to Chapter 3 for more detailed information in session one.

Following the first session, the clinician will see the Veteran for two additional weekly sessions, and then sessions continue biweekly until needs are resolved. Clinical judgement should be used to decide when fewer follow-ups are needed, and sessions can occur monthly instead of biweekly. (See Chapters 9 and 18 for additional information regarding session follow-up.) Suicide risk assessment and follow-up as needed will be conducted at every session as per VA policy. CRP/safety plans and case management needs will also be reviewed at every session.

Preparation for Implementation

To effectively implement the SUPERCEDE program, community referral sources are needed. A community mapping process used to identify referral sources applicable to Veterans is outlined later in this manual (see **Appendix 1**). The first step of this process is for the clinician to map out referral sources and keep this information handy when working with Veterans. It is also recommended that referral resources be kept on a shared drive and shared with other clinicians. The referral resources should be updated regularly (e.g., monthly) to ensure they are current.

After resources are identified, the next step is to reach out to these resources to establish relationships. This initial connection allows the clinician to explain the SUPERCEDE program and determine whether the organization can handle the referral flow from SUPERCEDE. The clinician also should ask if the organization can accept direct referrals from SUPERCEDE. Direct referrals can improve the Veteran's ability to access services at the organization. Additionally, clinicians should ask if the agency is able to provide a sliding scale for Veterans enrolled in SUPERCEDE.

CHAPTER 3: OVERVIEW OF SESSION ONE

Session One Overview

The first session of SUPERCEDE focuses on: (a) describing the structure of SUPERCEDE; (b) conducting an assessment of care; (c) conducting intensive case management; (d) conducting a suicide risk assessment and assessment of needs. As applicable the clinician will: (a) develop a crisis response plan (CRP)/safety plan or review the Veteran's existing CRP/safety plan; (b) discuss reasons for living; (c) conduct means restriction counseling; (d) consult the Veteran back into VA specialty care as needed; (e) schedule additional VA appointments if needed; (f) work to reduce duplicative care; (g) provide a therapy module. **Figure 3.1** outlines the flow for session one.

Session one starts with a suicide risk assessment and case management evaluation. Following the suicide risk assessment, the clinician should initiate intensive case management. This process focuses on understanding the Veteran's psychosocial and community care needs and assisting the Veteran in connecting with services. In particular, if there are psychosocial needs driving thoughts of suicide (e.g., financial challenges, relationship issues, legal issues), providing resources for these needs is critical. Next steps are coordinating any community care issues (e.g., canceled consult not rescheduled, etc.) and reducing duplicative care. The first SUPERCEDE session is scheduled for 90-minutes.

Figure 3-1. *Session One Flow*

THE CLINICIAN'S TASKS FOR SESSION ONE:	
1.	Describe the structure of SUPERCEDE (Chapter 2/3)
2.	Conduct a suicide risk assessment and case management evaluation/assessment of care (Chapter 4)
3.	Perform SUPERCEDE assessment of needs, help Veteran understand VA care vs. Community Care (Chapter 4)
4.	Initiate intensive case management (Chapter 8) **If applicable:** • Develop a crisis response plan (Chapter 5) • Discuss reasons for living (Chapter 6) • Conduct means restriction counseling (Chapter 7)
5.	Coordinate community care issues if needed
6.	Schedule additional VA appointments if needed
7.	Reduce duplicative care (Chapter 8)
8.	Choose an additional module, if time permits,

Session One Tasks

The following four steps are necessary at the first SUPERCEDE appointment:

STEP 1: DESCRIBE THE STRUCTURE OF SUPERCEDE

The clinician starts by describing the SUPERCEDE session components. The clinician provides a summary of the intervention by outlining that SUPERCEDE: (a) provides care coordination and brief mental health services for Veterans at risk for suicide who are enrolled in community care; (b) provides Veterans with the resources and referrals to meet their individual needs.

Clinician Script

Thank you for meeting with me today. I'm looking forward to getting to know you, sharing more about the SUPERCEDE program with you, and discussing what my role will be in your care. I know you were

given a referral into the community for _____. Have you had your first appointment yet, or have you been seeing that Dr. regularly? Ok, great. So let me share with you how I will be supporting you while you are being seen in the community. Please feel free to ask any questions as they arise.

I am a [social worker, psychologist, suicide prevention coordinator, mental health nurse practitioner, etc.*]. In this program, I will be assisting you in three main areas. First, I assist Veterans in navigating different health care systems and organizations so that they can get the services and resources they need whether they are being seen at VA or in the community. Second, I educate community health care providers how to best work with Veterans so that you can feel comfortable discussing issues you feel are related to your prior service with your community medical team and are supported in the best way possible. Finally, I help Veterans improve their mental health by teaching them coping strategies. What questions do you have about what I do?*

*Now, the reason I have crossed your path is first and foremost because VA cares about you. At some point, you shared with a VA provider that you had (*INSERT SPECIFIC SUICIDE RISK INDICATORS HERE, i.e., suicidal thoughts, a past suicide attempt, etc.*). It takes a lot of courage to be vulnerable and share your struggles, so I commend you for doing so in the first place. We know that these kinds of feelings and thoughts can come up anytime, even if right now, you feel like you are doing well.*

Therefore, my goal is to ensure that you have access to the resources you need to thrive as you go into the community for your appointments, especially regarding your mental health and any life stressors that might be present for you. There may be a point when you decide receiving mental health care would be helpful. I can help you get connected to that. There might be a situation when it would be helpful for me to speak with your providers about your VA care or military-related issues that would allow them to work with you in a more effective manner. What questions do you have about my role?

Having providers in the community who are experts in resolving the issues you have been struggling with, just like you have within VA, is going to benefit you. I am here to ensure that you are OK and getting what you need while you are interacting with those health care professionals in the community. Given the nature of SUPERCEDE, our time together will be short-term and time limited. We are meeting together today, and then we will move to brief, check-in's every other week. These check-ins will help me keep track of how you are doing, and if any additional needs arise, I can help you address them. What questions do you have about this?

I'd also like to ask you if you've ever been in therapy before or seen a mental health provider in the past? **[If yes]** *Tell me a little more about what that experience was like for you.* **[If no]** *Ok, no problem. I like to have a good idea of what experiences you've had prior to coming into the program.* **[Briefly explain your professional background and what kind of expertise social workers have. Emphasize that you are not a prescriber.]** *What questions do you have about my background?*

If you ever have any questions or concerns, I want you to feel comfortable asking me.

STEP 2: SUICIDE RISK ASSESSMENT

The clinician will conduct a suicide risk assessment using the VA standard suicide risk assessment protocol for eligible Veterans who consent to participation (see Appendix 2; Matarazzo et al., 2020; VA, 2019; Wortzel et al., 2014; Wortzel et al., 2013). The clinician will coordinate emergency services if the Veteran is at imminent risk for suicide based on the assessment. Refer to Appendix 2-B for the Therapeutic Risk Management - Risk Stratification Table as a tool to assess risk level.

Following the suicide risk assessment (see Appendix 2), the clinician will conduct the assessment of needs (see Appendix 3).

STEP 3: CONDUCT THE SUPERCEDE ASSESSMENT OF NEEDS

The next step is to conduct an assessment of needs, which is done to: (a) understand the Veteran's receipt of VA care vs. community care; (b) determine services that the clinician can assist the Veteran in finding; (c) understand if there is a need to speak with community providers and if so, seek necessary approvals. See Chapter 4 for more information on how to conduct the assessment. The assessment of needs is included in Appendix 3.

STEP 4: INTENSIVE CASE MANAGEMENT

In SUPERCEDE, the primary goal is to ensure the Veteran's risk for suicide is managed while they are engaged in community care. This is accomplished by using intensive case management to assess the Veteran's most urgent needs, planning and facilitating appropriate referral sources, coordinating the Veteran's care via warm handoffs, and evaluating the Veteran's experience as they go into the community for services. See Chapter 8 for more details on intensive case management.

If applicable, the following additional steps are taken:

Develop a Crisis Response Plan

If the Veteran endorses current suicidal ideation or recent suicidal behavior, the clinician develops a CRP collaboratively with the Veteran (Bryan & Rudd, 2018). The CRP is comprised of sections focused on identifying warning signs, coping strategies, social support, and emergency contact information. See Chapter 5 for additional information regarding the creation of a CRP.

Reasons for Living

When experiencing a suicidal crisis, an individual often cannot recall reasons for living. Instead, they tend to focus on reasons for dying (Bryan & Rudd, 2018). To address this issue and improve hope, the clinician reviews the reasons for living list with the Veteran (see Chapter 6). The clinician and the Veteran collaboratively identify the reasons why he or she has the desire to continue living. Refer to Chapter 6 for the reasons for living module.

Means Restriction Counseling

Means restriction counseling involves evaluating the Veteran's access to firearms or other lethal means and subsequently partnering with the Veteran and his or her social network to limit their access to these means until he or she is no longer experiencing a suicidal crisis (Bryan & Rudd, 2018). The clinician uses a Motivational Interviewing (Miller & Rollnick, 2012) approach to guide the Veteran through a discussion as to why limiting his or her access to means for suicide is an effective way to increase safety. The clinician is encouraged to continue reviewing means restriction as an option in subsequent meetings, even if the Veteran is initially unwilling to participate, as simply introducing the concept can often be the first step to future consideration. See Chapter 7 for more details on means restriction counseling.

STEP 5: COORDINATE THE VETERAN'S COMMUNITY AND VA CARE AS NEEDED

At times, Veterans can experience difficulties connecting with community care providers. For example, community agencies may cancel their consults without further follow-up. It is important to understand the community care the Veteran is receiving and to support them in obtaining this care. This may include assisting the Veteran with connecting to the provider or initiating additional consults to ensure continuity of care.

Depending on the Veteran's mental health symptoms, consider whether the Veteran needs to be connected back into VA mental health care. If the Veteran does need an appointment, put in a consult for the Veteran or consider possible community referrals depending on VA's ability to provide specialty mental health services and the Veteran's needs.

STEP 6: SCHEDULE ADDITIONAL VA APPOINTMENTS AS NEEDED

Ask the Veteran if they need additional care and determine if additional appointments with VA care providers are necessary. If the Veteran is receiving duplicative care from VA and VA community care providers, assist the Veteran in streamlining appointments.

CHAPTER 4: CONDUCTING THE ASSESSMENTS

Introduction

Assessment goals are to: (a) evaluate the Veteran's suicide risk level; (b) understand the needs of the Veteran that can be addressed during sessions; (c) assist the Veteran with proper mental health care coordination between systems. Since this intervention is short-term, the primary goal is to complete an assessment of needs the Veteran may be experiencing, which could increase risk of suicide. During the intervention, the clinician can immediately begin to address those needs. The goal is not to complete a comprehensive assessment. The assessment of needs focuses on issues associated with increased suicide risk, including financial issues, lack of social support, unemployment, housing instability, and inadequate mental health treatment (see Appendix 3; Blosnich et al., 2019; Liu & Zhang, 2018; Phillips et al., 2002; VA/DoD, 2019). Once the assessment is complete, the Veteran will rank the identified needs by priority—low, medium, or high—which will determine the starting point for connecting the Veteran to community resources.

The SUPERCEDE assessment consists of the Suicide Risk Assessment (see Appendix 2) and the Assessment of Needs (see Appendix 3).

STEP 1: INTRODUCE THE SUPERCEDE ASSESSMENT

The clinician briefly describes the assessment and explains the purpose for its use.

Clinician Script

Let's work together on a plan to connect you to the resources you need while receiving care in the community. Although you may feel fine right now, we find that many Veterans may struggle with focusing and making decisions when they experience stress during a crisis. Has that ever been true for you? Could you share your thoughts on your experience? **[Validate Veteran's experience].** *When you're under stress or experiencing a crisis, knowing where to get the help and support you need can feel very overwhelming. When you are navigating care and resources in the community and VA, it can be especially daunting.*

I would like to start by doing a thorough assessment of your current experiences, beginning with what's going well for you, followed by what you may need assistance with. First, I will ask you some questions about your life in general, health history, level of social support you have or may need from others, and community resources you've connected with. I'll also ask about your family system, any mental health symptoms you may be experiencing, your financial situation, and basic needs you may have. How do you feel about sharing your experiences about these topics with me?

Once we figure out what type and how much additional support or assistance you may need, we will prioritize them from most urgent to least urgent. Next, we will create a plan and learn some coping skills to address your thoughts about suicide. To address your needs, I will help you identify different resources in the community and across the state. I will help you connect with those resources and coordinate appointment you may need. How does that sound?

Once we connect you with various services and resources, I'd like your feedback on how your experience has been using them. I want to ensure that: (a) you can access them; (b) the services and resources will meet your needs and they are high-quality; (c) you are able to benefit from them. If any issues arise as you connect to those resources and services, I will advocate for you, and we can work towards a resolution. Or I can connect you to different options if necessary. I will keep records of the resources

you've connected with, what is going well, and what we still need to focus on. What questions or concerns do you have about this process?

STEP 2: CONDUCT THE SUPERCEDE ASSESSMENT

The clinician will begin the suicide risk assessment using questions from both the standard VA suicide risk assessment questions and the Columbia-Suicide Severity Rating Scale (see Appendix 2; C-SSRS; Posner et al., 2008, 2011; Katz et al., 2020; VA, 2022a; Wortzel et al., 2013; Wortzel et al., 2014) followed by a needs assessment (see Appendix 3). Since all Veterans participating in this intervention are at-risk for suicide, evaluating their level of suicide risk and coordinating emergency services if their risk is imminent are critical. During the needs assessment, the clinician can determine which factors may be driving suicidal ideation and assist the Veteran in prioritizing those needs. Please see the VA Risk ID SharePoint for additional suicide risk evaluation resources: https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx.

Clinician Script

To begin, I'd like to get to know how things are going for you. I'll ask you some questions about different aspects of your life, which will help us identify which resources would be most helpful to you. What you share with me is extremely important to help identify your needs and will help us plan the next steps.

I'd like to ask you some questions to help me understand more about you, how you're feeling, and your current situation. **[Administer suicide risk assessment; Appendix 2]. [Depending on how the Veteran was referred].** *Tell me about why you [called the Veterans crisis line] or how you were referred to our program. Thank you for sharing that.* **[If suicide risk is imminent, coordinate emergency services. The clinician can re-evaluate inclusion into the SUPERCEDE intervention once the Veteran is stabilized.] [See Chapter 18].**

Let's discuss your living situation. **[Note: only ask if unknown.]** If the assessment is virtual, ask: *where do you currently live? Do you live in the local area?* (**If not**, ask: *How long does it take to get here?*) *Who currently lives with you?* (**If family:** *Describe your relationships with your spouse, kids, etc.*) *Is there anything that you think would be important for me to know about your home life or how you and your family interact? Tell me about your support system? About how many people do you feel comfortable talking to about personal issues you may be experiencing? Who is part of your support system? Are you satisfied with your support system? (***If not:** *What changes would you like to make?)*

Please tell me about your method of transportation; how do you get where you need to go? Is this working well for you?

What is your highest level of education?

What is your employment status? Are you pleased with this? (**If employed:** *How is your work going for you? How is the work environment?)*

Tell me about your financial situation. Do you experience any difficulties related to debt, spending, paying your bills, or relationship conflicts over finances? Have you recently felt like you do not have enough food in your house?

Are you currently experiencing any legal issues?

Thank you for opening up to me about these questions. I know it may not be easy. We are nearly finished with this part. Let's shift gears and talk about your mental health. I have reviewed your chart and see

that you have previously experienced some mental health concerns, and I want to ensure that you know how to access resources and support when you need it, now or in the future. How has your mental health been lately? **[Provide the Veteran the time to share openly.]**

[If the Veteran seems to be doing well]: *That's wonderful. I am happy to hear that you have been doing well! I know you said you are feeling ok, but I want to make sure we don't miss anything. Now, I will read a list of common symptoms. I want you to tell me if you've experienced these symptoms in the past month, or 30 days.*

[If the Veteran seems to be struggling]: *I'm so sorry to hear that you have been struggling. You have some challenging things to manage. I imagine you may feel overwhelmed, and you may be unsure about what to address first, or how to get help. I am here to help you figure that out. I want to understand the symptoms you are experiencing, and I want to make sure we don't miss anything. Now, I will read a list of common symptoms. I want you to tell me if you've experienced these symptoms in the past month, or 30 days.*

[Read each symptom and explore the frequency and severity for each symptom the Veteran endorses]:

- *Anxiety*
- *Depressed/elevated mood*
- *Sleep problems*
- *Hopelessness*
- *Grief*
- *Guilt/shame*
- *Poor concentration*
- *Irritability*
- *Change in appetite, such as not eating, or binging/purging*
- *Feeling emotional*
- *Self-harm*
- *Fatigue*
- *Substance use, drinking, or use of illicit drugs*
- *Aggression*
- *Hyperactivity*
- *Panic attacks*
- *Mood swings*
- *Paranoia*
- *Dissociation, or feeling detached from your body or environment*
- *Hallucinations*
- *Phobias*

I appreciate you sharing openly. Have you been experiencing any other symptoms we have not discussed? [**The Veteran's suicidal ideation was evaluated earlier in this session; however, the clinician may revisit that as it relates to the above mental health symptoms.]**

Are you currently taking medications for any psychiatric diagnoses? What medications are you currently takings for any physical health diagnoses? Do you take your medications as prescribed?

Would you be willing to share the names of the following VA providers: your primary care physician, psychiatrist, and/or clinician? Have you recently received or are you receiving any treatments for a mental health diagnosis?

Regarding your time serving in the military, did you ever deploy? Did you deploy to a combat zone? If yes, when did you serve, and in which conflicts?

Lastly, I need information about the provider you will be seeing in the community. As we discussed earlier, I will assist in your care by serving as a liaison between VA and the providers you see in the community to optimize the care you are receiving and to assist you as questions or needs arise. Could you please provide the name and contact information of the provider you were referred to in the community? What health conditions or issues will the provider be treating you for? With which organization does the provider work?

STEP 3: SUMMARIZE THE ASSESSMENT

The Assessment of Needs Summary form is used to summarize the Veteran's needs (see Appendix 3). Next, go over the crisis response plan (see Chapter 5) and the reasons for living (see Chapter 6). Then, begin connecting the Veteran to resources and services to meet the needs identified throughout the intensive case management intervention. Chapter 8 provides guidance on the prioritizing needs and identifying and connecting with possible resources.

CHAPTER 5: CRISIS RESPONSE PLAN

Overview of the Crisis Response Plan (CRP)

The SUPERCEDE intervention includes a crucial element known as the crisis response plan (CRP; Bryan et al., 2017a; Bryan & Rudd, 2018), which is a tool used by clinicians and Veterans to prepare for suicidal crises or emotional distress that may lead to suicidal behavior. The CRP includes a checklist of actions to take during a crisis and offers alternative behavioral actions to suicide and is adapted from the work of Bryan & Rudd (2018). The checklist focuses on five areas, each helping the Veteran: (1) recognize warning signs of an impending suicidal crisis; (2) identify self-management or coping strategies to help manage the situation; (3) identify family and friends who can offer assistance and social support; (4) identify professional resources such as emergency services (i.e., 911), Veteran crisis lines (i.e., 988, option 1; VA, 2023), and mental health providers; and (5) identify and articulate reasons to live.

The primary goal of the CRP is to assist the Veteran in making decisions when they are experiencing emotional distress or when they are struggling with problem-solving. People who are considering suicide often struggle with thinking of solutions to difficulties they are experiencing compared to those who have not experienced suicidal ideation, regardless of whether they experienced major depression (Williams et al., 2005). Individuals who are at risk of suicide tend to exhibit an attentional bias towards information related to death and suicide, including negative emotions and pessimistic future expectations. During a crisis, an individual's cognitive tendencies are triggered to such an extent that those at risk of suicide are often inclined to overestimate the likelihood of future negative events (MacLeod et al., 1993), contributing to impaired problem-solving. Therefore, the CRP delineates the precise measures that an individual should take when faced with a crisis, serving as a decision-making tool that counteracts the decline in problem-solving abilities that occurs during acute crises. To summarize, the CRP offers alternatives to those contemplating suicide during a crisis, when they are most likely to consider it as an option. **Figure 5-1** presents a blank CRP template and an example of a Veteran's CRP. In the example, Javi has reported thoughts about driving his car off a cliff.

An index card is a way to document and preserve the CRP for the Veteran. It can be laminated and is easier to carry in a pocket or purse than a full-sized sheet of paper. Creating a personalized CRP may enhance the Veteran's sense of ownership and involvement in the planning process, and laminating the index card can provide a sense of perceived significance and emotional importance, which may decrease the likelihood of misplacing or losing it. If a Veteran does not have an index card, an alternative is to write the CRP on a piece of paper and take a picture to store the plan on a cellphone.

Veterans who have difficulty creating a CRP may have challenges recognizing the signs of an impending crisis and/or may not have the necessary skills to manage and cope with it effectively. Veterans in such situations frequently struggle to recognize or enumerate their own individual warning signs. To overcome this obstacle, the clinician can offer the Veteran a list of possible warning signs and allow them to choose the ones that are relevant to their situation. A list of possible warning signs is outlined in **Figure 5-2.** Next, the clinician can prompt the Veteran to recall self-management strategies that have been effective for them in the past. If the Veteran is having difficulty identifying their own self-management strategies, the clinician can provide a list of potential options to choose from, which are outlined in **Figure 5-3**.

The clinician must make sure that any self-management strategies suggested are appropriate for the Veteran's skill level. For example, if the Veteran is unable to use relaxation techniques effectively, then they should not be recommended as a self-management strategy. Prompting the Veteran to discuss how

they plan to use the strategy to manage their symptoms can aid the clinician in assessing the Veteran's competency level. The clinician must be cautious not to miscalculate the Veteran's abilities even in the case of seemingly "easy" self-management strategies.

STEP 1: ORIENT THE VETERAN TO THE CRISIS RESPONSE PLAN

The clinician initially presents the CRP by providing a brief description and reasons for its use.

Clinician Script

Given the information you shared with me earlier, it appears that when you feel suicidal, you also endure excruciating pain that seems unending. It can be challenging for individuals to concentrate and make good decisions when faced with such circumstances. Can you tell me about a time it was hard to make decisions when you felt suicidal?

It can be difficult to make good decisions when we are experiencing emotional distress. That's why having a pre-established plan in place can be helpful during times of a crisis. This plan, also known as a crisis response plan, is comparable to an emergency response plan, which prepares individuals for unforeseen natural disasters or major life circumstances. Have you ever formulated an emergency plan? For example, one that applies to your work or family, such as a fire safety plan, a tornado plan, or a hurricane plan. **[If yes]** *Please tell me more about those plans.*

As you pointed out, the majority of emergency plans feature straightforward checklists that outline the necessary steps to take when you encounter a difficult situation. In essence, a robust plan will provide a set of fundamental guidelines on what actions to take and how to address the situation effectively. Likewise, we can develop a crisis response plan to handle our individual crises. I propose that we create a crisis response plan specifically for you before concluding our session today. Are you willing to do that? We will document your crisis response plan on a small piece of paper, like an index card. This way you can keep it in an easily accessible place, such as your wallet or purse.

STEP 2: IDENTIFY WARNING SIGNS OF A POTENTIAL CRISIS

The clinician starts by asking the Veteran to identify their individual warning signs for symptom increases or an impending crisis. Frequently the Veteran has already talked about these warning signs in session. If the Veteran has difficulty remembering their warning signs, the clinician will provide the Veteran with a list of warning signs to assist in facilitating the discussion. **Figure 5-2** outlines warning signs that individuals commonly experience.

Clinician Script

To formulate an effective crisis response plan, we must initially identify the situations that would indicate that you may need to use the plan. It would be challenging to start using the plan appropriately if you are unsure when to use it. Therefore, let's identify some warning signs or red flags that indicate the possibility of a crisis. How do you recognize when you're becoming increasingly upset and may need to use this plan? Let's record a few of these red flags at the top of your card.

STEP 3: MAKE A LIST OF SELF-MANAGEMENT OR COPING STRATEGIES

The clinician prompts the Veteran to consider different strategies or activities that could alleviate their distress or distract their attention from the crisis. Inquiring about effective coping strategies the Veteran has used in the past, even if they are not currently using them, can be beneficial. If the Veteran struggles to identify strategies, the clinician can provide examples, such as those shown in **Figure 5-3**, to assist the

Veteran in recalling effective coping options. The clinician should ensure that the strategy suggested to the Veteran is practical and feasible for the Veteran's abilities and provide guidance on when and under what circumstances the strategy can be employed.

Clinician Script

Now that we have established when to use this plan, let's write down approaches that can help you in coping with your symptoms or even distract your attention from the situation. What are some activities or practices that have previously helped you feel more peaceful and less stressed, even if you haven't used them in a while? Are there any strategies you are using now? Let's write a few of these approaches under your list of warning signs. How much time do you believe you can spend on using these strategies? Let's write that down also.

STEP 4: CHOOSE FAMILY OR FRIENDS WHO CAN PROVIDE SUPPORT

The clinician will ask the Veteran to identify supportive individuals in their life who can be included in the crisis plan. The Veteran will be instructed to record the names and phone numbers of these individuals, regardless of whether they have already stored this information on their cell phone or elsewhere. The clinician makes it clear to the Veteran that they are not obligated to inform the supportive person that they are experiencing a crisis. Instead, they can reach out to obtain support or receive distractions from symptoms, suicidal thoughts, or any other distressing feeling or situation.

Clinician Script

There may be periods of time when using these strategies aren't feasible, such as during work, a social outing, or during a storm. Furthermore, there may be occasions when the strategies are applied, but you still experience feelings of distress or agitation. Therefore, it's beneficial to devise a backup plan for such circumstances, such as confiding in a supportive person. It's not always necessary to inform the person or people you choose that you're contemplating suicide or experiencing a crisis, but merely talking with them may help you feel better.

When you feel overwhelmed or upset, who is a person who distracts you and makes you feel better? Write down the name and contact information so it is readily accessible when you need assistance.

STEP 5: MAKE A LIST OF PROFESSIONAL HELP RESOURCES

The clinician shares their contact information, along with the contact information of other mental health or medical professionals on the treatment team or others who provide clinical coverage. It is critical for the clinician to clarify their policy on responding to communication from the Veteran outside of sessions. For example, the clinician should communicate the regular business hours of the office and discuss what the Veteran should do outside of regular business hours or if the clinician is unable to answer the phone. As the final step, the Veteran should list visiting the emergency department or 911 if they are in immediate crisis.

Clinician Script

It is crucial to ensure that you have access to professional help when you experience a crisis. First, include my contact information next on your plan, but please keep in mind that I may not be able to answer my phone at all times, because I may be attending to other responsibilities or helping other Veterans. Even if I'm unable to answer, go ahead and leave a detailed message with your contact information and time of your call, and I will respond as soon as I can. Write these details on your list.

Every day, I monitor my voicemail, so if you have left a message, I will return your call on the next business day. However, if my schedule allows, I may be able to call you back sooner. Regardless, I will always contact you within 24 hours of the next business day. Do you have any questions about this?

In case I am unavailable to answer your call, it's important that you have access to immediate support. We have a toll-free Veterans Crisis Line phone number that you can call anytime you need someone to talk to. When you call the Veterans Crisis Line (dial 988, press 1) you will be able to talk to someone about your symptoms and the crisis you are experiencing. The crisis line is available via phone (dial 988, press 1), or text (838255), or chat online 24/7 at https://www.veteranscrisisline.net/Chat, including holidays. You will always be able to connect with someone who will be there to help.

If none of the previous steps work, you always have the option to call 911 or walk into the nearest emergency department. Although the likelihood of reaching this step is low, many Veterans have found it helpful to include it in your plan as a precaution. As your final step, please write down "call 911" and "go to the ER".

STEP 6: REVIEW THE PLAN AND ASSESS VETERAN BUY-IN

Once the CRP is complete, the clinician will encourage the Veteran to go through each step verbally, which serves two purposes: to confirm that the Veteran comprehends how to use the CRP and to help the Veteran practice using it. If the Veteran has difficulty using any portion of the CRP, the clinician will review that part with the Veteran. The intervention is concluded by the clinician asking the Veteran about their likelihood of enacting their CRP when needed on a scale of 0 to 10, where 0 indicates "not at all likely" and 10 indicates "very likely."

Clinician Script

Let's review the order of your plan. When will you know it's time to go through the steps of this plan? What will your initial step be once you recognize the warning signs? If your initial strategy is not effective or doesn't fit the situation, what other options do you have? If you need to speak to a clinician or seek other professional help, what are the available options? That is a strong plan. Is it easy to understand? Does it seem practical for you? Do you have any questions about how to implement or follow through with it?

After finishing the plan:

What is the likelihood of enacting this crisis plan when needed on a scale from 0 to 10, where 0 indicates "not at all likely" and 10 indicates "very likely"?

If rating is lower than 7 out of 10:

Is there a portion of the plan that makes it less likely that you will use it? How can we modify the plan to increase the chance of you using it?

STEP 7: REVIEW AND REVISE THE CRISIS RESPONSE PLAN DURING EACH FOLLOW-UP SESSION

The plan includes self-management strategies and coping skills, which will be discussed in more detail later. In case the Veteran loses their crisis plan, the clinician will assist them in creating a new plan.

Clinician Script

Have you needed to use the crisis response plan since our last meeting?

If yes:

What were you experiencing at the time, and how did you use it?

If no:

What would you have done if you needed it?

Figure 5-1. *Crisis Response Plan Template and Example from Javi, who has reported thoughts of driving his car off a cliff.*

Note. Adapted from: Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

CRISIS RESPONSE PLAN TEMPLATE	CRISIS RESPONSE PLAN
I will use this crisis response plan when:	**I will use this crisis response plan when:** 1. My symptoms of depression start. 2. I get into fights with my partner. 3. I have difficulty sleeping, which makes my symptoms of depression worse.
Things I will do on my own for 30 mins:	**Things I will do on my own for 30 mins:** 1. Watch a standup comedy special. 2. Exercise 3. Listen to my favorite music.
If that does not work, I will contact other people:	**If that does not work, I will contact other people:** 1. Call my brother: 123-456-7890 2. Call my friend Peter: 987-654-3210 3. Call my mom: 654-321-9876
If I am still in crisis, I will contact a medical professional:	**If I am still in crisis, I will contact a medical professional:** 1. Call Dr. Smith and leave message with my phone number and time I called 2. Call crisis line: 988, press 1 3. Go to emergency room that is down the street from my house 4. Call 911

Figure 5-2. *Common Warning Signs That Precede Suicidal Crises*

Note. Adapted from Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

THOUGHTS	MENTAL IMAGES	EMOTIONS OR FEELINGS	BEHAVIORS OR ACTIONS	PHYSICAL SENSATIONS
• "I'm such a fool." • "I knew it wouldn't work out." • "This will never stop." • "I can't do anything right." • "No one would care if I didn't show up." • "Why do I bother?" • "I can't do this anymore." • "I deserved this." • "I'm a loser."	• Reliving negative experiences • Painful memories • Experiencing flashbacks • Imagining myself attempting suicide	• Feeling down or depressed • Shame or guilt • Remorse • Agitated • Anger	• Crying • Hitting objects • Seclusion or isolating self from others • Pacing • Avoiding activities Being quiet around others • Outbursts of yelling • Shaking • Aggression • Hurting self Rehearsing the suicide attempt • Preparing to attempt suicide	• Pain • Headaches • Agitation • Insomnia • Heart palpitations or racing heart • Muscle tension • Nausea/upset stomach • Chest tightness/breathing issues

Figure 5-3. *Common Self-Management Strategies*

Note. Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

SELF-MANAGEMENT STRATEGIES
• Go for a walk • Exercise • Watch a tv show or movie • Walk or play with a pet • Bake or cook • Listen to music • Relaxation exercises or mediation • Sing • Play an instrument • Play a sport • Take a bath or shower • Go to a park • Read a book • Read spiritual or religious material • Breathing exercises • Prayer • Mindfulness • Look at pictures of friends and family • Write a letter to a friend • Puzzles (e.g., Sudoku, crossword, Sudoku) • Think about or plan a positive event • Think about a fun or positive memory • Play a game on smartphone • Write in a journal • Read letters or emails from friends or family • Eat a favorite food

CHAPTER 6: REASONS FOR LIVING MODULE

Introduction to Reasons For Living Module

Veterans seeking treatment for suicidal ideation often have mixed feelings about suicide, as they may desire both to live and die simultaneously. When a Veteran is experiencing an emotional crisis, they may have difficulty recalling reasons for living and may focus only on reasons for dying (Bryan et al., 2016). Therefore, it is crucial to remind Veterans in crisis of their reasons for living to counteract their tendency to prioritize their reasons for dying. One way to achieve this is by guiding the Veteran through a list of reasons for living. This intervention helps the Veteran recognize and strengthen reasons to live rather than die.

The reasons for living list is an intervention used in Brief Cognitive Behavioral Therapy for suicide prevention (BCBT; Bryan & Rudd, 2018). The reasons for living list enhances the Veteran's cognitive flexibility by directing their attention towards the reasons that have prevented them from attempting or re-attempting suicide. This contrasts with the natural tendency to dwell exclusively on thoughts related to death and suicide. A cognitive bias towards suicide leads to a higher likelihood of a future suicide attempts (Cha et al., 2010; Nock et al., 2010) because the focal thoughts, beliefs, or memories may perpetuate suicidal ideation. Further, people who experience suicidal thoughts are prone to a cognitive bias that makes them less likely to believe that positive events will happen in their lives (MacLeod et al., 1993; MacLeod & Tarbuck, 1994) and endorse fewer reasons to live compared to non-suicidal individuals (Strosahl et al., 1992).

However, people with and without suicidal ideation have similar tendencies to reflect on possible negative future events, yet those with suicidal ideation may have more difficulty imaging positive outcomes. Therefore, the reasons for living list can help counterbalance this tendency and enable Veterans to consider both positive and negative possibilities for the future. This, in turn can lower feelings of hopelessness in the short-term (MacLeod & Tarbuck, 1994).

Creating reasons for living increases cognitive flexibility and introduces ambiguity, which may also reduce risk for suicide, even among Veterans with a will to die. Research has shown that a strong wish to die is correlated with a higher risk of suicide among those who lack the desire to live (Brown et al., 2005; Kochanski et al., 2018). It is important to note that even a small to moderate desire to live can offset the risk from strong desire to die.

Even if the Veteran is able to identify reasons for living, it is crucial to guide and support the Veteran in recalling what makes life worth living, as these reasons can effectively counteract the desire to die. In a clinical trial, incorporating a reasons for living discussion in BCBT's crisis response plan led to increases in positive mood and decreases in feelings of burdensomeness (Bryan et al., 2016). While the intervention may not directly decrease the Veteran's desire to die, it can create enough uncertainty about suicide to postpone the Veteran's decision to attempt suicide. Additionally, outside of a crisis, the more the Veteran discusses and contemplates reasons for living, the more their emphasis on life strengthens.

Creating a list of reasons for living is a straightforward process. The clinician initiates the exercise by asking the Veteran to share their reasons for not completing suicide. Frequently, suicidal Veterans deny having any reasons to continue living. If this happens, the clinician can inquire about factors that prevented suicide attempts or repeated attempts, if the Veteran has a history of suicide attempts. As the Veteran starts to verbalize reasons for living, the clinician should encourage the Veteran to provide as many specifics as possible, as this heightens the emotional impact of the activity. While the Veteran is speaking, the clinician should encourage the Veteran to write these reasons on the reverse side of their

CRP (typically on an index card). When feasible, laminate the index card after completion. The reasons for living list serves as an additional technique for self-management and should be included as an action in that section of the CRP. This allows the Veteran to connect strategies with the other fundamental tools for crisis management and emotional regulation that are being learned.

STEP 1: INTRODUCE THE REASONS FOR LIVING

The clinician discusses the purpose and explains the process of reasons for living to the Veteran.

Clinician Script

I understand that you have been experiencing increased levels of stress lately, which has had a negative impact on your daily life. However, today I'd like to focus on what has helped you persevere through these challenges and kept you going. I've noticed that during difficult times or when feeling overwhelmed, people often forget about the positive experiences they have had in their life, both recently and in the past. Does this sound familiar to you? This happens because our minds tend to recognize our current emotional state and selectively focus on information that matches that state. When feeling down and sad, it's natural for our minds to bring up memories or thoughts that reinforce those feelings. Likewise, when experiencing suicidal thoughts, our minds are inclined to focus on reasons for dying rather than reasons for living. This does not mean that you lack reasons to live, but rather, it's a natural tendency of our minds to forget reasons for living when we are experiencing intense negative emotions. By taking a moment to reflect and actively consider our reasons for choosing to live, we can gain a better perspective on our situation and move forward. Does this make sense?

STEP 2: CREATE A LIST OF THE VETERAN'S REASONS FOR LIVING

Initially, the clinician prompts the Veteran to write their reasons for living. Another way to approach this exercise is to encourage the Veteran to state the reasons why they have not attempted, or have refrained from, attempting suicide.

Clinician Script

What has helped you stay alive? What are your reasons for living that have prevented you from taking your own life? Despite the significant challenges you have faced, you are still here with me today, which suggests something has been sustaining you day-to-day.

STEP 3: INCREASE THE EMOTIONAL SALIENCE OF THE VETERAN'S REASONS FOR LIVING

The clinician helps the Veteran recognize their reasons for living and encourages them to discuss all details to enhance recollection. Following this, the clinician should prompt the Veteran to practice recalling one or two reasons for living during the session.

Clinician Script

Possible open-ended questions to facilitate discussion:

Please elaborate on that further?

Could you walk me through what happened?

What makes you want to continue living when you think about that?

How does that particular factor contribute to your reason for living?

What is it about that experience that brings you joy?

What makes that person significant to you?

As you reflect on these reasons for living, how does your mood shift?

After several reasons for living have been discussed:

You have considered multiple reasons for living, and I am interested in knowing which of them holds the most significance or has the greatest impact on you. What sets it apart and makes it more powerful than the others?

Let's take a moment and really reflect on this reason. I encourage you to close your eyes and envision it vividly, using all five senses. Can you recall a positive memory or story related to this reason for living? Please share it with me, so I can try to understand your perspective as much as possible. As you focus on this reason for living, how do you feel? Do your mood change? Your thoughts? If so, can you elaborate?

STEP 4: WRITE A LIST OF THE REASONS FOR LIVING

Encourage the Veteran to write their reasons for living either on the back of the CRP or on an index card. It is preferable to have the card laminated.

Clinician Script

To easily access your reasons for living when you experience a crisis, let's write down your reasons for living. I suggest keeping them in a place that is easily accessible. Some people have found it beneficial to add their reasons for living on the other side of their crisis response plan. This ensures that all necessary resources are in one place and easily accessible when needed. You can just write them on the back of your card. Does this sound reasonable?

STEP 5: CREATE A PLAN TO REVIEW THE REASONS FOR LIVING AND ASSESS VETERAN BUY-IN

Lastly, the clinician will ask if the Veteran is willing to regularly review their list and create a plan with the details of how often, when, and how long they will do so. It is important that the Veteran commits to this practice, even on days when they are feeling stable. Consistently reviewing their plan helps the Veteran develop coping skills, increase learning, and increases cognitive flexibility. The clinician should ensure that the Veteran is fully invested in the plan by having them self-report their commitment to practice on a scale from 0 to 10, with 0 representing "*not at all likely*" and 10 representing "*very likely*".

Clinician Script

I recommend reviewing your reasons for living list daily, even multiple times throughout the day, to strengthen your memory of them. This will help you recall them more easily when you're feeling stressed or in crisis. Can you commit to doing this regularly? How often do you think you could realistically review the list during the day?

Let's take this a step further and consider how much time you can dedicate to each review session. It's important to really immerse yourself in the details and visualize each reason. Is there a specific place where you would like to practice, such as in your home or somewhere else? Additionally, are there any specific times of day that may be more beneficial for you to practice? For example, some people find it helpful to do this first thing in the morning.

After finishing the plan:

It seems like we have a well-defined plan in place. Before we wrap up, may I ask you to rate on a scale of 0 to 10, with 0 indicating "not at all likely" and 10 indicating "very likely," how likely you are to stick to the plan and practice this skill?

If rating is lower than 7 out of 10:

Which part of the plan do you think makes you less likely to use it? Is there anything we can change or modify to make it more likely that you would use it? Discuss ways to modify.

CHAPTER 7: MEANS RESTRICTION COUNSELING

Introduction to Means Restriction Counseling

Means restriction counseling can be divided into two separate yet connected facets: (a) determining the accessibility of a firearm or other lethal means among a Veteran at risk for suicide; (b) collaborating with the Veteran and their social support system to aid in restricting access to lethal means until suicidal thoughts cease (Harvard University School of Public Health., n.d.). There are many notable interventions for preventing suicide; however, lethal means restriction is highly supported by the empirical evidence and has prevented more deaths by suicide across populations and samples than other interventions (Anestis et al., 2021; Bryan et al., 2011; Mann et al., 2005). Public health studies indicate that limiting access to lethal means is effective when the method of choice is more prevalent and lethal (Mann et al., 2005). Means restriction has played a significant role in suicide prevention for some time, but only recently have clinical guidelines, recommendations, and trainings become available for clinicians working with suicidal patients (Britton et al., 2016; Bryan et al., 2011).

Although eliminating access to lethal means completely would be ideal for all suicidal patients, it is not always reasonable or plausible. Means restriction emphasizes the separation of a patient who is at-risk for suicide from their lethal means of choice, particularly during a suicidal crisis. To create this separation, barriers to access lethal means are put into place. Safe storage devices, such as trigger locks, cable locks, and/or gun safes, as well as storing a gun and ammunition in separate places, can be utilized by at-risk clients who own firearms and refuse to remove them from their household (Bryan et al., 2011). Incorporating these barriers provides time and space between the Veteran experiencing a suicidal crisis and their access to lethal means, which may give them enough time to stop and think about their actions, recover from the crisis, or seek help.

Clinicians widely believe the lethality of a suicide attempt is most strongly related to the severity of the individual's emotional distress. However, studies show that the strongest correlation with deaths by suicide is accessibility of lethal means (Barber & Miller, 2014; Brown et al., 2004; Gunnell et al., 2000; Swahn & Potter, 2001). In countries like the United States, where firearms are widely accessible and common, the rate of lethality is higher. For that reason, inquiring about a Veterans access to firearms remains a key factor for the clinician, even when the Veteran does not report it as a means to end their life. During means restriction counseling, the clinician must be sensitive to the Veteran's autonomy by offering several options to safely store their lethal means. This allows the Veteran to have more control over their personal property and instills personal responsibility for keeping themselves safe. Restricting lethal means can sometimes threaten or intimidate the Veteran. To ensure that the patient does not feel this way, the clinician is encouraged to approach lethal means safety as a method to promote safety versus suicide prevention (e.g., address "gun safety" instead of "restriction of gun access"). This approach allows the Veteran to feel more autonomous in this process, which increases buy-in and the likelihood the Veteran will continue with lethal means counseling. The clinician may also encourage the Veteran to include a concerned significant other or someone in their social network to be part of the lethal means safety planning (i.e., the person would hold onto lethal means during crisis situations, agree to be contacted during crisis).

Means Restriction Steps Using Motivational Interviewing

Means restriction counseling is an intervention used in Brief Cognitive Behavioral Therapy for suicide prevention (BCBT-SP; Bryan & Rudd, 2018). The clinician and the Veteran discuss means restriction and develop a plan to keep the Veteran safe during times of emotional crisis. Once the clinician and Veteran

develop a plan, it should be recorded onto a means restriction plan and receipt template (see **Figure 7-1**). The template includes three primary components: (1) developing specific steps to limit access to lethal means; (2) identifying people in the Veteran's social network who will assist with the plan; (3) deciding on the specific conditions that must be met to restore access to the lethal means. At times, the Veteran may continue to express ambivalence and concern about limitations to access lethal means. Therefore, the best approach is to address means restriction counseling in stages, which is aligned with the principles of motivational interviewing: engage, focus, evoke, and plan (Miller & Rollnick, 2012).

- **Engage.** To initiate the conversation, the clinician should introduce the concept of means restriction counseling and invite the Veteran to candidly discuss their initial thoughts and feelings. The clinician should consider the Veteran's perspective when determining the best course of action. It is also important for the clinician to collaborate with the Veteran to move away from thoughts of suicide and towards reasons for living while discussing of accessibility to lethal means.
- **Focus.** Having a guided discussion may help the client feel more comfortable talking about means restriction. The clinician can focus on balancing the conversation between directly addressing lethal means restriction and engaging in an open discussion with the Veteran to encourage choice and autonomy in participating. The Veteran should have the opportunity to express any thoughts or concerns.
- **Evoke.** Once the Veteran agrees to discuss means restriction, the clinician invites them to identify possible reasons it may be beneficial to restrict access to lethal means during times of crisis. To reinforce that the Veterans autonomy (Hoyt et al., 2021), the clinician poses a situation in a way that allows the patient to consider how means restriction can prevent suicide. To encourage openness, the clinician should listen to any concerns the Veteran may have regarding means restriction and respond in a nonjudgmental and unbiased manner, which helps to establish rapport. It may take more time for some Veterans to agree to the idea of means restriction. Consistently raising the topic of means restriction as an option to keep the Veteran safe can be the initial step for future change.
- **Plan.** The clinician should aid the Veteran in creating a realistic plan of action. Writing the plan down on paper is a great way to reinforce the lethal means restriction plan. The clinician begins by introducing the means restriction plan and receipt template (see **Figure 7-1**). The clinician should help the Veteran identify specific goals for the plan and determine who in their social support system (i.e., concerned significant other) could assist in carrying out the plan (e.g., have a friend store my firearms; use a trigger lock; safely store extra medications). The created plan should be mutually agreed upon by the clinician and the Veteran. Once the plan has been finalized, the concerned significant other will confirm their willingness to participate in the plan by signing the document.

Figure 7-2 highlights talking points for the clinician when discussing means restriction. Sarah's example means restriction plan and receipt are displayed in **Figure 7-3,** which shows that Sarah agreed to keep a limited supply of the prescribed dose of pain medication in a pill box at home. She will give the rest to her sister who lives nearby for safekeeping, who will either come to the house and refill the pill box or Sarah can take the pill box to her sister's home the following week. Sarah consented to invite her sister to attend the next session to educate her about means restriction and confirm her agreement to implement the plan when necessary.

Means restriction counseling focuses on three main assumptions: (a) the individual's suicidal distress is acute and brief, (b) further attempts of suicide are unlikely if the individual survives a previous suicidal crisis, and (c) ease of access to lethal means is strongly correlated to the likelihood of a lethal suicide attempt outcome (Bryan & Rudd, 2018). The fluid vulnerability theory suggests that suicide risk is

fundamentally dynamic over time with phases of imminent risk being fairly brief and time-limited (Bryan et al., 2020; Rudd, 2006). The literature supporting this theory indicates that most individuals who attempt suicide reported that they made their final decision to act within one hour of the attempt (Simon et al., 2001). Because this time frame is limited and does not give the clinician or concerned significant others an opportunity to intervene, introducing means restriction when the individual is in extreme emotional crisis and before an attempt is often the first step in preventing death by suicide. One study indicated that only 10% of people who survive a suicide attempt requiring medical aid end up dying from a future suicide attempt after being introduced to means restriction (Owens et al., 2002). Therefore, it is unlikely that those individuals who have recovered from a suicide attempt will attempt suicide in the future.

STEP 1: DISCUSS SAFETY AND SCREEN FOR FIREARM ACCESS

The clinician begins means restriction counseling from the perspective of improving outpatient safety and reviews the recommended discussion points listed in **Figure 7-2**.

Clinician Script

We've been discussing the difficulties you've been dealing with that are causing stress in your life. I appreciate your open discussion with me. I know it has not been easy. With everything you're experiencing, I'm wondering if you'd be willing to talk about how we can keep you safe while you're in treatment?

As you've likely experienced firsthand, the desire to die by suicide can come quickly. When you have easy and convenient access to potentially lethal methods for killing yourself, it can be very dangerous when you're experiencing a crisis. I'd like us to consider how temporarily limiting your access to any form of lethal methods can keep you safe. As your therapist, you probably know that my preference is that you have no access to a potentially lethal method. However, that may not be preferable or possible. So, I was hoping to meet you halfway and discuss how we can come up with a plan to increase your safety while you are in control of your well-being. How does that sound to you?

Are you open to taking a few minutes to discuss how we can create a plan to keep you safe while you're in treatment.

STEP 2: EXPLAIN THE IMPORTANCE OF FIREARM SAFETY TO THE VETERAN

The clinician explains why there is a focus on firearm safety and reviews the discussion points listed **Figure 7-2**. Next, the clinician invites the Veteran to discuss possible reasons to safely store their firearms temporarily.

Clinician Script

Safely storing firearms is one major way to increase safety. Let's talk about gun safety since having easy access to guns when you're feeling extremely upset could potentially lead to a bad outcome. How many guns do you have access to in your home? Do you have access in any other places?

Open-ended questions to facilitate discussion:

What are your thoughts about firearm safety?

What are your thoughts about someone you care about having access to guns when you are really upset and are thinking about suicide?

What are some benefits of temporarily limiting your access to firearms?

If completely removing access to guns is not possible, what other options can you think of for practicing good gun safety while you're going through this treatment?

What do you think about creating a plan together for this?

STEP 3: CREATE A WRITTEN MEANS RESTRICTION PLAN

The clinician and the Veteran collaborate to create a written plan for means restriction and the Veteran identifies a concerned significant other who would be willing and able to assist the Veteran in carrying out the plan.

Clinician Script

Now that we've created a plan to keep you safe, let's write this down so you have it if you need it. Including a trusted friend or a family member in this plan will significantly increase the likelihood it will help you when you need it. Who do you think could be helpful to you in carrying out the plan? Would you be open to inviting that person to meet with us to talk about our plan and about firearm safety?

If yes:

That's great to hear! Would you see if they can come to our next appointment?

If no:

Ok, no problem. Even if they aren't able to come in, are you open to discussing our plan with them and asking them to help?

If yes*:*

"Great, you could go over the plan with them and have them sign it to confirm they agree."

After finishing the plan:

What is the likelihood that you will follow this plan on a scale from 0 to 10, with 0 being "not at all" and 10 being "definitely"?

If 7 out of 10 or lower:

What are some reasons that you may not use the plan? What changes could we make to the plan that would make it more likely that you would use it?

Figure 7-1. *Means Restriction Plan Template*

Note. CSO – concerned significant other. Adapted from Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

Means Restriction Plan

Questions? Contact your provider. Emergencies call: 911.

QUESTION	ANSWER
Provider's Name:	*First Name, Last Name*
Provider's Contact:	*Phone Number*

QUESTION	ANSWER
Veteran's Name:	*First Name, Last Name*
CSO's Name:	*First Name, Last Name*
CSO's Contact:	*Phone Number*
Safety Plan:	*Safety Plan Details*
Terms for Ending Plan:	*Terms for Ending Plan*
Veteran's Signature:	*Veteran Sign Here*
CSO's Signature:	*CSO Sign Here* *(To be signed upon completion of means restriction)*

Figure 7-2. *Recommended Topics for Means Restriction Counseling*

Note. Adapted from Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

RECOMMENDED TOPICS FOR MEANS RESTRICTION COUNSELING
1. Desire to die by suicide can emerge and escalate very rapidly.
2. During a crisis, access to lethal means is dangerous.
3. Temporary means restriction during crisis can lessen the chance of a lethal outcome.
4. If removal of all lethal means is not feasible, these options will enhance safety: a) Temporarily give access to the lethal means to a trusted friend or family member during a crisis. b) Lock up the lethal means in a safe to restrict access. c) For firearms: 1) Take the firearm apart, separate a key piece and give to a concerned significant other (trusted family or friend). 2) Keep the firearm in a safe and provide the key or combination to a concerned significant other. 3) Unload the firearm and store the firearm and ammunition separately. 4) Use a gun lock, gun safe, or trigger lock.
5. Hiding lethal means (especially firearms) without unloading, is not safe because someone may find it.

RECOMMENDED TOPICS FOR MEANS RESTRICTION COUNSELING
6. When children live in the home or parent's share custody, take extra precaution that all lethal means are securely stored. Involve a concerned significant other to help with means restriction and safe storage of firearms.

Figure 7-3. *Example Means Restriction Plan for Sarah*

Note. CSO – concerned significant other. Adapted from Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention*. Guilford Publications.

Means Restriction Plan

Questions? Contact your provider. Emergencies call: 911.

QUESTION	ANSWER
Provider's Name:	Dr. Lisa Patel
Provider's Contact:	XXX-XXX-XXXX
Veteran's Name:	Sarah
CSO*'s Name:	Grace (sister)
CSO's Contact:	123-456-7890 (sister's cell phone)
Safety Plan:	• Only keep a limited amount of prescribed medication in a pill box at home. • Allow Grace to keep pill bottles/any extra supply, and only refill pill box at Grace's house when she is present. • Let husband check pill box regularly to hold Sarah accountable for only taking the prescribed amount.
Terms for Ending Plan:	Completion of treatment
Veteran's Signature:	*Veteran Sign Here*
CSO's Signature:	*CSO Sign Here* *(To be signed upon completion of means restriction)*

CHAPTER 8: INTENSIVE CASE MANAGEMENT

Introduction to Intensive Case Management

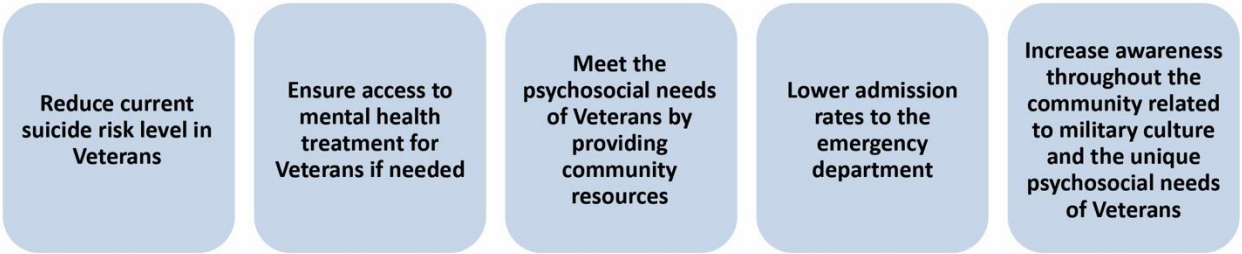
Integrated case management within VA is designed for Veterans who are eligible for and/or receiving VA health care. For Veterans who are enrolled in VA Community Care, at risk for suicide, and not engaged with VA mental health, there is, unfortunately, no manual or, disseminated case management strategies to provide direction for these Veterans. The following is an attempt to provide guidelines for intensive and comprehensive case management services for at-risk Veterans outside of the VA health care system.

Case management is "a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes" (Case Management Society of America, 2017). Case management provides both positive impacts for the patient's entire system (e.g., their family/social support system, the health care delivery systems, and the broader community) and streamlines care (Case Management Society of America, 2017).

Intensive case management (ICM) provided by SUPERCEDE involves several steps to ensure continuity of care while being connected to services addressing social determinants of health in the Veteran's local community and outside the VA health care system, including connection to mental health care if needed. There are four primary principles guiding ICM steps adopted by the VA's current integrated case management system. First, ICM includes the Veteran's entire social network, when appropriate, to discuss physical and mental health care, which fosters inclusivity. Second, as care coordination is initiated, ICM strategies seek to develop trusting relationships and partnerships among the clinician, Veteran patients, and community providers. Third, and in a timely fashion, appropriate psychosocial needs of the Veteran are provided by the ICM clinician. Finally, the clinician maintains regular communication with the Veteran and community care agencies involved in the Veteran's care in an effort to continuously evaluate the value and quality of service being provided. Increasing access to needed services by transitioning the Veteran into community referral partners' care is the goal of SUPERCEDE.

Figure 8-1 highlights the five primary goals of ICM in SUPERCEDE. The main goals of ICM with Veterans at-risk for suicide and enrolled in VA Community Care within the SUPERCEDE intervention are supported by the four principles of ICM: inclusive, trusted relationships and partnerships; accountability; and quality and value. Accomplishing these goals throughout VA and non-VA health care systems will better align these systems to provide comprehensive care to Veterans.

Figure 8-1. *Goals of Intensive Case Management in SUPERCEDE*



STEP 1: UNDERSTANDING WHERE CARE IS ACCESSED

Determining where the Veteran accesses their care is important and is tracked in the assessment of needs (see Appendix 3). One example is identifying and reducing duplicative care the Veteran may be receiving. Also, the clinician should assess the Veteran's need for mental health treatment. If necessary, the clinician may need to provide a consult for the Veteran to return to VA mental health care. If the Veteran is receiving mental health treatment outside of VA, that information should be updated in the Veteran's medical record so there is no duplication of care on the VA side. As appropriate, the clinician should consult with VA Office of Community Care and/or the Suicide Prevention Team and coordinate mental health efforts over multiple providers, as necessary.

Case Study

Marcus, a Veteran, needs knee replacement surgery. His local VA does not offer this service, and he will be sent out for community care. Marcus is currently unemployed and homeless, reporting that he is living out of his car when he is unable to stay at a friend's house. The Veteran had a suicide attempt 5 years ago. He engaged with VA mental health for a few sessions following his suicide attempt and then disengaged from VA mental health care. Marcus still has a diagnosis of PTSD on his problem list and is not receiving any mental health care from the VA. Veteran Marcus's surgery will be difficult, and his recovery will require pain management, clean dressing changes to avoid post-operative site infection, and functional rehabilitation, as well as support at home during recovery.

The clinician's role to help Marcus with the following:

Conduct an assessment of needs.

Obtain permission from the Veterans to discuss mental health needs pertaining to surgery and recovery with the surgical team.

Assess whether Marcus needs mental health treatment currently, particularly due to his upcoming surgery since issues surrounding surgery and recovery may increase risk for suicide.

Assess availability of transitional housing prior to and during post-operative recovery.

Assess resources available for food insecurity and other basic needs.

STEP 2: PRIORITIZE THE VETERAN'S NEEDS FROM THE ASSESSMENT

When determining which issue to address first, the clinician should use a combination of the Veteran's goals, clinical judgement, and guidance from Maslow's hierarchy of needs (Maslow, 1943). Maslow's hierarchy of needs in order of priority include physiological needs, safety needs, love and belonging, esteem, and self-actualization. To align the priority of needs with the Veteran's self-stated goals, the clinician and the Veteran should work collaboratively (use the Assessment of Needs provided in Appendix 3). Mental health care needs to be the primary referral for all Veterans. The clinician should emphasize that the Veteran should attempt to connect with the referral prior to the next session. Encourage the Veteran to call and let you know that they made the call or create another system of accountability that involves a deadline for making the call. Systems of accountability help the Veteran make connections and build momentum.

Maslow's Hierarchy of Needs to Prioritize the Assessment of Needs

After making the connection to mental health, the next referrals should be based on a collaborative discussion with the Veteran guided by Maslow's hierarchy of needs (Maslow, 1943), which states that a

person's physiological needs must be met before any other needs. Needs such as difficulty accessing water, food, or clothing, or getting enough sleep, should take priority. The clinician should balance physiologic needs with other needs that are influencing suicidal ideation. For example, if a relationship break-up is influencing suicidal ideation, that may take precedence over basic needs.

Safety, including securing housing/shelter, resources, employment, health, and other aspects of personal property, should be addressed after the Veteran's physiological needs. Securing a Veteran's access to health care and resources likely would be the primary and possibly most time-consuming needs to be addressed in the safety category. Again, addressing needs that influence suicidal ideation are the priority.

Once physiological and safety needs are addressed, needs relating to belonging and love may be addressed. This category centers around having social support and a sense of connection to others. Having a support system of trustworthy people the Veteran can lean on in times of high stress and crisis is imperative in suicide prevention. Another priority is helping the Veteran find ways to grow their social circle, if it appears lacking, and spending adequate time working with the Veteran to identify people they would feel comfortable talking with if in distress.

Needs related to esteem are near the top of the hierarchy of needs. Veterans participating in SUPERCEDE will likely need support from the clinician in improving their sense of competence and independence, particularly related to managing suicidal ideation and health care challenges. The clinician should be thoughtful of this by regularly checking how the Veteran feels throughout each step of the SUPERCEDE process. It is likely that the Veteran's needs for esteem will be addressed and improved by using this manual to guide the Veteran through their present problems.

The final tier of Maslow's hierarchy of needs is self-actualization, which occurs when an individual reaches his or her full potential (Maslow, 1943). It is important for the clinician to recognize that the Veteran's motivation to work on personal growth may be increased once other needs are met. Self-actualization is a subjective appraisal of what a Veteran believes they are capable of accomplishing.

In collaboration with the Veteran, make a complete list of the Veteran's needs on the Assessment of Needs Form (see Appendix 3) by having an open discussion about what the needs are and the priority of each need. To better understand the holistic nature of the Veteran's needs, it's important to take detailed notes. Have a collaborative discussion of priorities based on both the Veteran's and clinician's perspectives. After this discussion, create a list of needs in order of priority, ranked as low, medium, and high levels. A low-level priority is a need that is not currently driving suicidal thoughts, and may not need to be addressed immediately. A medium level priority may be driving suicidal thoughts or is a need that should be addressed immediately. A high-level priority is one that drives suicidal thoughts and needs to be addressed immediately.

STEP 3: CONNECT THE VETERAN WITH NEEDED RESOURCES

In SUPERCEDE, the clinician using this manual is the Veteran's intensive case manager. The clinician will serve as the Veteran's primary point of contact for questions or concerns that come up as the Veteran navigates community services. Taking the sole ownership of care coordination off the Veteran can increase the Veteran's adherence to treatment recommendations. The clinician, as case manager, helps create a trusting relationship between the Veteran and community referral partners providing care.

After identifying the Veteran's priority of needs, provide resources starting with the highest priority need -- the one that helps the Veteran make positive changes and reduces suicide risk. First, the clinician

should ask the Veteran if he or she would like a referral, followed by making every effort to call these resources to make appointments with the Veteran.

The clinician uses community asset mapping to identify the possible local referral sources (see Appendix 1). If time permits and the clinician has identified few relevant resources, the clinician should make the first contact attempt with the Veteran in session. This strategy may increase the Veteran's trust in the ICM process, the clinician, and the community partners. Part of ICM work involves a trial-and-error component and the clinician may find that a referral source is not a good fit for the Veteran. If this happens, the clinician should try a different option, which demonstrates competence and trust navigating an otherwise intimidating and confusing process.

Clinician - Veteran Script

Clinician: *Thank you for answering my questions and opening up to me about your life. Now that I have a better understanding of what has been going on for you, I'd like for us to prioritize your needs as low, medium, or high-level needs. You indicated that you are currently living out of your car because you lost employment, and you are scheduled to have surgery. Your unemployment and unstable housing seem to be increasing your feelings of depression and thoughts of suicide. You are also trying to submit disability claim paperwork to VA. Additionally, you are not currently receiving mental health care, and you have no health insurance or steady income. To me, your mental health needs and housing seem to be the most important issues to address. What do you think?*

Veteran: *I agree, my thoughts of suicide have gotten worse since I lost my job and it's really scaring me. I'm also feeling pretty hopeless, not knowing where I can find a safe place to sleep.*

***Clinician**: I know you don't have health insurance and you are working to get a PTSD disability claim through the VA benefit system, which can take a while. I do know that the local hospital system, Moorewood Hospital, provides free health care to individuals. Do you currently have any source of income?*

Veteran: *Right now, no.*

Clinician: *Okay, based on that, the good news is that it seems like you qualify for this program. The sooner we get you started with their intake process the better, what do you think?*

Veteran: *Yes, I agree.*

Clinician: *Ok, great. I'm going to give you the contact information. I really think it's important that you call them today. What do you think about pausing our sessions for a few minutes, so you can call the hospital? It shouldn't take you more than 15 minutes. If you have to leave a voicemail, I would leave your name, phone number, and that you want information on services. Does this sound OK?* **[If Veteran is on Zoom/telehealth, it is preferable if he/she can stay on video during the phone call. If session is being held via phone, have the Veteran hang up, call, and instruct them that you will call him/her back in 15 minutes.]**

Veteran: *Yes, I can do that.*

Clinician: *OK, great, we'll rejoin our session in 15 minutes and go from there.*

Clinician: *How did the call go?* **[Help Veteran problem-solve or make plans for next steps to contact or receive services from referral.]** *This kind of accountability is exactly what we will have set up at every step of the SUPERCEDE program. This is how you start to take ownership and some control over your*

health and livelihood, and it helps us stay on track accomplishing your treatment goals. Does this type of continued accountability throughout our time working together sound reasonable to you?

Veteran: *Yes, I like the idea of having a way to be accountable.*

Clinician: *Great! The next priority is housing.*

Veteran: *Yes, I never know when I will have to sleep in my car, and I'm worried about my upcoming surgery.*

Clinician: *Yes, that is a big concern. There is a local, non-profit organization called Veteran Housing works that assists Veterans in finding housing. Would you like to connect with them?*

Veteran: *Yes, that would be great.*

Clinician: *Ok, let's call them together now.* **[Clinician helps the Veteran set up an appointment]. [Clinician continues to address all of the Veterans needs until they finish the list].** *To make sure our efforts are aligned with what you want to see change in your life, we will keep returning to these needs as we work together.*

Some Veterans may have difficulty engaging in the referral process and establishing care. Accountability, as mentioned previously, is critical for these Veterans. As the Veteran reaches out to clinical and other referrals, it is important to set deadlines. You can always suggest that the Veteran call you for a brief check-in by phone if they are having difficulty connecting with an organization. Additionally, have the Veteran call the clinician instead of the clinician continually checking-in on the Veteran, as this will help support momentum in establishing care and getting the help needed for recovery. Have a conversation with the Veteran if they continue to struggle with establishing referrals. If the Veteran is unable to successfully follow-through, the SUPERCEDE program may not be the right fit. It could also suggest that the Veteran is experiencing barriers that are a contraindication for SUPERCEDE, such as substance use or alcohol use disorder requiring detoxification, or cognitive issues that are severe enough that making connections to community care isn't possible. Either way, discuss the reasons the Veteran has not connected to the referrals. This will help the clinician understand if SUPERCEDE isa good fit or if the Veteran needs more intensive services for recovery.

CHAPTER 9: OVERVIEW OF SESSIONS TWO THROUGH SIX

Overview of Sessions Two Through Six

After session one, the clinician will continue with the SUPERCEDE module sessions as well as case management and community care coordination based on the assessment of needs. Chapters 10 through 17 contain modules that focus on a variety of topic areas. The clinician selects applicable modules based on the Veteran's needs. In prior clinical trials, treatments tailored to include modules the clinician could choose based on needs produced better outcomes compared to less flexible treatments (Davidson et al., 2007). The clinician should pay careful attention to needs and challenges that may contribute to the Veteran's suicidal thoughts. For instance, if the Veteran experiences thoughts and beliefs that drive suicidal ideation, the clinician can consider including Chapter 12, which focuses on changing thoughts. The clinician should determine which modules to use based on clinical judgment, the assessment of needs, and the suicide risk assessment. Session content is outlined below and in **Figure 9-1**.

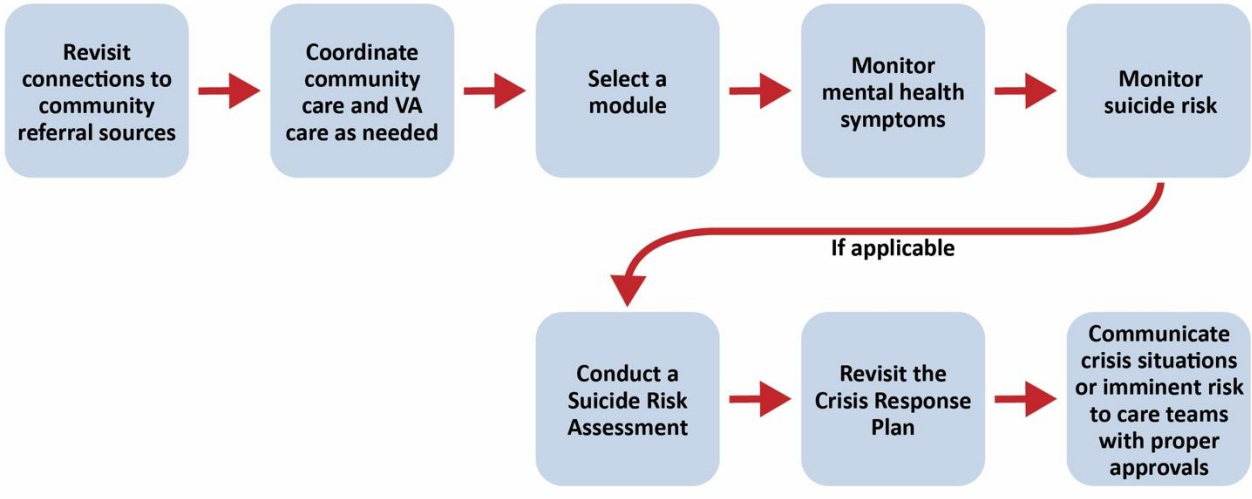
SESSION CONTENT

1. Revisit connections to community referral sources
2. Coordinate community care and VA care as needed
3. Select a module (Chapters 10-17)
4. Monitor mental health symptoms
5. Monitor suicide risk
   If applicable:
6. Conduct a Suicide Risk Assessment
7. Revisit the Crisis Response Plan (CRP)
8. Communicate crisis situations or imminent risk to care teams with proper approvals

SUICIDE RISK ASSESSMENT

Continue the suicide risk assessment (see Chapter 4 and Appendix 2) at all additional sessions.

Figure 9-1. *Session Content for Modular Sessions*



Revisiting the Crisis Response Plan

The crisis response plan (CRP) is an important part of the SUPERCEDE intervention. At every additional session, the clinician should ask if the Veteran used their CRP since the last session. If the Veteran has used the CRP, the clinician should go over the circumstance(s) that led to suicidal ideation and how they enacted their plan. If the Veteran was able to successfully enact the plan, the clinician should provide positive reinforcement. The clinician should also troubleshoot any barriers to enacting the CRP, which may necessitate changes to the plan. Portions of the crisis response plan that the Veteran found ineffective should be modified or removed.

STEP 1: MONITOR MENTAL HEALTH SYMPTOMS

The clinician should check in with the Veteran to see if they have had any changes or an increase in mental health symptoms, such as symptoms of depression or PTSD. If so, the clinician should re-evaluate their current care plan to ensure they will be connected to long-term mental health care. Further, the clinician should consider symptom exacerbations when choosing modules.

STEP 2: REVISIT CONNECTIONS/REFERRALS

Next, the clinician should ask whether the Veteran was able to connect to the community referrals for resources and services that were provided, whether the connection was successful, and how the resources were able to meet the Veteran's needs. Although the clinician may have connected the Veteran with the referral and assisted with scheduling their initial appointment, the Veteran may not follow-through with the referral. When checking in with the Veteran, the clinician can examine what barriers may have impacted the Veteran in connecting to the referral and can discuss solutions to overcome those barriers. One possible issue is that the Veteran may have a negative experience connecting with or interacting with the referral source. Depending on the situation, the clinician could respond by either reaching out to the referral source on the Veteran's behalf to explore options for resolution, or assist the Veteran in exploring options to address the issue independently. Occasionally, the clinician and the Veteran may decide that the referral source is not a good fit, is not able to meet the Veteran's needs, or is not providing high-quality services, and an alternate community referral can be provided.

STEP 3: SCHEDULE ADDITIONAL VA APPOINTMENTS AS NEEDED

In the case study from Chapter 8, Marcus is having knee surgery and may need additional VA appointments as he goes through this process. The clinician can ask him what additional care he may need and collaborate to determine what additional VA provider appointments are necessary.

STEP 4: SELECT A MODULE

Following the suicide risk assessment, the CRP review, and the status of community referrals, the clinician can choose which of the following modules would be most appropriate based on the Veteran's needs and the clinician's judgement. Modules are grouped by category of focus and are discussed in various chapters of this toolkit.

Module Chapters by Topic Category

Cognitions (Chapters 10-13)

Chapter 10 – Coping Cards

Chapter 11 – Thought Log ("ABC") Worksheets

Chapter 12 – Challenging Thoughts and Beliefs Worksheets

Chapter 13 – Addressing Problematic Thinking Worksheets

Behavior (Chapter 14)

Chapter 14 – Activity Planning

Sleep (Chapter 15)

Chapter 15 – Stimulus Control and Sleep Hygiene

Relaxation (Chapter 16)

Chapter 16 – Relaxation and Physiological Regulation Skills Training

Mindfulness (Chapter 17)

Chapter 17 – Mindfulness and Meditation Training

Once a community placement has been made or once the Veteran has completed three sessions, the Veteran will progress to the follow-up phase of the intervention (see Chapter 18 for more details).

CHAPTER 10: COPING CARDS

Introduction to Coping Cards

Coping cards are a tool used to remind Veterans of positive, affirmative statements and encourage Veterans to use the information learned during treatment sessions (Bryan & Rudd, 2018). Positive statements are written on index cards, which are convenient for the Veteran to carry with them to remind them of ways to adapt their thoughts or behaviors. Coping cards serve as a concrete, visual aid to assist the Veteran in recalling how and when to apply the cognitive and behavioral skills they learned in treatment.

In addition to reminding Veterans of ways to adapt their thoughts and behaviors, coping cards can be used to help a Veteran interpret internal emotional stimuli related to suicidal thoughts differently or can alter a Veteran's reaction to an interaction, circumstance, or environment. A separate coping card could be designed to remind Veterans to utilize a coping skill (e.g., meditation) when they encounter a situation that historically elicits an urge to react undesirably (e.g., an urge to use an illegal substance). Coping cards serve as convenient references, similar to study cards used to prepare for a test.

Figure 7-1 provides an example of Sarah's coping cards (Bryan & Rudd, 2018). The cards can be used across situations and applied to a variety of circumstances. Cards A and B strengthen cognitive reappraisal skills. The Veteran records a suicidal thought or maladaptive belief they have experienced on one side, and records an adaptive, alternative response on the other side to provide guidance. Veterans using cards A or B can be instructed to review these cards periodically throughout the day (e.g., when they wake up, during a lunch break, or after dinner), particularly when they are likely to experience maladaptive thoughts. The coping cards serve a similar purpose as the ABC Worksheets (see Chapter 11), Patterns of Problematic Thinking Worksheets (see Chapter 12), and Challenging Questions Worksheets (see Chapter 13). Cards C and D may help the Veteran learn additional coping strategies or behavioral patterns. The behavioral coping cards include an example of a circumstance the Veteran may experience on one side and a series of helpful actionable steps on the other side. Coping cards are designed to replace a maladaptive targeted behavior or suicide-related belief with more adaptive actionable steps the Veteran can follow. The use of the coping cards may provide support as the Veteran attempts to change thoughts and behaviors, which enhances the probability of adopting a new response pattern. Coping cards have a similar objective as a crisis response plan (Bryan & Rudd, 2018).

During a session, the clinician can guide the process of creating the coping cards. The clinician can provide two or three index cards for the Veteran to handwrite their statements for best results. Once the coping cards are created, they can be laminated to last longer and increase their significance. For best results and greater impact, instruct the Veteran to review the coping cards a few times a day, even if they feel their current circumstances do not warrant review.

Coping cards serve as a quick reference and a reminder of what the Veteran learned in treatment. As with other Brief Cognitive Behavioral Therapy (BCBT; i.e., problem-solving skills) interventions, skills can be rehearsed and learned through the use of the coping cards (Bryan & Rudd, 2018).

STEP 1: INTRODUCE THE IDEA OF THE COPING CARD

The clinician introduces the purpose of the coping card as a memory tool to assist in acquiring a new skill or alter a response.

Clinician Script

Based on what we have discussed, we will now create a coping card to assist you in developing and efficiently mastering this new skill. You can think of a coping card as a tool, like a study card you may have used to prepare for a test. It can assist you in remembering new skills. Here is an index card where we will record the parts of the skill that will be most beneficial to you. Always have the coping cards available as a quick reference to what we have learned here. You can store them in your bag, pocket, or anywhere that is easily accessible.

STEP 2: CREATE COPING CARDS

When creating the coping cards, the clinician should ensure the content correlates to a BCBT intervention.

Clinician Script

For cognitively oriented cards:

This belief seems to stand out and may require effort and concentration as you work on this. Would you consider creating a coping card for this specific belief? The card would provide a reminder and a reference about what we discussed today.

On one side of the index card, you can write down the belief that we are working on. On the other side, you can write the alternate response to that belief that we discussed.

For behaviorally oriented cards:

Learning a new skill and using it in daily life can be difficult. It seems like this specific skill in certain circumstances may be a challenge. Would you like to create a coping card to provide a reminder of how to respond in this particular circumstance using the alternate behavior we discussed today?

On one side of the card, you can write the situation that presents a challenge. On the other side, you can write out the newly introduced behavior that could replace your previous response. Sometimes, it can be beneficial to break a new skill or behavior into smaller steps, like following a recipe. Would it be helpful to break this behavior into individual steps?

STEP 3: CREATE A PLAN TO REVIEW COPING CARDS BETWEEN SESSIONS

The clinician and Veteran should develop a strategy to regularly review and use the coping cards outside of session. Frequently reviewing and using the cards as situations arise enhance the likelihood that the information is being learned efficiently and the skill is being practiced. The clinician can explain the importance of reviewing the coping cards according to the agreed upon plan, even if the Veteran feels it is unnecessary at that time. The clinician can assess the probability of the Veteran adhering to the schedule by asking the Veteran to rate the likelihood of reviewing the cards according to the schedule on a scale from 0, representing "*not likely at all*" to 10, representing "*very likely*".

Clinician Script

Regularly reviewing your coping cards throughout the day, even when you are not confronted with a trigger, will help you learn and implement the skill. Reviewing the cards consistently will help you recall the information quickly. By practicing the information regularly, you will be more prepared to incorporate this knowledge when you do need to utilize the skill. Do you know what I mean?

Let's figure out times during the day that you would feel comfortable pulling out the cards to review them. If you review them regularly, it shouldn't take much of your time. It may help to identify specific moments that occur each day when you could pull out the cards, that way you do not have to worry about finding time every day. The times would already be decided upon. Options that work for some people are before or after meals since that occurs multiple times each day. Another time to review the cards could be during bathroom breaks, which occur regularly as well. What times of day do you think would work for you?

STEP 4: EVALUATE VETERAN BUY-IN

Clinician Script

I think we have figured out a good strategy to review the cards throughout each day. You can practice by reading your card at those times, and you can practice using the skill when you are confronted with a trigger. On a scale from 0 representing "not likely at all" to 10 representing "very likely," how would you rate the likelihood that you will use the cards according to the plan?

If rating is lower than 7 out of 10:

What part of your strategy might make it hard for you to review the card or use the card when you are faced with a trigger? What ideas do you have to improve the strategy to increase the likelihood of using it?

Sample coping cards (Bryan & Rudd, 2018) from Sarah, who reported thoughts about overdosing on prescription pain medication, are shown in **Figure 7-1.**

Figure 7-1. *Sample Coping Cards from Sarah*

Note. Adapted from Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention*. Guilford Publications.

FRONT	BACK
My pain will never improve.	New treatments for fibromyalgia pain are currently being developed. I have hope that one will work for me.
My kids need a mom who can be active with them, not one who constantly needs to rest and rely on them.	My kids are independent teenagers who regularly tell me they love me. They have adjusted well to my mobility issues.
I don't have time or energy to do my physical therapy exercises and yoga stretches.	Set an alarm throughout the day for the number of minutes I need to complete my exercises. Do the exercises even if I'm in pain, just do them slower. They will help. Have husband ask how my exercise went.

FRONT	BACK
I just want to stay in bed in the morning.	Set out my comfy slippers and robe the night before. Pre-set my coffee machine so I smell it brewing in the morning. Place a card on my mirror to remind myself “I can do anything I set my mind to. Today will be good day.”

CHAPTER 11: THOUGHT LOG ("ABC") WORKSHEETS

Introduction to Thought Log Worksheets

Thought Log Worksheets (also referred to as "ABC" worksheets) are commonly utilized within a cognitive therapy framework and was developed for Cognitive Processing Therapy by Dr. Patricia Resick (CPT; Resick et al., 2007). ABC worksheets are also used as an intervention in Brief Cognitive Behavioral Therapy (BCBT) for suicide prevention developed by Bryan and Rudd (2018). Within the context of SUPERCEDE, ABC worksheets help the Veteran to identify negative thoughts, particularly suicide-related thoughts. Veterans are asked to identify negative thoughts and appraise the associated beliefs underlying the thoughts. This process enables the Veteran to identify and address potential cognitive biases both in and out of session.

The worksheets demonstrate the reciprocal relationships between thoughts, feelings, and behaviors. For example, Veterans experiencing suicidal thoughts are often unaware that their understanding of identified experiences (internalized thoughts or external influences) may be influenced by a negative or pessimistic view, which in turn perpetuates maladaptive behaviors and emotions associated with those experiences. These worksheets serve as a self-management tool used to interrupt a potentially negative stream of thoughts, emotions, and behaviors. Essentially, ABC worksheets require the Veteran to "pause" throughout the process of analyzing identified experiences to evaluate their reactions. In time, this pause-and-evaluate exercise becomes ingrained in Veterans' appraisals, and thoughts that previously elicited strong negative reactions become less powerful and disruptive. This introspection may lower the intensity and frequency of a Veteran's negative response to a triggering experience.

Worksheets should be introduced and completed together with the Veteran in session. The clinician should encourage the Veteran to write responses rather than stating them aloud. Once the Veteran understands this process through practice in session, the clinician should also encourage the Veteran to continue completing worksheets outside of sessions. Completing the worksheets in writing facilitates attention and emotional engagement, and provides the Veteran with a tangible outcome that reflects their effort and progress. Engaging in this active process aligns with a skills training perspective and provides the Veteran an opportunity to translate cognitive restructuring or reappraisal into a behavioral skill.

Cognitive restructuring is a trainable skill present in many evidence-based treatments for reducing suicidal behaviors (Brown et al., 2005a; Linehan et al., 2006; Rudd et al., 2015). Such reappraisal focuses on identifying and modifying core beliefs, which are deeply held beliefs one has about self, the world, or others. Specific beliefs differ in endorsement among individuals with and without a history of suicidal ideation and attempts, which include hopelessness, perceived burdensomeness, self-hatred, hopelessness, perceived brokenness, and shame (Bryan et al., 2014b; Bryan & Rudd, 2018). Endorsement of these beliefs can be more predictive of suicide attempts than prior attempts, emotional distress, or suicide ideation (Brown et al., 2000; Bryan et al., 2010; Bryan et al., 2014b). Remedying core suicide-related beliefs is crucial in effective treatments for suicide prevention; however, the Veteran must first identify the beliefs, re-evaluate their helpfulness, and understand how they contribute to emotions and actions. The following worksheet activity - the ABC Worksheet – serves as a tool for clinicians to facilitate this process.

The ABC Worksheet consists of three components, depicted in **Figure 11-1**: A, for activating event or the antecedent or precipitating experience (i.e., "what happened"); B for the Veteran's belief" (i.e., "what do I believe about myself as a result of the event"); and C for emotion-based consequence" (i.e., "how

do I feel"). **Figure 11-2** illustrates the ABC components and two Socratic questions that prompt the Veteran to reappraise their thoughts (Bryan & Rudd, 2018). First, *Are the thoughts in "B" helpful?* encourages the Veteran to distinguish between adaptive thoughts that facilitate positive or neutral responses and maladaptive thoughts that result in negative feelings or behaviors. The second question, "*What can I say to myself in the future that is more helpful?",* is designed to facilitate a functional assessment of the thought (e.g., "helpful" vs "unhelpful"), rather than assess whether the beliefs are reasonable. Given that many Veterans experiencing suicidal thoughts perceive their beliefs as reasonable, the focus on functionality prevents the opportunity for the Veteran to confirm an irrational belief or engage in self-criticism (e.g., "I am an unreasonable person").

When presenting the worksheet, the clinician should begin by introducing the concept of the cognitive behavioral triangle (see **Figure 11-1**). Understanding the bi-directional nature of the relationships between thoughts, feelings, and behaviors will help the Veteran understand the important links between the ABC components of the worksheet (i.e., internal experiences such as thoughts are associated with emotions which in turn influence behaviors, and vice versa). Given the critical significance of suicidal thoughts or prior suicide attempts on future ideation and attempts, the clinician is encouraged to have Veterans focus on a prior suicide attempt or recent suicidal thought as the focal experience for the introduction of the ABC worksheet (see **Figure 11-2**). The clinician should prompt the Veteran to recall the triggering event that led to the suicide-related experience and provide a summary of what happened in Box A. For the first run through of the worksheet, it is prudent for Veterans to skip Box B (beliefs), as it can be initially challenging for many Veterans to identify their belief or automatic thought. Instead, the clinician should first ask the Veteran to provide a detailed description of the emotions experienced in relation to the triggering event in Box C. Finally, the clinician should aid the Veteran in identifying the thoughts and/or beliefs that resulted from the designated event by engaging in a dialogue. The use of Socratic questioning may be necessary to identify an automatic thought or to elicit additional automatic thoughts to uncover underlying core beliefs.

Unearthing core beliefs can be difficult for both Veteran and clinician; however, certain techniques can be implemented to ease the process. One such strategy is the *downward arrow technique*, wherein the clinician asks the Veteran to identify the result of the thought using an "if…then" statement (Bryan & Rudd, 2018). Specifically, "If [automatic thought] is actually true, then what does it reveal about me as a person." For example, Julia described that following an argument with her mother (A, antecedent), she felt angry, discouraged, and hopeless (C, consequence). After the argument, Julia began criticizing herself and thought (B, beliefs): "She's right, I always make bad decisions." Utilizing the *downward arrow technique*, the clinician would ask: "If it is true that she was right and you always make bad choices, what does that reveal about you as a person?" Julia will be able to follow this exploration of the thought towards her core belief. For example, she might state "I am a failure, and I will always make bad decisions." A sample ABC worksheet that Julia may have completed is shown in **Figure 11-2**.

While this technique may often be effective, the Veteran may occasionally respond by providing an additional automatic thought, or an assumption (e.g., "I made another mistake again"), rather than identify a core belief. If this occurs, the clinician should continue the *downward arrow technique*, replacing the previous thought or assumption with a new one e (e.g., "If it's true that you made another mistake, what does that say about you as a person?").

After completing boxes A, B, and C on the worksheet, the clinician should encourage the Veteran to read and respond to the following two Socratic questions to aid in cognitive reappraisal: *Are the thoughts in "B" helpful? What can I say to myself in the future that is more helpful?* After the Veteran identifies a more helpful thought (or belief), the clinician should probe the Veteran to describe how substituting the

new thought would change their emotional reaction. In Julia's case, she reports that blaming herself or referring to herself as a failure is not helpful because it makes her "want to escape." When asked what she could say instead during arguments with her mother, Julia says, "I sometimes make mistakes, but everyone does. Instead of giving up, I'm going to try to learn from them." (See **Figure 11-3**).

The Veteran and the clinician should complete several worksheets during sessions with increasing independence to demonstrate basic mastery of the process. To reinforce skills, the Veteran should continue completing worksheets independently between each session in addition to an allotted practice time in-session. In addition to focusing on the reason for therapy, the clinician should encourage the Veteran to identify other stressors that may result in negative thoughts and behavioral patterns, rather than focus only on the initial therapeutic focus (i.e., suicide-related thoughts or behaviors). Relating and practicing these skills across multiple experiences and/or domains of their life will promote rapid generalization and skill mastery.

ABC Worksheet Implementation

STEP 1: INTRODUCE THE RATIONALE FOR ABC WORKSHEETS

The clinician introduces the rationale for using ABC Worksheets during and outside of therapy and reviews how the cognitive behavioral model (see **Figure 11-1**) is used to understand and treat emotional distress (Bryan & Rudd, 2018).

Clinician Script

Today, let's start by discussing some thoughts that you may have during stressful or uncomfortable experiences, as well as the beliefs we hold about ourselves, others, and our world, and how those impact our behaviors. In our last session we talked about how our self-talk or the thoughts we have about ourselves impacts our outlook on life and how we see the world. For example, if a person sees themselves as a failure, then any small mistake is met with the thought that "I messed up because I can never do anything right." This might make them feel discouraged or upset with themselves. These feelings might make them want to withdraw from situations and isolate themselves, or even start using alcohol or other substances to cope with their emotions. However, let's consider if that person felt differently about themselves. If the person viewed themselves as competent, that same isolated mistake might result in a completely different response. They might think, "It's okay, everyone makes mistakes sometimes; It isn't a big deal." This reaction allows the person to address the mistake and move on with their life. Even though they might still be frustrated about the mistake, they realize mistakes happen, everyone makes them, and they don't necessarily feel sad or guilty. The underlying beliefs we hold about ourselves and the world impact how we interpret events, our feelings about them, and how we react. What are your thoughts about that?

Let's talk about how the thoughts and beliefs you have about yourself may have contributed to your thoughts about suicide and how they influence your feelings, particularly any distress you feel regularly. We will begin this process by going over an ABC worksheet that will help us better understand your thoughts. It is designed to help us identify the thoughts, beliefs, and feelings that influence our decisions and actions.

STEP 2: USE A PAST SUICIDAL EPISODE OR SUICIDE ATTEMPT TO COMPLETE AN ABC WORKSHEET

When completing the first worksheet, the clinician should guide the Veteran to focus on suicide-related thoughts, beliefs, and behaviors that precipitated the reason for the referral. The clinician should explain

the specific components of the worksheet and then assist the Veteran using Socratic questioning. The clinician should guide the Veteran to recognize the bidirectional nature of thoughts, feelings, and behaviors (via the Cognitive Behavioral Triangle; see **Figure 11-1**). The clinician should focus on core beliefs using the *downward arrow technique* or Socratic questioning. While the worksheet is completed jointly by the Veteran and clinician, the Veteran should be instructed to record the answers on each section of the worksheet.

Clinician Script

This worksheet has three main sections, followed by two questions to help us understand our thought process. The worksheet components will make more sense as we go through this together. The title "ABC Worksheet" comes from the main components. "A" stands for "antecedents" where we identify the triggering event, or "what is going happening." Start by thinking back to your most recent suicidal experience. What event triggered your suicidal thoughts or behaviors? Write that event in the space provided on your worksheet.

Let's skip the middle box, B, and go to Box C for now. "C" stands for "consequence," or what emotion did you experience after the triggering event. Although we can write down various consequences, I want you to focus on describing the feelings you experienced after the event. Start by asking yourself, "What did I feel as a result of x?" Think back to that suicidal experience we discussed. After your triggering event, what were you feeling? Write that down in the space provided.

Let's go back to box B. We skipped this section at first because sometimes identifying the feelings you wrote in box C helps us answer box B, which stands for "beliefs." To complete this box, we need to identify what thoughts you experienced at the time of the event. You can start by asking yourself, "What did I tell myself after that event?" After your most recent crisis, what did you tell yourself? Write that down in the space provided.

If the Veteran initially identifies an automatic thought but does not provide a core belief:

Let's examine that thought to help us understand it a bit more. Let's just assume that thought you experienced is accurate. Then ask yourself what that says about you as a person.

Let's revisit our discussion. You started treatment after you experienced a suicidal crisis, which resulted from the activating event. You began to experience negative thoughts like [insert automatic thought]. *Then you experienced negative feelings like* [insert feeling]. *To help us look more closely at this situation, here are some questions. First, "Are the thoughts you wrote in B helpful?" What are your thoughts? In the situation you experienced, was* [insert thought] *helpful to tell yourself? Why might that thought be unhelpful? Write down your response in the space provided.*

It sounds like you're beginning to understand that some of the thoughts and beliefs you have may be unhelpful. Let's think of what you could replace those unhelpful thoughts and beliefs with. What is one thing you could tell yourself that might be helpful if you ever have a similar experience again? Write down what you could tell yourself in the future in the space provided.

It seems like you know how to complete this worksheet. I know this process can be difficult or confusing. Asking yourself these questions may help you understand better. What questions do you have? Let's try another worksheet.

STEP 3: COMPLETE ADDITIONAL WORKSHEETS TARGETING A VARIETY OF STRESSFUL SITUATIONS

To expedite skill proficiency, the clinician will facilitate the completion of additional worksheets addressing a variety of stressful situations. The goal of this process is to encourage the Veteran to engage in thought processing. The clinician will provide sufficient physical copies of the worksheet and continue to guide the Veteran in completing these worksheets.

Clinician Script

On the next worksheet, think of a different situation where you felt sad or overwhelmed. Do you have a situation in mind? Just like before, we will go through each question to identify the thoughts, feelings, and beliefs about that situation and determine whether they were helpful.

Let's start with box A, antecedents. In that situation, what was going on? Write that down in box A.

Next, let's look at C, the consequence. What feeling did you experience? Record your answer in box C.

Finally, let's think about your beliefs in box B. What were you thinking about yourself during that experience, or what did you say about yourself as a person? Record your answer in Box B.

Let's review this experience. During this stressful situation in box A, you told yourself what you wrote in box B, which resulted in the negative emotions you felt, including [insert emotions].

Were the thoughts in box B helpful to you during that situation? Why or why not? Record your answer.

If they were unhelpful, what could you tell yourself differently in the future if you experienced a similar situation? Record your answer here.

You're really getting the hang of this! Great work! What questions do you have? How would practicing this process outside of session be helpful?

STEP 4: CREATE AND IMPLEMENT A PLAN FOR PRACTICING WORKSHEETS OUTSIDE OF SESSION

The last step is to elicit Veteran buy-in to practice by completing worksheets between sessions. The clinician should assign and encourage the Veteran to complete at least one worksheet each day before the next appointment. Although the Veteran can examine the ABCs for any distressing experience, at least some worksheets should target the Veteran's suicide-related thoughts and behaviors. Since Veteran adherence is crucial, the clinician should evaluate buy-in by asking the Veteran to rate the likelihood of completing one worksheet each day between sessions on a scale from 0 to 10, with 0 indicating "*not at all likely*" and 10 indicating "*very likely*". The clinician should provide the Veteran with sufficient worksheets to be completed prior to the next appointment.

Clinician Script

The key to success is practicing this process of evaluating your thought process. Here are enough worksheets for you to practice each day before our next session. They can be completed quickly. Do you think you could complete one additional worksheet per day before our next session? In-between our sessions? Although you can use any situation you've experienced, it's best to reserve at least one worksheet examining the original crisis that brought you in. How does that sound?

STEP 5: ASSESS VETERAN BUY-IN

Clinician Script

Considering our plan, on a scale from 0 to 10, with 0 indicating "not at all likely" and 10 indicating "very likely," rate the likelihood that that you will follow through with the plan before our next session.

If rating is lower than 7 out of 10:

What part of our plan makes it less likely that you'll practice? What can we do to make following the plan easier?

Figure 11-1. *The Cognitive Behavioral Triangle*

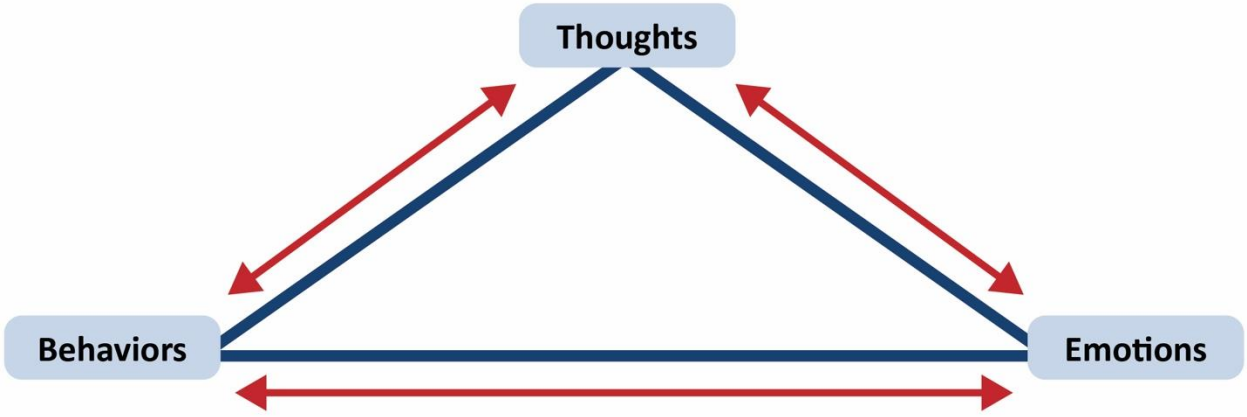


Figure 11-2. *ABC Worksheet Template*

Note. Adapted from: Resick, P. A., Monson, C. M., & Chard, K. M. (2007). *Cognitive processing therapy: Veteran/military version.* Department of Veterans Affairs.

BOX A: ANTECEDENTS	BOX B: BELIEFS	BOX C: CONSEQUENCES
What happened? What was the mental/physical trigger or event?	What thoughts or beliefs do I have about myself as a result of the event?	What do I feel or what emotions did I experience?
Answer here	*Answer here*	*Answer here*

HOW HELPFUL IS THE BELIEF ABOVE IN BOX "B"?	WHAT ELSE CAN I TELL MYSELF IN THE FUTURE WHEN IN A SIMILAR SITUATION?
Answer here	*Answer here*

Figure 11-2. *Example ABC Worksheet from Julia*

Note. Adapted from: Resick, P. A., Monson, C. M., & Chard, K. M. (2007). *Cognitive processing therapy: Veteran/military version.* Department of Veterans Affairs.

BOX A: ANTECEDENTS	BOX B: BELIEFS	BOX C: CONSEQUENCES
What happened? What was the mental/physical trigger or event?	What thoughts or beliefs do I have about myself as a result of the event?	What do I feel or what emotions did I experience?
Argument with my mother.	*She's right, I always make bad decisions.* *I'm a failure and always struggle with making the right decision.*	• *Discouraged* • *Angry* • *Hopeless*

HOW HELPFUL IS THE BELIEF ABOVE IN BOX "B"?	WHAT ELSE CAN I TELL MYSELF IN THE FUTURE WHEN IN A SIMILAR SITUATION?
No, because it only makes me want to stop trying and escape.	*I make mistakes sometimes, but everyone does. Instead of giving up, I can try to learn from them.*

CHAPTER 12: CHALLENGING THOUGHTS AND BELIEFS WORKSHEETS

Introduction to Challenging Thoughts and Beliefs Worksheets

Once the Veteran identifies maladaptive thoughts and the underlying core beliefs, the Veteran can progress to the next step, which is to systematically challenge those core beliefs. The Challenging Thoughts and Beliefs worksheet is used to guide Veterans through the process of critically evaluating beliefs that may contribute to distressful or suicide-related thoughts and/or behaviors and was developed by Resick and colleagues (2017; see **Figure 12-1**). This worksheet is used by Brief Cognitive Behavioral Therapy for suicide prevention (BCBT; Bryan & Rudd, 2018) and builds upon the skills developed while using the ABC worksheets discussed in Chapter 11.

These strategies are aligned with the cognitive-behavioral framework, which is efficacious for reducing suicide attempts (Brown et al., 2005a; Linehan et al., 2006; Rudd et al., 2015). Cognitive reappraisal used in these worksheets is designed to change and replace maladaptive cognitions that reinforce suicidal beliefs by adopting more positive, adaptive cognitive perspectives like hope (Dogra et al., 2011), self-efficacy (Bryan et al., 2014c), optimism (Bryan et al., 2013c; Hirsch & Conner, 2006; Hirsch et al., 2007; Hirsch et al., 2009), pride (Bryan et al., 2013b), finding value or meaning of life (Bryan et al., 2013d; Dogra et al., 2011; Heisel & Flett, 2008). Risk factors that impact cognitive restructuring of suicidal thoughts and behaviors are guilt and shame (Bryan et al., 2013e; Bryan et al., 2013a; Bryan et al., 2015b; Hendin & Haas, 1991). Guilt and shame may be modifiable risk factors that could be addressed in therapy, since research suggests they impacts the ability to forgive oneself, which is associated with reduced risk for suicide attempts (Bryan et al., 2015d).

The Challenging Thoughts and Beliefs Worksheet should be introduced after mastery of the ABC worksheet skills (i. e., identifying situations and drawing connections between thoughts and emotions). The worksheet helps the Veteran identify and then challenge unhelpful thoughts, primarily those related to suicidal beliefs. Using the worksheet, the clinician guides the Veteran in identifying and challenging these core beliefs, with the goal of reducing the risk of suicide. The worksheets are designed to be introduced by the clinician, then completed collaboratively with the Veteran. To support behavioral activation, this worksheet should be completed in writing.

Prior to reviewing the Challenging Thoughts and Beliefs worksheet (see **Figure 12-1**), the clinician is advised to revisit the ABC worksheet (see **Figure 11-2**) discussed in Chapter 11. This provides context for this next step in the therapy process and reminds the Veteran that the Challenging Thoughts and Beliefs worksheet builds upon skills developed from the ABC worksheet.

To complete the first question on the worksheet, the clinician asks the Veteran to identify an example of a maladaptive core belief (ideally related to suicide) and to write that example at the top of the worksheet. A new worksheet should be completed for each core belief. Next, the Veteran is asked to respond to a series of Socratic questions designed to critically evaluate the identified core belief. The clinician and Veteran can collaboratively work their way through the questions and discuss helpful responses considering each core belief. As the Veteran identifies alternative perspectives, the clinician encourages them to document their response on the worksheet. Continue this process for the remainder of the questions.

Veterans may initially have difficulty identifying and challenging core beliefs and may struggle with completing the worksheet. This is normal and should not deter treatment. The difficulties a Veteran may

experience with this exercise may not reflect treatment disengagement or lack of progress but may represent the pervasiveness of suicide-related cognitions. These core beliefs are deeply ingrained and may persist throughout the treatment process. Importantly, the clinician's initial goal is to help the Veteran evaluate alternative core beliefs rather than extinguish longstanding beliefs.

As an example, consider Sarah, the Veteran discussed previously who identified "I am a loser" as a core belief and recorded it on the worksheet. Next, Sarah is prompted to answer the Socratic questions related to that belief. When answering the second question (i.e., '*Are there facts or is this a habit*?'), Sarah identified several mistakes she has made in the past and records them as evidence supporting her belief that she is a loser. As an alternative to disputing this perspective directly, the clinician could use additional Socratic questions to assist the Veteran in considering the possibility that the belief is more like a habit. Questions could include:

- How often do you have the thought "I am a loser"?
- How many times each day do you tell yourself you are a failure or a loser?
- Can you think of some successes you've had?
- Is it easy to identify situations that you feel you failed in the past?
- Is telling yourself, "I am a loser" a habit?

Sarah's responses may provide valuable insights into the pervasiveness of this maladaptive thought. For example, she may report that she thinks of herself as a loser up to five times every day. She perceives every little mistake as evidence that she cannot make good choices. Through the discussion she acknowledges that calling herself a loser has become a habit. To reinforce the process of helping the Veteran identify this maladaptive core belief, the clinician could say, "*It sounds like this belief that you are a loser is something you are used to telling yourself.*" If Sarah continues to argue that this belief is a fact, the clinician can ask if Sarah thinks the statement could be both a fact and a belief, which does not create resistance. By not directly resisting what the Veteran says, the clinician may create a greater chance of Veteran buy-in. In this example, Sarah may not be able to extinguish the identified core belief, but the clinician can strengthen the alternative perspective, which may lead to a gradual reduction of the maladaptive core belief. See **Figure 12-2** for a sample worksheet.

From the introduction of this worksheet through mastery, the clinician should guide the Veteran in completing multiple worksheets per session. These worksheets can address a variety of maladaptive beliefs; some should target beliefs related to suicide (i.e., "*I am a burden*"). The clinician can assign several worksheets to be completed in-between sessions and can stress the importance of adhering to homework.

STEP 1: INTRODUCE THE CHALLENGING THOUGHTS AND BELIEFS WORKSHEET

Once the clinician introduces the worksheet, a review of the general concepts is provided (Bryan & Rudd, 2018; Resick et al., 2007).

Clinician Script

Last week we worked a lot on the ABC worksheets, where we learned about how our thoughts and beliefs interact during activating events, leading to feelings of distress. The ABC worksheets helped you evaluate whether a thought or belief was helpful or unhelpful, and whether an alternative thought or statement would reduce emotional distress. Through this process, we learned that what we tell ourselves can significantly impact our thoughts, feelings, and actions in response to different situations. Evaluating our beliefs using the ABC worksheet can facilitate a more adaptive approach.

Today, we will build on the concepts from our last visit using the ABC worksheets. For the next couple of weeks, we will use the Challenging Thoughts and Beliefs worksheet. This worksheet will assist you in identifying a specific belief and examine whether it is helpful or adaptive by answering a series of questions. The process will assist you in developing a healthy way of dealing with thoughts and beliefs.

STEP 2: COMPLETE THE WORKSHEET USING A PRESENTING PROBLEMATIC SUICIDE-RELATED BELIEF

The clinician guides the Veteran in completing the first worksheet using a suicide-related belief identified in an earlier session. The clinician explains how each section of the worksheet assists in the cognitive reappraisal process. If the Veteran has difficulty responding to the worksheet prompts, the clinician can engage in a Socratic dialogue. This is especially helpful if the Veteran responds to the prompts with statements that support the maladaptive belief. The clinician encourages the Veteran to physically write the responses on the worksheet.

Clinician Script

This worksheet includes two sections. In the first section, at the top, identify a thought or belief that we have previously discussed, which will be the focus of our work. To simplify the process, we will focus on one belief per worksheet. In the second part, we will evaluate your perspective of the identified belief by answering a set of questions. These questions will challenge your belief and evaluate how that belief impacts you and how helpful the belief is. As you think about the questions, write your responses in the space provided, which will help determine whether the belief is helpful or harmful.

First, you will choose a belief to focus on. Think about what brought you here into treatment. We first want to focus on thoughts or beliefs you have about your suicidal crisis. When you've identified a belief, write it down at the top of your worksheet. Next, you will answer each of the questions as they relate to the belief you wrote down. Our goal is to determine how helpful this belief is.

Please read the first question out loud. How will you answer that question? How does your answer relate to the belief you wrote above? Write about that in the space provided.

Repeat the procedure for each question listed on the worksheet:

Now please read the next question. How will you answer that question? Write your answer in the space provided.

You are really doing well with this. Now that you have answered each question on the worksheet, let's think about the belief you wrote at the top. What are your thoughts now about your original belief? How has your view changed? What questions or thoughts do you have about this process? Let's continue practicing by identifying another belief. Here is another worksheet.

STEP 3: COMPLETE ADDITIONAL WORKSHEETS TO ADDRESS OTHER PROBLEMATIC BELIEFS

As with the skills taught previously, the Veteran benefits when they have an opportunity to apply the skills in additional contexts or across situations. To facilitate generalization of the skill, the Veteran can complete additional worksheets that address more general maladaptive beliefs in addition to suicide related beliefs.

Clinician Script

We are going to continue this process with a new belief. Take a moment to think about a belief that has been unhelpful. Please write it in on the top of the worksheet. Just as we did before, we want to determine whether this belief is helpful or unhelpful to you, if see if we can consider a new perspective. Let's complete the worksheet now.

Please read the first question out loud. How do you want to answer that? Write your response in the space provided.

Repeat for all remaining questions on the worksheet:

Please read the next question out loud. How do you want to answer it?

Please record your answer in the space provided.

You're doing a fantastic job. You are really catching on. What questions do you have about the worksheet? How Is this worksheet helpful? Is there anything that is unhelpful? How could you practice this exercise on a regular basis?

STEP 4: COLLABORATE ON A PLAN FOR PRACTICING WORKSHEETS OUTSIDE OF SESSION AND ASSESS VETERAN BUY-IN

Once the process is explained and practiced, the clinician can encourage the Veteran to complete additional worksheets to practice, with a goal of at least one worksheet per day. Although any maladaptive belief can be addressed, the need to specifically identify and challenge suicide-related beliefs can be discussed. To enhance success of skill practice, Veteran buy-in is crucial. The clinician can ask the Veteran to rate how likely they are to complete the assignment between sessions on a scale from 0 indicating "*not at all likely*" to 10 indicating "*very likely*". At the completion of the appointment, the clinician can provide the Veteran with sufficient blank worksheets.

Clinician Script

You seem to understand the concepts we discussed and can complete the worksheets on your own. Working through them between sessions will help make the most out of our time together. How do you feel about completing one worksheet per day between now and our next session? You can focus on any of your core beliefs, including at least one suicide related belief that led you to treatment. How does that sound? What questions do you have? Here are some blank worksheets for you to complete this week.

After developing the plan:

Considering our plan for completing the worksheets between sessions, on a scale from 0 to 10, with 0 indicating "not at all likely" and 10 indicating "very likely", how likely are you to complete at least one worksheet each day between now and our next session?

If rating is lower than 7 out of 10:

What part of this plan decreases the likelihood that you will complete this task? What change can we make to encourage you to complete the worksheets?

Figure 12-1. *Challenging Thoughts and Beliefs Worksheet Template*

Note. Adapted from: Resick, P. A., Monson, C. M., & Chard, K. M. (2007). *Cognitive processing therapy: Veteran/military version.* Department of Veterans Affairs. Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

QUESTION	ANSWER
Thought or Core Belief:	*Answer here*
1. What evidence do you have for or against this belief?	*Answer here*
2. Is your belief based on habit or facts?	*Answer here*
3. If someone else made that statement about themselves, would you believe them? Is their belief accurate?	*Answer here*
4. Are your thoughts black-and-white, or all-or-nothing, or are there exceptions? Why or why not?	*Answer here*
5. Do you use extreme words or statements (i.e., always, never, forever, should, need, must, every time, and can't)?	*Answer here*
6. Is your focus only on one aspect of the event, leading you to ignore important facts about the situation that would help you explain the situation from a different perspective?	*Answer here*
7. Where does this belief come from? Is the belief reliable?	*Answer here*
8. Is this belief an exaggeration? Or the opposite: does the belief minimize things?	*Answer here*
9. Is your belief based on your facts or feelings? Please explain	*Answer here*
10. Do you tend to focus on trivial details about the situation?	*Answer here*

Figure 12-2. *Example Challenging Thoughts and Beliefs Worksheet from Sarah*

Note. Adapted from: Resick, P. A., Monson, C. M., & Chard, K. M. (2007). *Cognitive processing therapy: Veteran/military version.* Department of Veterans Affairs. Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

QUESTION	ANSWER
Thought or Core Belief:	I am a loser.

QUESTION	ANSWER
1. What evidence do you have for or against this belief?	For: I have a hard time making the right decisions over and over. My family constantly points this out to me. Against: Sometimes I must make difficult decisions where there isn't always an obvious answer. I can think of some good decisions I've made during my life.
2. Is your belief based on habit or facts?	Habit – I tend to tell myself this every day, so now I think it's true.
3. If someone else made that statement about themselves, would you believe them? Is their belief accurate?	I guess not. I'm sure most people struggle with situations in life, and they just try their best to make good choices.
4. Are your thoughts black-and-white, or all-or-nothing, or are there exceptions? Why or why not?	Black and white, I always think I'm a loser, even when I've done something well.
5. Do you use extreme words or statements (i.e., always, never, forever, should, need, must, every time, and can't)?	Yes, I say always.
6. Is your focus only on one aspect of the event, leading you to ignore important facts about the situation that would help you explain the situation from a different perspective?	Yes, I usually focus on all the times my family has criticized me for making bad decision. I guess I ignore the times I've done well.
7. Where does this belief come from? Is the belief reliable?	It comes from me, what I tell myself. I guess since it's my opinion, my belief is not reliable.
8. Is this belief an exaggeration? Or the opposite: does the belief minimize things?	Yes, I suppose it's an exaggeration. Maybe when my family tells me I made a bad decision, they are trying to get me to see things from a different perspective, so I don't go back to the bad habits I am working on changing.
9. Is your belief based on your facts or feelings? Please explain	It's based on feeling. I guess I'm just disappointed in myself. I'm not where I want to be or where I thought I'd be in life.
10. Do you tend to focus on trivial details about the situation?	Yes, I'm worrying so much that my husband wants to will divorce that I don't actually work on solving my problems.

CHAPTER 13: ADDRESSING PROBLEMATIC THINKING WORKSHEETS

Introduction to Addressing Problematic Thinking Worksheet

The Addressing Problematic Thinking Worksheet is a tool to facilitate the growth of cognitive skills Veterans acquired in previous sessions. These worksheets help Veterans understand cognitive distortions and how unrealistic viewpoints can result in suicide-related thoughts and behaviors. This worksheet was developed by Resick and colleagues (2017) and has been adapted for Brief Cognitive Behavioral Therapy (BCBT) for suicide prevention by Bryan and Rudd (2018). It is critical to help Veterans understand that cognitive distortions that may contribute to dysfunctional ways of thinking. Cognitive distortions may lead to problematic or unhelpful thinking patterns that support biases, negative emotions, and beliefs (Beck & Beck, 1972; Burns, 1999). The Addressing Problematic Thinking Worksheet helps Veterans identify the distortions underlying maladaptive automatic thoughts or core beliefs. This worksheet is designed to help the Veteran gain awareness of their own maladaptive thought patterns and to consider less problematic perspectives by exploring thought patterns.

The Addressing Problematic Thinking Worksheet is displayed in **Figure 13-1.** The worksheet contains a list of common cognitive distortions along with general descriptions of each, with space at the top for recording a core belief, and space underneath each description for the Veteran to record how that core belief may relate to the cognitive distortion. Like previous worksheets, the clinician and Veteran should complete them collaboratively in session.

To begin, the clinician should review the concepts learned in previous sessions (i.e., ABC Worksheets and Challenging Thoughts and Beliefs Worksheets) before completing the worksheet with the Veteran. In particular, this review should focus on describing how thought patterns reinforce Veteran distress (i.e., cognitive distortions) and how these patterns can fall into categories. The clinician should then encourage the Veteran to identify a core belief specifically focused on suicidal thoughts or behaviors and instruct the Veteran to record this core belief at the top of the sheet. The clinician then should ask the Veteran to read each cognitive distortion and its description out loud. Afterwards, the clinician should use Socratic questioning to help the Veteran identify if their belief fits within one or more categories. During the process, the clinician should encourage the Veteran to write their reasoning for the belief and the matching cognitive distortion in the space below the label. They should continue this process until the Veteran reaches the end of the list. Refer to **Figure 13-2** for an example worksheet consistent with Sarah's core beliefs.

Veterans should complete multiple worksheets in session as time allows and independently between sessions to ensure skill mastery and generalizability. Importantly, at least one worksheet should focus on suicide-related core beliefs.

By completing worksheets, the Veteran actively engages and gains practice in cognitive reappraisal by categorizing core beliefs. Through this approach, the Veteran has the opportunity to consider "how" a thought can be dysfunctional rather than "if" the thought itself is problematic. Sorting thought patterns into the categories allows the Veteran to see the flaws inherent to these approaches of thinking. The Veteran can see the thinking errors and understand the maladaptive nature of the identified core belief. Veterans will be successful in this exercise when they are willing to examine the belief from this perspective.

STEP 1: INTRODUCE THE ADDRESSING PROBLEMATIC THINKING WORKSHEET

The clinician provides an explanation for the Addressing Problematic Thinking Worksheets, explains how it builds on previous concepts, and revisits cognitive reappraisal (Bryan & Rudd, 2018; Resick et al., 2007).

Clinician Script

As you recall, in a previous session, we used the ABC worksheets to help us understand the bidirectional relationship between thoughts, behaviors, and emotions. Next, we used the Challenging Thoughts and Beliefs Worksheet to explore how certain thoughts or beliefs can be either helpful or not helpful as we respond during difficult situations. Today we will apply what we've learned to explore a new method to further evaluate the role of our thoughts and beliefs, which is addressing problematic thinking.

*Over the course of our lives, people often develop patterns in thinking and behaving. Unfortunately, some of these thoughts or behaviors are problematic and unhelpful. For example, at times, a person might think, if one thing goes wrong, everything will go wrong. This is considered "**all-or-nothing**" thinking and may result in the person admitting defeat. This oversimplification inhibits the person from acknowledging that there are sometimes shades of gray. They are only able to see only one perspective at a time. Can you think of someone in your life who sees things as black and white? Can you think of an example of a time you may have done this?*

*Let's move on to another form of maladaptive thinking: **jumping to conclusions**. This thinking pattern might look like someone who automatically thinks something bad will happen or will continue to happen, despite no evidence to support that perspective. For example, try to imagine a person having an argument with their partner. This person may automatically assume that the argument is because their partner doesn't love them and will result in their partner breaking up with them. This person tends to perceive that negative events will likely occur in the future, despite insufficient evidence (i.e., this incident was the first conflict in the relationship in 5 years). Can you think of an example when someone in your life jumped to conclusions? Can you think of a time when you jumped to conclusions? Do you tend to form automatic judgements during stressful situations?*

Now, let's discuss these approaches and a few others and how they can be helpful or unhelpful. We will use this Addressing Problematic Thinking Worksheet, which highlights seven unhelpful patterns of thinking. We just finished discussing the first two: oversimplifying and jumping to conclusions. Let's take a look at these other distortions.

***Exaggerating** is another problematic perspective. Exaggeration is reacting to something in a disproportionate way than is necessary in that situation. For example, let's imagine I was invited to party but was afraid I would embarrass myself and then no one would like me. That is an exaggeration for two reasons: first, because I am reacting to fear of embarrassment by not going to the party; second, I'm exaggerating my expectation of other's responses to me if I do something embarrassing.*

*A similar, yet opposite form of problematic way of thinking is **minimizing**. Minimizing is discounting or disregarding an important factor in the situation. For example, if I were in leading a highly successful project, but denied having any role its success, I would be minimizing or discounting my own role in the success of the project and minimizing my value.*

***Discounting** positive aspects of a situation occurs when a person only attends to any negative aspect of a situation. For example, instead of celebrating a score of 95% on an exam, a person might focus on the few questions missed and that he/she should have studied harder.*

Overgeneralization *is another distortion in thinking. Overgeneralizing occurs when one event is perceived as representing all events. For example, one mistake at work translates to the employee feeling like a failure and believing that they mess everything up. The person can overgeneralize beyond the situation where the mistake occurred, believing they are a failure at everything at all times.*

Mind-reading *is another form of problematic thinking and occurs when a person believes others are thinking about them or perceiving them in a certain way without evidence of that happening. Mind-reading is typically associated with negative thoughts. For example, if I meet a highly successful person, I might make the assumption "they probably think I am a failure," despite no evidence to support that they think I am a failure.*

Lastly, ***emotional reasoning*** *occurs when an emotion drives a belief. For example, if I feel sad during a situation, I assume that I am a failure, I did something wrong, or a can't do anything right. I used my emotion of feeling sad as evidence that I failed.*

STEP 2: COMPLETE THE ADDRESSING PROBLEMATIC THINKING WORKSHEET USING A SUICIDE-RELATED BELIEF

After providing the worksheet, the clinician guides the Veteran through the prompts focusing on a suicide-related belief that contributed to the episode that brought them into treatment. It is crucial that the clinician ensures the Veteran understands the cognitive distortions listed on the worksheet during the session. The clinician should also engage in Socratic questioning when the Veteran is unsure of how a core belief fits into a cognitive distortion category. Socratic questioning can also be utilized to highlight the relationship after a Veteran finds a link between their belief and a specific distortion and before they record their explanation on the worksheet.

Clinician Script

We will start to fill in this worksheet, which has two parts. First, we identify one specific thought or belief. You will write that in the top part of the worksheet. Next, you'll see a list of problematic thoughts or cognitive distortions along with their definitions that we just reviewed. We will examine the belief and determine which type of problematic thinking that falls under. Although the belief may fit into just one category, some beliefs can fit onto multiple types of problematic thinking.

First, I want you to choose a belief. Think back to the suicidal event that brought you to treatment. What is one thought you experienced at the time of the crisis? Write that down in the space provided. Now, let's explore how that thought may be related to the thought patterns listed below.

Please read the first distortion and definition. Would you classify your belief as an example of jumping to conclusions?

If yes:

Explain how your belief is an example of jumping to conclusions? Please write that down.

Repeat the process for all the questions on the worksheet.

Let's work on the next one. Read the thought and its definition out loud. Is your belief an example of [cognitive distortion]*? How is it an example? Write that in the space provided.*

Great work. We completed the entire worksheet. What do you think about this process? What do you notice about your belief or these forms of distortions? What questions do you have?

STEP 3: COMPLETE ADDITIONAL WORKSHEETS USING OTHER MALADAPTIVE BELIEFS

To strengthen the generalization of a Veteran's cognitive reappraisal skills, the clinician and Veteran should work together to complete several more worksheets focused on different suicidal or maladaptive beliefs. In addition, the clinician should provide blank copies of the worksheet for the Veteran to complete between sessions and as a guide for future individual practice. To strengthen this skill, the Veteran must be able to identify beliefs and record responses to the worksheet independently.

Clinician Script

For the next worksheet, think about another belief that has been unhelpful to you. What belief would you like to focus on? Write that belief at the top of the worksheet.

Now, we will repeat the process of evaluating each type of distortion to help us understand what thought distortion might be consistent with this belief.

Please read the first distortion aloud. Decide whether this thought is consistent or inconsistent with that approach. Please record your answer.

Repeat for all distortions on the worksheet:

Look at the next distortion. Does your belief fit with this thought pattern? Why or why not? Write your answer in the space provided.

You're really catching on. What questions do you have about this process? How could this worksheet be helpful to you now and in the future? What benefit is there for completing this worksheet regularly?

STEP 4: CREATE A PLAN TO COMPLETE WORKSHEETS OUTSIDE OF SESSION AND ASSESS VETERAN BUY-IN

Finally, after making sure the Veteran understands how to complete the worksheet, the clinician and Veteran discuss how the Veteran can practice the concepts outside of session. The clinician should encourage the Veteran to complete at least one worksheet every day until the next appointment. Although Veterans should be encouraged to use multiple worksheets and examine different core beliefs, at least one worksheet should address suicidal beliefs. Importantly, buy-in should be assessed by asking the Veteran to rate their likelihood of engaging in the exercise on a scale from 0 representing "*not likely*") to 10 representing "*very likely*". The clinician then provides the Veteran with enough blank worksheets to complete between sessions.

Clinician Script

Now that you are able to complete these worksheets, I'd like you to complete worksheets independently between sessions. Regularly completing these worksheets will help you apply this in your daily life. What questions or concerns do you have? How do you feel about completing one worksheet between our sessions? I would like you to examine a suicide-related thought and at least one of the worksheets before our next session. You can focus on any other distressing belief for the others. What questions do you have? Here are your blank worksheets to complete before our next session.

After finishing the plan:

Now that we have a plan before our next session, on a scale from 0 representing "not likely" to 10 representing "very likely," how likely will you be able to complete one worksheet each day between now and our next session?

If rating is lower than 7 out of 10:

What part of the plan seems difficult for you to complete these worksheets? How can we increase the chance that you will be able to complete a worksheet each day before our next session?

Figure 13-1. *Addressing Problematic Thinking Worksheet Template*

Note. Adapted from: Resick, P. A., Monson, C. M., & Chard, K. M. (2007). *Cognitive processing therapy: Veteran/military version.* Department of Veterans Affairs. Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

QUESTION	ANSWER
Jumping to conclusions: when there is insufficient evidence to determine that conclusion, or if there are clear contradictions against that conclusion	*Answer here*
Exaggerating or minimizing: a circumstance is viewed in a disproportionate manner	*Answer here*
Disregarding: important factors related to a specific circumstance	*Answer here*
Oversimplifying: an experience is dichotomous. For example, good/bad or right/wrong	*Answer here*
Overgeneralizing: is making conclusions and seeing a pattern from an isolated situation	*Answer here*
Mind reading: assumption that people are perceiving you negatively when there is no evidence to support this belief	*Answer here*
Emotional reasoning: assumptions are driven by emotion, and you believe there is a reason without evidence	*Answer here*

Figure 13-2. *Example Addressing Problematic Thinking from Sarah*

Note. Adapted from: Resick, P. A., Monson, C. M., & Chard, K. M. (2007). *Cognitive processing therapy: Veteran/military version.* Department of Veterans Affairs. Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

QUESTION	ANSWER
Jumping to conclusions: when there is insufficient evidence to determine that conclusion, or if there are clear contradictions against that conclusion	*"I always struggle and make the wrong decisions."* Assume that I've never made good decisions.

QUESTION	ANSWER
Exaggerating or minimizing: a circumstance is viewed in a disproportionate manner	*"I never feel happy anymore."* Minimizes all the times I feel happy spending time with my kids or husband.
Disregarding: important factors related to a specific circumstance	*"My pain will never get better."* Disregards daily research to find more effective treatments, and one could be developed in my lifetime that will help me.
Oversimplifying: an experience is dichotomous. For example, good/bad or right/wrong	*"I'm a loser."* Making this statement based on one mistake, even though I've done many good things throughout my life.
Overgeneralizing: is making conclusions and seeing a pattern from an isolated situation	*"My family sees me as an annoyance."* Over-generalizing from two arguments I got into with them a while back.
Mind reading: assumption that people are perceiving you negatively when there is no evidence to support this belief	*"My kids need a mom who can be active with them."* My kids say they love me and always say "thank you" when I attend school events. They have told me they are happy hanging out at home.
Emotional reasoning: assumptions are driven by emotion, and you believe there is a reason without evidence	*"Nobody understands me."* Driven by feeling exhausted and sad about my chronic pain, and I assume nobody else experiences this.

CHAPTER 14: ACTIVITY PLANNING

Review of Activity Planning

Behavioral models of depression assert that the onset of depression results from a decrease in enjoyable events and/or an increase in experiencing aversive events (Ferster, 1973; Lewinsohn & Graf, 1973; Lewinsohn & Libet, 1972). Further, the imbalance in the frequency of experiencing enjoyable and aversive life events is what sustains mood disturbance over time. Veterans who have experienced suicidal behaviors and/or ideations may have a history of more aversive life events and may experience difficulties in their interpersonal relationships. Further, choices and behaviors resulting from these experiences may inadvertently maintain emotional distress over time.

Research has shown that activity planning can reduce symptoms associated with depression and suggests it could be a key factor in preventing relapses. Compared to cognitive therapy, treatments focused on behavioral activation, such as activity planning, were found to be equally effective in maintaining recovery (Dimidjian et al., 2006; Gortner et al., 1998). Behavioral activation involves increased participation in enjoyable activities and may be highly effective for recovery and maintenance of therapeutic gains among those with severe depression (Dimidjian et al., 2006). Veterans often benefit from participating in planned activities when done with one or more other people (e.g., spouse, friend), which can lead to increased social support (Bryan & Hernandez, 2013; Kaslow et al., 2005). Social support is a protective factor and plays a key role in reducing suicide risk and suicidal behavior. Therefore, developing a plan that invites more social interaction could prove to be highly effective (Bryan & Hernandez, 2013), as these interactions likely reduce thoughts and beliefs associated with depression and suicide (e.g., perceived burdensomeness, guilt, and shame). An additional protective factor is developing a sense of purpose, so considering activities that are meaningful and important to the Veteran may be an effective way to reduce suicide risk (Bryan et al., 2013d).

For example, imagine a Veteran with suicidal ideation who stops attending social gatherings or cancels appointments for treatment. This behavior limits their overall social interaction, both positive and negative. The intent of activity planning is to increase opportunities for the Veteran to take part in enjoyable activities and significant life events that they may have previously abandoned. Participating in social activities and important life events increases social support and may improve the Veteran's mood and lead to more adaptive coping responses (Bryan & Rudd, 2018).

Increasing the occurrences of enjoyable life events as part of treatment should improve this imbalance. As the Veteran's ratio of experiencing enjoyable verses aversive life events increases, their mood disturbance and distress may decrease and possibly resolve. Encouraging opportunities for the Veteran's exposure to more pleasurable life events may also prove helpful in altering maladaptive core beliefs. For instance, engaging in fun activities with friends or family can result in thoughts that aren't aligned with suicidal thoughts, such as the Veteran thinking about how fun the activity is and not thinking that they are a burden to others.

The introduction of activity planning begins with the clinician discussing what activities the Veteran enjoys or used to enjoy. An option when the Veteran appears emotionally distressed, resistant, or "stuck" (i.e., "I do not enjoy anything") is to encourage them to think of activities that they wish they could engage in but may not have had the opportunity, time, resources, or the tools to do so. Once the Veteran identifies an activity, the clinician and Veteran can collaborate on a plan for the Veteran to engage in that activity, which may include a discussion of lessening barriers to involvement or gradual immersion into the activity.

The effectiveness of activity planning is determined by the clinician's ability to identify and develop solutions to barriers that impact participation. Engaging in physical exercise is a common activity encouraged in Brief Cognitive Behavioral Therapy (BCBT; Bryan & Rudd, 2018). The Veteran, however, must follow a step-by-step process to achieve this goal. The clinician and Veteran should collaborate on steps to successfully achieve this goal, such as deciding what type of exercise to engage in and when and where the activity should take place (i.e., before or after work and at a gym versus at home) as well as what preparatory steps the Veteran would take to prepare for this activity (i.e., getting a gym membership). Veterans who experience insomnia or work late hours may benefit from a plan that lets them exercise later in the day. Veterans who are parents may have greater success exercising away from home at a gym, or during hours that their children are at school, or at home while the children are sleeping. Another commonly scheduled activity in BCBT is cooking or baking. If the Veteran prefers cooking or baking, the clinician may collaborate by creating step by step plan beginning with meal prep and creating a grocery list.

The activity plan that the clinician and Veteran create needs to be specific, measurable, and practical. The more detail that an activity plan has, the easier it will be to follow. Measurable plans can be quantified (i.e., when, where, how long, and how often), and practical plans are likely to be accomplished. Simply expressing the desire to "exercise more" is not specific (e.g., what is "more" exercise) and is not measurable (e.g., will exercise be measured in time or distance). Similarly, the desire to suddenly run 5 miles every day may not be practical for someone who has not been running consistently. Breaking a goal into incremental steps (i.e., "I will run for 1 mile followed by walking for 5 minutes, and gradually increase the running time and total time each week") makes this goal more achievable. The clinician and Veteran may need to collaborate and discuss whether or not the activity qualifies as specific, measurable, and practical, and if not, what can be changed or what steps can be added to make that happen.

STEP 1: INTRODUCE ACTIVITY PLANNING

The clinician explains the rationale for the activity planning (Bryan & Rudd, 2018).

Clinician Script

Sometimes, when we feel stressed, overwhelmed, under pressure, or even sad, it can be easy to stop engaging in meaningful and enjoyable activities. Maybe we don't think we have the time for those activities anymore. We might stop doing activities we enjoy because we simply lose our motivation or interest in them, or they no longer bring us joy. Avoiding activities might seem necessary or optimal when dealing with a current situation or stressor; however, if our life circumstances don't change and we continue to feel stressed or overwhelmed, we continue not engaging in activities we once enjoyed. This can result in our life feeling unbalanced because the ratio of enjoyable to stressful events is not balanced. This may result in even more stress, less enjoyment, and lower life satisfaction. We may experience more stress than enjoyment and begin viewing our problems as permanent and more burdensome, and life may seem pointless. Does this resonate with your current experience? How so?

STEP 2: IDENTIFY ENJOYABLE ACTIVITIES

The clinician can ask the Veteran to make a list of activities that they enjoy. If the Veteran expresses difficulty thinking of enjoyable activities, the clinician can ask the Veteran to recall past enjoyable activities.

Clinician Script

To restore the balance between non-enjoyable activities of daily life and pleasurable activities, I encourage you to increase or resume your participation in pleasurable activities. Most people who feel stressed, depressed, overwhelmed, or suicidal feel like they can't engage in these activities. However, despite obstacles, once people begin engaging in these pleasurable activities, even when they don't feel like it or doubt themselves, they begin to feel balance in their lives again. Tell me what activities you used to enjoy, but don't do as often as you'd like to now?

If the Veteran is unable to identify enjoyable activities:

It seems like you are struggling with thinking of activities. Even if you're not doing them now, what are some things you used to enjoy in the past?

STEP 3: CREATE A PLAN TO PARTICIPATE IN THE ACTIVITY

Together, the clinician and the Veteran develop a plan to participate in the chosen activities.

Clinician Script

Suggestions for open-ended questions:

How do you feel about making a schedule to begin participating in that activity (e.g., fishing)?

When and how frequently have you engaged in the activity?

Does that frequency and schedule seem like it would work for you now?

In the past how often did you do the activity?

How much time would you like to spend on the activity each day/week?

How soon would you be able to start?

Would you be interested in doing the activity with others? Who would you like to join you in this activity?

Where would this activity take place?

Can you think of anything you would need to do beforehand to prepare?

What barriers to participation do you envision?

How would you deal with this barrier so it wouldn't prevent you from participating?

STEP 4: ASSESS VETERAN BUY-IN

Once the activity plan has been developed and a plan has been agreed upon, the clinician should assess the Veteran's motivation to engage in the plan by rating the likelihood on a scale from 0 (*not at all)* to 10 (*very likely*).

Clinician Script

This sounds like a great plan! How do you feel about it? Please rate the likelihood that you will stick with this plan. On a scale of 1-10, 0 meaning you have no intention of sticking with the plan, and 10 meaning it is highly likely you will stick to this plan, what would you rate your likelihood?

If rating is lower than 7 out of 10:

What about the plan makes it more difficult to follow? What changes would make it more feasible?

CHAPTER 15: STIMULUS CONTROL AND SLEEP HYGIENE MODULE

Introduction to Stimulus Control and Sleep Hygiene

Among Veterans, suicidal ideation was 3 – 5 times higher in those who screened positive for clinical and subthreshold insomnia compared to those who did not experience insomnia (Byrne et al., 2021). Tubbs and colleagues (2022) found that a 5-point increase in severity of insomnia among Veterans was associated with a 37% greater risk for current suicidal ideation. More research is needed to determine the reasons behind sleep difficulties and suicidal thoughts and behaviors; however, co-occurring depression has been identified as a mediator between sleep disturbances and suicidal thoughts and behaviors (Bryan et al., 2015a). Cognitive-behavioral therapy for insomnia (CBT-I) reduced suicidal ideation severity and improved sleep quality in Veterans (Trockel et al., 2015). In conclusion, a sleep intervention to treat insomnia and sleep disturbances is effective in reducing suicidal thoughts and behaviors.

Stimulus control and sleep hygiene are two interventions used to reduce suicidal thoughts and behaviors and have been used in Brief Cognitive Behavioral Therapy for suicide prevention (Bryan & Rudd, 2018) and are discussed in this chapter. First, stimulus control incorporates learning theory and concepts of classical conditioning to establish an association between the bed and sleep. This method helps eliminate the relationship between the bed and wakefulness activities that could interfere with sleep, such as watching the television, scrolling through social media, spending time on a cell phone, or reading. Studies on stimulus control have shown 50 - 60% increases in rates of sleep improvement (Taylor et al., 2007). Drinking caffeine or smoking before bed are additional activities that may interfere with sleep quality.

Sleep hygiene, another cognitive behavioral intervention, targets such activities performed before bed to help improve sleep. Developing healthier sleep hygiene practices, such as settling in a quiet, dark area, and refraining from caffeine and nicotine prior to bedtime, promote healthy sleep by reducing factors that interfere with sleep. Typically sleep hygiene and stimulus control are used together (Bryan & Rudd, 2018). The main concepts of stimulus control are:

- **Bed is for sleep and sex only.** It is common for individuals to engage in activities related to wakefulness (i.e., reading, using a smart device, or watching TV) while in bed. In turn, these activities establish an association between being awake and being in bed. To enact a behavioral change, the bed must be limited to sleep and intimate acts only, reinforcing that association, making it easier to fall asleep in bed.
- **Get out of bed if you have not fallen asleep within 15 minutes of bedtime.** Good sleep hygiene includes only lying down in bed when it is time to sleep, and you are sleepy. Having trouble falling asleep can lead to frustration (i. e., lying in bed with the lights off but still struggling to reach that sleep state). Best practice is to break the association of being awake and lying in bed by getting out of bed and performing light, relaxing, non-stimulating activities. Activities to be avoided include those that emit blue light, which stimulate the brain, such as watching TV or using a smart device.
- **Return to bed only when sleepy.** The feeling of tiredness and sleepiness are not always interchangeable. Tiredness means to be drained physically or mentally, which can happen without feeling sleepy. When sleepy, individuals may demonstrate symptoms of sleep readiness (i.e., increased yawning or dozing off). It is in the Veterans' best interest for the clinician to explain these differences and instruct them to get into bed only when they are sleepy.

When incorporating stimulus control and sleep hygiene, the first step is to provide an educational handout explaining the processes (**Figure 15-1**). To determine the best plan, the clinician should review the list with the Veteran and have them determine which items could be addressed to improve their sleep. The clinician should make a detailed plan of all relevant items to help the Veteran develop an appropriate goal. Some adjustments may be more difficult than others; however, integrating motivational tactics can help improve morale. The Veteran needs to understand that sustainable changes are not made over night and can take several days or weeks for noticeable results.

STEP 1: INTRODUCE FACTORS TO IMPROVE STIMULUS CONTROL AND SLEEP HYGIENE

The clinician explains the process and rationale for stimulus control and sleep hygiene facilitates a discussion with the Veteran using a handout as a guide (Bryan & Rudd, 2018).

Clinician Script

You've shared that you have been experiencing difficulties with your sleep and that you would like to improve your sleep. That is a beneficial goal, as insomnia may contribute to suicidal thoughts and behaviors and improving your sleep may help with that. How do you feel about discussing two effective approaches that work to alleviate insomnia: stimulus control and sleep hygiene? This handout reviews the guidelines that promote healthy sleep. [Provide a copy of the handout; see **Figure 15-1**].

STEP 2: EXPLAIN STIMULUS CONTROL AND SLEEP HYGIENE GUIDELINES

After the clinician provides a copy of the handout (see **Figure 15-1**), they will review each section together. The clinician will discuss the applicability of each factor to the Veteran's current symptoms. If a Veteran shares that a factor is relevant to them, the clinician will probe for details to discuss in future sessions.

Clinician Script

Let's discuss the factors listed on this handout and how they relate to your sleep situation. Do you mind reading the first one aloud? What are your thoughts? Does this apply to you?

If yes:

Please describe how? (If applicable, mark the question for later discussion). Let's mark this question to discuss later.

For now, let's move on to the next one. Could you read the next one aloud, please?

If no:

Ok, let's move on to the next item. Could you read the next statement aloud please?

Continue this process for each item on the handout.

STEP 3: CREATE A PLAN AND EVALUATE VETERAN BUY-IN

Finally, the clinician and the Veteran will collaboratively review the marked items to decide which can be addressed and implemented immediately. They will create a tailored plan to improve sleep. The clinician will ask the Veteran to rate the probability of success in implementing the plan on a scale of 0 representing "*not at all likely*" to 10 representing "*very likely*". If the Veteran seems uncertain of their ability to change, the clinician may utilize motivational interviewing techniques (Miller & Rollnick, 2008).

Clinician Script

Now that we have reviewed the worksheet and identified a plan to initiate some changes to improve your sleep, let's continue our discussion. For the first marked item, what are your thoughts on how you can make that change? Please write that down in the space provided.

(Continue for each marked item)

After the plan is completed:

What is the probability that you will implement this change on a scale 0 to 10, with 0 representing "not at all likely" and 10 representing "very likely".

If the Veteran rates are lower than 7/10:

In evaluating the plan, what makes it difficult to follow it? What changes could we make changes to the plan to increase the likelihood of success?

Figure 15-1. *Stimulus Control and Sleep Hygiene Guidelines to Improve Sleep*

Note. Adapted from Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

GUIDELINES TO IMPROVE SLEEP	WHAT TO AVOID BEFORE BEDTIME	WHAT PROMOTES HEALTHY SLEEP
Wait until you are tired to go to bed.	**Caffeine:** Avoiding caffeine intake, which is a stimulant, at least 6 to 8 hours prior to bed may be help you fall asleep easier. Even if you don't feel that caffeine makes it hard to sleep, it may still impact the quality of your sleep. Caffeine should be avoided, especially by those individuals with insomnia. Remember that the following items contain caffeine: coffee, soda, tea, energy drinks, chocolate, medications such as Excedrin, and certain snacks.	**Exercise:** Exercising for at least half an hour each day can promote sleep as long as it occurs at least 2 hours before bedtime. The impact of exercise on sleep may take a few weeks to notice.
Do not try to sleep if you are not tired. When you are not sleepy, it is more likely for the mind to wander and your brain to stay active, which may lead to frustration. You may recall events of your day, plan for the next day, and even worry about the impact of not being able to sleep. Attempting to force oneself to sleep may result in greater difficulty falling asleep and perpetuate insomnia. Going in bed only when sleepy can eliminate these possibilities. It is best practice to wake up at the same time daily, regardless of what time you went to sleep.	**Nicotine:** Despite popular belief, nicotine is a stimulant and can impact sleep similarly to coffee or caffeine. Smoking before bed should be avoided.	**Comfortable Bedroom:** A dark, quiet bedroom at a moderate temperature, as well as the use of blackout curtains and sleep masks, may help promote sleep. If needed, incorporate a white noise machine or a fan to eliminate background noise that may otherwise distract you. Having a supportive, comfortable mattress and pillows may also promote sleep. Removing clocks or placing them out of sight may decrease anxiety from watching the clock.

GUIDELINES TO IMPROVE SLEEP	WHAT TO AVOID BEFORE BEDTIME	WHAT PROMOTES HEALTHY SLEEP
Do not stay in bed if you are having trouble falling asleep or staying asleep. If you have difficulty falling asleep while in bed, it is best to get out of bed and engage in relaxing activities so that you don't associate the bed with being restless. If you wake up in the middle of the night and are unable to fall asleep within 15 minutes, get out of bed and do something relaxing. Once you feel sleepy again, you could try going back to bed to sleep to reinforce the connection between sleep and bed. Signs that you are sleepy include dozing off or increased yawning. This will make it easier to fall and stay asleep.	**Alcohol:** Although alcohol is a depressant and can make you sleepy, it disrupts quality sleep and may hinder the ability to reach deep sleep.	**Downtime:** At least one hour before bed, make time to decompress and relax by engaging in activities that are not physically or intellectually stimulating, which can make it difficult to go to sleep. These activities (i.e., reading, watching television, art, talking with family, listening to music) are best completed away from the bedroom.
Minimize the Activities Done in Your Bedroom. Only use your bed for sleep and intimate activities. Minimizing bedroom activities during the daytime and evening establishes a stronger association between sleep and the bedroom, which increases the chances of rest and relaxation. This association can be reinforced by engaging in all leisure activities (i.e., watching television, reading, eating, or browsing the internet) outside of the bedroom. Consider removing radios, computers, and televisions from the bedroom.	**Naps:** Napping throughout the day, more than an hour late in the afternoon, may make it harder to fall asleep and stay asleep at night. If a nap is necessary, set an alarm for up to half an hour to avoid disrupting sleep later.	**Stick to Your Sleep Schedule:** Keep a consistent sleep-wake schedule even on weekends and holidays. Waking up at the same time despite the previous night's bedtime will help create a sleep-wake schedule. Furthermore, you should get out of bed you're you are awake to maintain the association between bed and sleep. Oversleeping can make it more difficult to fall asleep at night, whereas getting out of bed at the same time each morning can help you maintain a schedule and regulate your natural sleep cycle.
-	**Heavy Meals:** Eating larger meals before bed may also impact how fast you fall asleep and stay asleep. High fat or gas inducing foods should be avoided. If you tend to wake up in the middle of the night, avoid eating a heavy meal before bed, as it may disrupt your sleep. Going to bed too full or too hungry can make it difficult to fall asleep and stay asleep. Light snacks before bed can prevent the feeling of hunger when you wake up during the night.	-
-	**Sleep Medications:** Avoid regular use of sleep medications or supplements. Studies have shown that regular intake of sleep aids may gradually loses effectiveness over time, and withdrawal symptoms may cause insomnia. Withdrawal symptoms after prolonged use may further reinforce overuse of sleep aides, and continuing use may disrupt sleep.	-

CHAPTER 16: RELAXATION AND PHYSIOLOGICAL REGULATION SKILLS TRAINING MODULE

Introduction to Relaxation Training

Relaxation training is empirically supported, cognitive behavioral intervention that can serve as a stand-alone or adjunctive tool for decreasing depression symptoms, distress, emotional turmoil, agitation, and anxiety (Jain et al., 2007; Luebbert et al., 2001; Stetter & Kupper, 2002). These techniques aid in emotion regulation and improve outcomes for various psychological and behavioral disorders. Importantly, techniques such as progressive muscle relaxation have been identified as effective tools in treating insomnia (Taylor et al., 2007).

Relaxation training is used in Brief Cognitive Behavioral Therapy (BCBT) for suicide prevention (Bryan & Rudd, 2018) and is a common tool for Veterans engaged in cognitive-behavioral therapy for insomnia (CBT-I; Pigeon et al., 2017), which is associated with a reduction in suicidal ideation. Relaxation training aids in the management of physiological arousal by learning to activate the parasympathetic nervous system, which can positively impact both physical (e.g., high blood pressure, irregular breathing) and emotional symptoms (e.g., anger, distress, and fear). Relaxation techniques include strategies such as diaphragmatic, or deep breathing, and systematic, or progressive, muscle relaxation (Bryan & Rudd, 2018).

Figure 16-1. *Diaphragmatic Breathing and Progressive Muscle Relaxation*

Note. Adapted from Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

DIAPHRAGMATIC BREATHING AND PROGRESSIVE MUSCLE RELAXATION
• **Diaphragmatic (deep) breathing.** Diaphragmatic breathing is inhaling air slowly and deeply to allow the lungs to completely fill with air, referred to as "belly breathing." After fully inhaling, the individual slowly breathes out until all air is released from the lungs. An effective strategy for teaching this technique includes a brief demonstration with verbal and physical prompts, followed by having the individual practice with the clinician while following prompts. To effectively teach diaphragmatic breathing, the clinician may encourage the Veteran to place their hands on their diaphragm as they breathe in so they can feel their diaphragm expanding, which helps ensure complete expansion. The clinician may also provide feedback by encouraging proper body position and technique (e.g., "extend your stomach" or "let your shoulders relax").
• **Progressive muscle relaxation.** Progressive muscle relaxation is a systematic technique used to release muscle tension and teaches the Veteran to identify the difference between feeling tense and feeling relaxed. This technique includes a series of tensing and then releasing a muscle or muscle group (e.g., shoulders). Progressive muscle relaxation is often a full-body process. The clinician may start with instructing the Veteran to tense then relax muscles at the base of the body (e.g., feet) and gradually work their way up the body. For each part of the body, the clinician prompts the Veteran to briefly tense the muscles for several seconds, then release the muscle tension. This process should span all muscle groups. This process throughout the entire body should be at a slow and steady pace and may take several minutes. Progressive muscle relaxation provides an awareness of feeling relaxed by pairing it with tension and offers an appreciation and encouragement for relaxation.

Diaphragmatic breathing and progressive muscle relaxation are some of the most commonly used strategies; however, there are a plethora of helpful techniques, such as guided imagery and autogenic relaxation.

Like many strategies based on cognitive-behavioral principles, relaxation training is best paired with educating the Veteran about the body's physical reaction to stress (i.e., autonomic arousal). Explaining how the autonomic nervous system functions, including the "fight, flight, fawn, or freeze" response,

allows the Veteran to appreciate the value of relaxation. After educating the Veteran, the clinician can begin to systematically practice a mindfulness technique in session. Although the process may vary by Veteran, the clinician typically verbally instructs the Veteran how to conduct the exercise. The clinician may develop their own technique or use a sample relaxation script provided in **Figure 16-1.** After completing the relaxation exercise, the clinician can use Socratic questioning to determine what parts of relaxation were helpful for the Veteran. This evaluation of the exercise allows the Veteran to gain self-efficacy in implementing the exercise and fosters a greater appreciation for the use of relaxation.

STEP 1: INTRODUCE RELAXATION AND PROVIDE PSYCHOEDUCATION ON THE AUTONOMIC NERVOUS SYSTEM

The clinician starts with an introduction of relaxation and provides psychoeducation about the activation and deactivation of the autonomic nervous system.

Clinician Script

Let's start today by talking about what happens to our bodies when we are emotionally upset. When you are emotionally upset, how do you know? What happens in your body? Do you notice any physical sensations? How does your body feel different when you are angry, compared to when you are sad or happy? Are there any similarities? In the past, what physical changes have you experienced when you became stressed or upset?

Some physical symptoms you may have experienced include an increased breathing rate, a rapid heart rate, dry mouth, tense muscles, and sweating are considered stress responses. Everyone experiences the stress responses. They are designed to protect us from danger. These stress responses are the body's way of alerting us when we perceive something bad or dangerous is about to happen. This is often referred to as the "fight or flight" response. What do you know about this?

When we experience fear or stress, or when we feel unsafe, our bodies react in a way that either gives us the best chance to "fight" for our lives or "flight," escape from danger. Our bodies react physically to prepare for fight or flight. For example, our heart rate increases, we begin to sweat, our mouth feels dry, and our muscles tense. These reactions may occur to some degree when we become stressed or upset. When we are consistently upset, stressed, or feel unsafe, our bodies may be in a fight or flight state for prolonged periods, which takes a toll on our minds and our bodies.

Based on our conversations, this reaction sounds like it may be happening in your life. Tell me about your experience with that.

Fortunately, we can learn ways to manage our stress responses. We can slow down our breathing and we can learn to relax our muscles, which can lessen that response, so we don't feel so bad. These strategies are called relaxation techniques. Have you ever learned any breathing techniques or relaxation techniques?

If yes:

Please tell me a little about some things you have tried in the past. How did they work for you? What did you learn by using the relaxation techniques?

If no:

I'd like to show you a simple way to help manage your stress reaction. It won't take much time, but there is a lot of research that shows it can be very helpful. Would you be interested in taking some time to learn about it?

STEP 2: PRACTICE RELAXATION EXERCISE

After eliciting Veteran buy-in, the clinician begins the guided instructions for the relaxation exercise. The process should move at a natural pace, allowing the Veteran sufficient time to engage in the activity.

Clinician Script

Now, I would like you to sit back in your chair. Make yourself comfortable but be sure to sit straight without slouching. It is important not to become rigid and stiff but to remain relaxed. Many people close their eyes or fix their gaze on something in front of them, like a point on the wall. You can do whichever you feel is easier for you. It is important that your eyes do not wander during this exercise.

The clinician reads a structured relaxation script like the one provided in **Figure 16-1** or provides their own relaxation dialogue.

STEP 3: REFLECT ON THE RELAXATION EXPERIENCE

After walking the Veteran through the relaxation exercise, the clinician should use Socratic questioning to help the Veteran understand the process and how relaxation can be an effective tool. Socratic questioning will often include open-ended questions, but in the case of limited insight or lower cognitive abilities, may require more direct questioning.

Clinician Script

Sample questions to check comprehension and promote self-application:

How did that feel to you?

What changes did you notice when you did the exercise?

How did you change physically (e.g., heart rate, muscle tension, breathing)?

Tell me what you noticed during the exercise.

Did you find the exercise difficult at all?

What part of the exercise was the easiest?

What was your favorite part of the exercise?

STEP 4: CREATE A PLAN FOR FUTURE USE AND ENGAGE THE VETERAN IN ESTABLISHING GOALS

In this last step, the clinician will introduce the idea of using relaxation techniques outside of sessions. The plan may differ for each Veteran. For example, some Veterans may be unwilling to engage in daily relaxation. It is important to provide structure and develop a plan that meets the Veteran's wants and needs. The plan should specify the type, frequency, and duration of relaxation techniques to be practiced. The Veteran should be asked to describe their investment in practicing on a rating scale from 0 to 10, with 0 indicating "not very invested" and 10 indicating "very invested" in completing relaxation activities outside of session.

Clinician Script

As you saw during the last few minutes, relaxation techniques are easy to do and can be completed in a short period of time. Most people find that frequent relaxation practice allows them to become more engaged in their daily lives and that they subsequently feel less stressed. Whether you practice multiple times a day, daily, or a couple times a week, it can have a positive impact on your life. I wonder, how often do you think you would be willing to practice this technique during the next week? How many minutes should each relaxation session be? Are there certain situations or places that cause you to become particularly stressed? What about places that would be conducive to practicing relaxation? What about times of day where you feel it would be useful, or easy to engage in this practice? What might I be able to do to help you successfully complete relaxation exercises?

After finishing the plan:

I want you to think about the plan we just discussed. On a scale of 0 to 10, with 0 indicating "not very invested" and 10 indicating "very invested" in completing relaxation activities according to the plan we created?

If rating is lower than 7 out of 10:

Is there a specific part of this plan that you believe reduces your likelihood for using it? What could we change to make you more likely to use it?

Figure 16-2. *Example Relaxation script*

Note. Adapted from Bryan, C. J., & Rudd, M. D. (2018). *Brief cognitive-behavioral therapy for suicide prevention.* Guilford Publications.

RELAXATION SCRIPT
NOTE: … indicate places where the clinician should pause for an unspecified amount of time. This could range from a few seconds to 30 seconds depending on the Veteran response.
First, let us take a very slow breath in through your nose. Feel the air going into your nose and expanding into your belly… then, very slowly release the breath through your mouth … good … I want you to repeat this process. Breathe in slowly through your nose… feel your stomach inflate … then very slowly release the breath… very good … continue breathing in and slowly out… in … and out … in… and out… good. Continue this process, focusing on filling your diaphragm to capacity… in … and out… just like that…
[Pause for 15 seconds]
As you continue to breathe, I would like you to notice your body. With each breath, release the tension in your body… let your shoulders fall … breath in… and out… feel the tension like little weights… in… and out… with each breath let your shoulders fall a little more, allow the muscles to relax… in… and out… let the tension fade away… in… and out… good. Keep breathing into your belly and out through your nose. Each time you breathe out, feel the tension release. Continue this process… breathing and releasing ... Very good.
[Pause for 15 seconds]
Now that you can feel your body relax, I want you to take another deep breath in… and slowly out. Continue to breathe… This process can be done anywhere, with anyone. As you breathe in again, this exercise comes to a close… when you are ready you can open up your eyes and return to the session.

CHAPTER 17: MINDFULNESS AND MEDITATION TRAINING MODULE

Introduction to Mindfulness and Meditation Training

Mindfulness training is an intervention that has been effective in reducing suicidal ideation and suicide attempts (Katz et al., 2004; Lynch et al., 2006; Miklowitz et al., 2009; Rudd et. al., 2015). While both mindfulness and relaxation exercises are similar in that they lower distress (Jain et al., 2007; Kabat-Zinn et al., 1992; Speca et al., 2020; Stetter & Kupper, 2002), the underlying processes by which they operate differ. Specifically, relaxation exercises focus on the physical aspect, whereas mindfulness exercises focus on the Veteran's cognitions and have been found to reduce cognitive rumination and increase positive emotions(Jain et al., 2007). Mindfulness has been used in Brief Cognitive Behavioral Therapy (BCBT) for suicide prevention (Bryan & Rudd, 2018).

Mindfulness and meditation techniques are commonly practiced with Veterans to help them regulate emotions, examine thoughts in a non-judgmental manner, and connect with internal processes occurring in the present moment. Many adverse experiences that influence the likelihood of suicidal thoughts or behaviors occur without the Veteran being consciously aware (Ingram et al., 2006), leading to unintended reactions to triggering events (i.e., elevated reactivity; Ingram et al., 2006). Veterans who experience suicide-related beliefs generally experience greater reactivity and are more likely to report mood disruptions (i.e., depression, anxiety, anger). These mood disruptions occur in reaction to unconscious thought processes rather than conscious thought processes.

Practicing mindfulness helps Veterans regulate internal emotional states and may alter the flow of problematic thinking by allowing them to pause, examine, and react to situations in a thoughtful manner. For example, a Veteran at risk for suicide may fixate on negative beliefs (e.g., "I am worthless"), which in turn leads to significant distress. By taking a present-centered approach, Veterans redirect their focus to internal states (i.e., thoughts, emotions) and are able to gain a degree of intentional control.

The purpose of mindfulness is not to distract or avoid, but to allow an individual to examine internal and external experiences in the present, with curiosity and without judgement. When a Veteran engages in mindfulness, they respond with greater awareness and acceptance. Veterans expand their awareness from the negative experience to all aspects of their internal and external states and take in the thoughts and sensations experienced in the present moment. While this expanded awareness does not make the current stressor go away, it does allow the Veteran to experience the stressor as part of a broader set of positive, negative, and neutral experiences, thereby making it seem less overwhelming and more manageable.

Mindfulness exercises are practiced in a variety of methods and forms. To teach the Veteran how to practice mindfulness as a skill, the clinician should provide psychoeducation on the link between attention and perseveration on how we experience stress. The idea that negative experiences can be handled by allowing the distress to be felt rather than avoiding it seems counterintuitive. After explaining the principles and benefits of mindfulness, the clinician should offer to work through a mindfulness exercise with the Veteran in session. The clinician should provide enough information and clear instructions so that the Veteran can practice the exercise independently outside of session. After the exercise, the clinician systematically asks questions about the experience to connect with the Veteran and help expand their awareness.

Mindfulness Training Steps

STEP 1: INTRODUCE MINDFULNESS AND ATTENTIONAL BIAS

First, the clinician introduces mindfulness and attentional bias (Bryan & Rudd, 2018).

Clinician Script

Let's talk about attention. Are you aware that attention is influenced by emotions, especially in situations when we are upset? When we feel upset, our attention tends to focus on only what upsets us, and we feel overwhelmed. We may experience what we call "tunnel vision." Can you think of a time you felt like that? Please tell me about it.

When we experience "tunnel vision" it is difficult to make a well-informed decision, primarily because our attention is mostly focused on the problem, leaving little room to focus on solutions. When you are stressed, it is difficult to maintain perspective and see the bigger picture. As the stress intensifies, our attentional awareness shrinks. This sometimes impacts our self-talk and the way we view ourselves (i.e., thoughts and beliefs). For example, if we continually view ourselves as bad people, when we become stressed and only focus on thoughts and beliefs consistent with that perspective to the point that we discount evidence that is inconsistent.

Often, people respond to this by trying not to think about the issue. Tell me about your experience with this.

Research shows that trying hard not to think about something has the unintended effect of thinking about it more. A more adaptive way to deal with stress is to allow yourself to objectively reflect on the experience, rather than trying not to think about it. Examining a situation from a nonjudgmental perspective allows you to see all aspects more clearly. Can you think of a time you were able to do this in the past? How do you think you would respond to a situation if you were to objectively examine it without interference or judgment?

Would you be willing to try a mindfulness exercise with me? I'd like you to experience how mindfulness can become a helpful part of your daily routine. Learning to notice your thoughts and feelings without judgment can be challenging at first and it takes practice. During mindfulness practice, the goal work is not avoiding our problems or distressing situations but taking a step back and looking from an outsider's perspective. In doing so, the hope is that the problem seems less cumbersome. Are you willing to try a mindfulness exercise?

STEP 2: IN-SESSION MINDFULNESS EXERCISE

The clinician then invites the Veteran to practice a mindfulness exercise for a few minutes, with the goal of providing a foundation for mindfulness skills. The clinician then instructs the Veteran to get in a comfortable position, then guides them through the following exercise.

Clinician Script

When you are ready, sit up in your chair. Position your body so that you feel relaxed and comfortable. Try to focus on sitting comfortably, not slouching or sitting stiffly. Next, try to fixate your eyes on something in front of you, or you can even close your eyes completely if you feel comfortable. I will start and lead you through deep breathing practice. As we begin, you may experience different thoughts entering your mind. That is a completely normal. Do your best to dismiss those thoughts and not judge yourself as

those thoughts pop up. Instead, notice them while you continue to breathe, then listen to my voice as I continue to lead you through this this mindfulness exercise.

Now, we will work on the breathing technique, as I demonstrate and guide you through it. First, start by inhaling deeply through your nose for 4 seconds. Next, hold your breath for 4 seconds. Finally, slowly exhale through your mouth for six seconds. We will continue this by repeating this cycle for 3 minutes. It will sound like this: [The clinician will model this breathing technique for the Veteran, intentionally breathing audibly so client can hear the timing of inhaling, holding, and exhaling.]

Now, let's begin. Take a deep breath in through your nose for

1….2….3…4… Hold for 1…2…3…4…and slowly exhale through your mouth for 1…2…3…4…5…6. [Clinician leads Veteran through repeated cycles for 3 minutes, informing the Veteran when the final cycle is completed.]

Whenever you are ready, please slowly start to wiggle your fingers and toes. Then open your eyes.

STEP 3: REFLECT ON THE MINDFULNESS EXPERIENCE

After completing the exercise, the clinician uses Socratic questions to encourage Veteran engagement and feedback on this process. For the initial exercise, the clinician should aid the Veteran in identifying how mindfulness could be of value to their life. It is very important to use open-ended questions for this portion of the process to allow the Veteran to examine how mindfulness might enhance their own wellbeing. At times, direct questioning may be needed for Veterans who appear less engaged in the mindfulness exercise.

Clinician Script

Recommended process questions include:

What did you notice about this experience?

What did you like about this exercise?

Were you able to shift the focus of your attention?

What made changing your focus to being nonjudgmental difficult?

What was easy about altering your focus? What was stressful about shifting your attention?

How was this process similar or different from strategies you've tried on your own?

What was it like to look at your stressful situation objectively and not get caught up in your emotions?

STEP 4: CREATE A PLAN FOR FUTURE MINDFULNESS USE AND ENGAGE THE VETERAN IN ESTABLISHING GOALS

At the end of the mindfulness exercise and the Socratic question check-in. the clinician and the Veteran discuss how mindfulness can be applied in their daily life. The clinician encourages the Veteran to practice mindfulness regularly and work with them to develop a strategy to incorporate regular practice. This plan should set specific goals by outlining the type, frequency, timing, and duration of mindfulness practice. Once a plan is developed and agreed upon by both the clinician and Veteran, the clinician should ask the Veteran to rate likelihood of please rate the likelihood of you achieving your practice plan this week on a scale from 0 to 10, with 0 indicating *"not likely at all"* and 10 indicating *"very likely".*

Clinician Script

As you have learned, much of the practice of what you've learned in therapy is done outside of our session times. Practicing consistently outside of session leads to greater progress and application of skills and helps get the most out of our time together. People who practice daily can transition into self-directed mindfulness more easily. Not only does mindfulness become easier with practice, it has a positive impact on how you handle stress and difficult situations, because you are able to view a situation objectively. With that in mind, over the next week, how often do you think you would be able to complete a mindfulness session? What would be a reasonable length of time to practice mindfulness? What are some barriers to completing your practice sessions? Thinking about this week, are there times or situations where it might be beneficial to practice mindfulness?

After finishing the post-session plan:

Now that we have a practice plan in place, please rate the likelihood of you achieving your practice plan this week on a scale from 0 to 10, with 0 indicating "not likely at all" and 10 indicating "very likely".

If rating is lower than 7 out of 10:

What made you rate yourself a __ (INSERT NUMBER) *and not a ____* (INSERT LOWER NUMBER)*? What is the difference between __* (INSERT NUMBER) *and a ___* (INSERT HIGHER NUMBER)*? What obstacles do you see that may get in the way of achieving this practice goal? How can we make it easier or more likely that you will complete the plan? What changes would you make?*

CHAPTER 18: FOLLOW-UP

Introduction

When treating Veterans who are at risk for suicide, following up is important, particularly with caring contacts (Comtois et al., 2019; Fleischmann et al., 2008; Motto, 1976). The Zero Suicide framework refers to this as a "pathway to care" (Zero Suicide Institute, 2016). Therefore, the SUPERCEDE intervention includes continued follow-up sessions with the Veteran to ensure their needs are being met, and care is coordinated in the community. Further, caring contacts are utilized in the SUPERCEDE intervention. Once a Veteran is established in community care, the clinician is encouraged to follow up, continue monitoring their suicide risk, and revisit progress by connecting to community referrals and services.

1. Structure of follow-up: outline a contact schedule
2. Content of follow-up calls

    a) Assess suicide risk using the Columbia- Suicide Severity Rating Scale (C-SSRS; Posner, 2008)
    b) Revisit crisis response plan
    c) Revisit referrals/connections
    d) Monitor the Veteran's progress
    e) Evaluate success of community care coordination

STRUCTURE OF THE FOLLOW-UP: OUTLINE A CONTACT SCHEDULE

During the follow-up phase, the Veteran will receive three biweekly calls. The clinician can provide the Veteran with a planned contact schedule (i.e., contact method, date, time, and duration of the contact). The goal of the intensive case management intervention is for the Veteran to rely less on contact from the clinician and to increase their sense of independence and self-advocacy.

CONTENT OF FOLLOW-UP

The follow-up should align with the beginning of modules from sessions two and three. The follow-up should include completing a risk assessment, revisiting the crisis response plan and case management needs, monitoring the Veteran's progress, and evaluating success of community care coordination.

MONITOR PROGRESS AND VETERAN'S EXPERIENCE

The clinician continuously monitors the Veteran's progress on goals and experiences throughout the SUPERCEDE intervention, which will increase adherence to treatment, enhance engagement in care, and ensure community care coordination. Communication between VA and community referral partners encourages accountability and timely services.

A primary purpose of the SUPERCEDE intensive case management intervention is to increase the level of communication and coordination of care between the VA and VA community care systems that provide care for the Veteran. When the clinician needs to assist with care coordination by reaching out to a referral partner, it is important to consider how to ensure a seamless warm handoff. This may include little to no interruption or delay in care, a way to verify the Veteran was successfully connected to care, and facilitation of coordination of anticipated needs or interventions. As the Veteran is receiving services and navigating care in the community, the clinician can provide encouragement and positive reinforcement as the Veteran achieves their goals.

ADDITIONAL CARING CONTACTS

In addition to biweekly phone sessions, SUPERCEDE utilizes caring contacts, which have been shown to prevent death by suicide (Motto, 1976). The clinician is encouraged to establish caring contacts by sending birthday and holiday cards and sending a quarterly newsletter throughout treatment and the follow-up phases.

RE-EVALUATION FOLLOWING EMERGENCY SERVICES

If at some point the Veteran uses emergency services for suicide risk during the intervention, and a warm hand-off has been made, the clinician is encouraged to follow up with the Veteran within the next several days. During the follow-up, the clinician can re-evaluate the Veteran for SUPERCEDE eligibility, as it is possible that the Veteran received sufficient community referrals to meet their needs. If so, the Veteran can progress to the follow-up phase. If the Veteran remains eligible for SUPERCEDE, they can begin at with the first session and progress through the intervention.

TERMINATION

After the follow-up period, the Veteran should have established care coordination and have identified needs met, at which point the intervention will be terminated.

Clinician Script

We've been working through the program for several months, and today is our last follow-up session. When you began, you had a lot going on and were struggling with getting some of your needs met. Now, you've worked through so many of the issues you were experiencing, and you seem to be handling things with more confidence. What are your thoughts?

One of the first things you accomplished was creating your "Plan for a bad day" [name of crisis response plan here]*. At that time, you seemed to feel very overwhelmed and were having thoughts of killing yourself. Although you had difficulty thinking clearly at that moment, you created an effective coping tool that you could use when you've felt overwhelmed. Since you created that plan, I'm wondering, what plans do you have for using this in the future? What has been most helpful when referring to your plan? Would it be helpful to make any changes to your plan before you leave today? I want to remind you that* ***if you're ever have thoughts of killing yourself, and you can't access your plan, please call the Veteran's Crisis Line 24/7 by dialing 988 and pressing option 1.***

Let's review your overall experience in the SUPERCEDE program. To review, our primary goal was to assist with coordination in community care and connect you with resources and services to address your needs. What has been most helpful for you as we connected you with resources and referrals and assisted with community care coordination? How do you see yourself continuing to use these resources as you move forward? What questions or concerns do you have about coordinating community care or getting connected to needed services in the future?

I have enjoyed getting to know you and assist you in your journey to navigate VA, community care, and connect with referrals. I will miss working with you, and I feel confident that now you feel more equipped to navigate community care and community resources. I hope you have received help and met some friendly people who are happy to help you, too! While I will no longer be working with you in SUPERCEDE as your primary clinician, you can always call our office during normal business hours for questions, and we will do our best to provide an answer.

APPENDIX 1. COMMUNITY ASSET MAPPING

To successfully implement SUPERCEDE, clinicians should use community asset mapping to create a list of psychosocial resources available to Veterans that can be shared during case management sessions. Community asset mapping involves gathering information about local resources to increase the accessibility and utilization of those resources. Oftentimes, Veterans may experience a variety of psychosocial stressors that can elevate suicide risk, such as mental health disorders (DeBeer et al., 2018; Ilgen et al., 2010; Kimbrel et al., 2016; Lee et al, 2018), difficulties in social relationships (DeBeer et al., 2014; Pietrzak et al., 2010; Steele et al, 2018), legal issues (Holliday et al., 2020; Palframan et al., 2020; Steele et al., 2018), financial problems (Park et al., 2015), and homelessness (Hoffberg et al., 2018; Holliday et al., 2021). Additionally, greater numbers of risk factors are associated with a greater likelihood of suicide attempts (Lee et al., 2018). Veterans may benefit from being connected with resources to address psychosocial needs and decrease risk factors for suicide. Some Veterans may be ineligible for VA care and therefore may be required to seek community services. Using community asset mapping to leverage resources for Veterans may help to address suicide risk factors and connect Veterans to care.

Community asset mapping can benefit VA employees as well. Some employees, such as suicide prevention coordinators and patient safety officers, may face significant learning curves as they gather information and learn about different services available for Veterans in the community. A shared community asset map allows ongoing shared resources among clinicians. Continued gathering, updating, and sharing of psychosocial community resources for Veterans help clinicians retain access to resources when they transition to other jobs.

The steps to community asset mapping are described below. A corresponding template of a Microsoft Excel spreadsheet used to organize the information systematically can be found in **Figure A1-1**. **Figure A1-2** provides an example of a completed community asset map. The Microsoft Excel spreadsheet can be placed on a shared drive or a SharePoint as a living document so that suicide prevention coordinators, patient safety officers, and other VA employees can access, add, and update resources as community agencies change and grow.

Building a Community Asset Map for Veterans at Risk for Suicide: A Network of Referrals

1. Use Microsoft Excel to record the name, address, and point of contact for organizations that can assist with Veterans' psychosocial needs.
2. Ask for recommendations from VA coworkers to identify local community organizations that serve individuals at risk for suicide and/or Veterans. This process is a snowball recruitment method, in which organizations are identified and recruited from acquaintances and colleagues. Individuals working in some VA health care system offices may be able to assist in the search, including:

    a) Suicide Prevention (https://www.veteranscrisisline.net/find-resources/local-resources/),
    b) Mental Health,
    c) Patient Services,
    d) Homelessness Programs,
    e) Patient Safety,
    f) Public Affairs, and
    g) **Veterans Experience Office (VEO) Community Engagement Boards (CVEBs**). VEO CVEBs are community councils led by VA leaders and Veterans that advocate for the needs of Veterans and their loved ones. These boards may have a pre-existing list of community resources, and the

website to identify local CVEBs can be found here: https://department.va.gov/veterans-experience/community-veterans-engagement-boards/

3. Conduct Internet searches to find appropriate organizations in the community and continue to build the Microsoft Excel spreadsheet. Some of the Internet searches may yield names of organizations you have already found, but you may also find additional resources that could benefit Veterans. Use your preferred search engine to search for organizations, such as Veterans Service Organizations (VSOs), Vet Centers, state Suicide Prevention (SP) coordinators, and other organizations.

    a) **VSOs:** VSOs are local organizations that provide Veterans care. Use this link to identify recognized VSOs or VSO representatives in your area by city, state, and/or ZIP code: https://www.va.gov/vso/. For example, recognized Colorado VSOs include the Colorado Division of Veterans Affairs and The Retired Enlisted Association. VSOs and VSO representatives may have lists of organizations that assist Veterans in meeting their psychosocial needs.

4. **Vet Centers:** Vet Centers are community centers that are typically independent of the VA and provide mental health care services to Veterans. The VA webpage has a direct link to locations of VA Vet Centers based on city, state, and/or ZIP code: https://www.va.gov/find-locations/?facilityType=vet_center. For example, Denver Vet Center is a Colorado-based Vet Center that provides counseling for Veterans.
5. **State Suicide Prevention (SP) Coordinators:** Many individual states have statewide suicide prevention coordinators who implement policies and programs to prevent suicide. It may be worthwhile to build relationships with those responsible for state suicide prevention to see if they have resources to serve Veterans or Veterans eligible for VA care Use your preferred Internet search engine to search for "[state name] suicide prevention coordinator" to identify suicide prevention coordinators in your state.
6. **Other Mental Health Organizations:** State-sponsored mental health services and private mental health services sometimes offer mental health resources for individuals who receive no or low income. Search "[state name] mental health services" in your preferred Internet search engine to identify such services for your state. Substance Abuse Mental Health Services Administration (SAMHSA), a government agency, offers resources that may be helpful for Veterans: https://www.samhsa.gov/
7. **Not-For-Profit Mental Health Organizations:** National not-for-profit organizations can be used to identify mental health resources available to Veterans, including Mental Health America (MHA), National Alliance on Mental Illness (NAMI), and American Foundation for Suicide Prevention (AFSP). The following links can be used to identify additional resources for Veterans:

    MHA: https://mhanational.org/
    NAMI: https://nami.org/Home
    AFSP: https://afsp.org/
    Other Resources:
    Local food banks,
    Housing services: The National Coalition for Homeless Veterans provides a state by state resource list: https://nchv.org/
    Financial services, and
    Legal services
    Joining Community Forces is one organization that provides additional resources for Veterans: https://www.whitehouse.gov/joiningforces/

The Military and Veteran Care Network (MCVN) is an organization associated with the American Red Cross that connects Veterans' caregivers with resources and support. The MCVN has a directory of services including food, housing, transportation, occupational, and legal resources that can be found based on ZIP code. Use the following link from MCVN to identify additional psychosocial resources for Veterans: https://www.redcross.org/get-help/military-families/services-for-veterans/military-veteran-caregiver-network.html

8. Reach out to the organizations identified in your search. Explain that you are seeking resources for Veterans who are at risk of suicide and are either eligible or ineligible for VHA care. Ask about their capacity to take on Veteran referrals and record the information provided in the Microsoft Excel spreadsheet.
9. When reaching out to individuals serving these organizations, ask if can recommend additional resources for Veterans in your community to add to the Microsoft Excel spreadsheet.
10. Make the Microsoft Excel spreadsheet easily accessible to other case managers in SUPERCEDE. Consider sorting the resources in the spreadsheet according to the services they offer, which can help you efficiently direct Veterans to needed resources.

Figure A1-1. *Community Asset Map Excel Sheet Template*

VA DEPARTMENT	ORGANIZATION / FACILITY	ADDRESS	POINT OF CONTACT & PHONE	SERVICES OFFERED FOR VETERAN	SUICIDE PREVENTION SERVICES OFFERED	NOT-FOR-PROFIT	MISSION
DEPARTMENT OF VETERANS AFFAIRS OFFICE WITH A SUICIDE PREVENTION MISSION	-	-	-	-	-	-	-
HEALTHCARE SYSTEMS	-	-	-	-	-	-	-
[MENTAL] HEALTH AND HUMAN SERVICES (HHS)	-	-	-	-	-	-	-
STATE, CITY, AND COUNTY OFFICIALS	-	-	-	-	-	-	-
VETERANS COUNCIL(S)/ COALITION(S)	-	-	-	-	-	-	-
UNIVERSITIES	-	-	-	-	-	-	-
OTHER ORGANIZATIONS	-	-	-	-	-	-	-

Figure A1-2. *Example Community Asset Map Excel Sheet*

VA DEPARTMENT	ORGANIZATION / FACILITY	ADDRESS	POINT OF CONTACT & PHONE	SERVICES OFFERED FOR VETERAN	SUICIDE PREVENTION SERVICES OFFERED	NOT-FOR-PROFIT	MISSION
HEALTHCARE SYSTEMS	Solace Healthcare	4500 East Cherry Creek South Drive Glendale, CO 80246	Phone: (303) 432-8487	Accepts Tricare West	-	-	Hospital/ Clinics/ Others/ Home Health Institution
HEALTHCARE SYSTEMS	Cherry Creek Wellness Center	425 South Cherry Street Glendale, CO 80246	Phone: (303) 333-3493	Accepts Tricare West	-	-	Hospital/ Clinics/ Others/ Outpatient Physical Therapy
HEALTHCARE SYSTEMS	BHG DENVER Treatment Center	5250 Leetsdale Drive Denver, CO 80246	Phone: (303) 629-5293	Accepts Tricare West	-	-	Hospital/ Clinics/ Others/ Hospital-Psychiatric/ Opioid Treatment Program (OTP)
HEALTHCARE SYSTEMS	AFC Urgent Care – Denver East	1295 Colorado Blvd Denver, CO 80206	Phone: (303) 639-1000	Accepts Tricare West	-	-	-
[MENTAL] HEALTH AND HUMAN SERVICES (HHS)	Mental Health Center of Denver	4141 East Dickenson Plaza Denver, CO 80246	Phone (303) 504-7900 M-F 0800-1700	Accepts Tricare West	-	(501c) (3)	https://www.wellpower.org/suicide-prevention/
[MENTAL] HEALTH AND HUMAN SERVICES (HHS)	Rocky Mountain Crisis Partners	PO Box 460695 Denver, CO 80246	Mental Health and Substance Abuse: Phone: (844) 493-8255	-	Follow up care for Crisis Lines and Emergency Department partners.	-	Provides its services to Colorado, free of charge to individuals, through phone and electronic messaging.
[MENTAL] HEALTH AND HUMAN SERVICES (HHS)	Mile High Psychology Center	2727 Bryant St STE 430 Denver, CO 80211	Phone: (303) 473-0707	Community Care Network	-	-	We offer a wide variety of professional psychology services including: individual therapy, couples counseling, and mental health evaluations.

APPENDIX 2. NEEDS ASSESSMENT

SUPERCEDE Suicide Risk Assessment

This program utilizes the VA's standard Comprehensive Suicide Risk Evaluation (CSRE), the same that is used in the VA Suicide Risk Identification (Risk ID) program (Matarazzo et al., 2020). Please see the VA Risk ID SharePoint for additional resources:

https://dvagov.sharepoint.com/sites/ECH/srsa/SitePages/Risk-ID-Resources.aspx.

STEP 1: UTILIZE COLUMBIA SUICIDE SEVERITY RATING SCALE

The Suicide Risk ID process starts with the C-SSRS Screener (C-SSRS; Matarazzo et al., 2019; Posner et al.,2008, 2011). Figure A2-1 outlines the C-SSRS screening questions and scoring criteria.

Figure A2-1. *Columbia Suicide Severity Rating Scale (C-SSRS) Screen*

QUESTION	ANSWER	DESCRIBE
1. Over the past month, have you ever wished you were dead or wished you could go to sleep and not wake up?	☐ Yes *Proceed to question #2 regardless of response.* ☐ No	*If yes, describe:*
2. Over the past month, have you actually had any thoughts of killing yourself? (*If no, go to question 6.)*	☐ Yes *If yes, proceed to question #3.* ☐ No *If no, proceed to question #7.*	*If yes, describe:*
3. Over the past month, have you been thinking about how you might do this?	☐ Yes *Proceed to question #4 regardless of response.* ☐ No	*If yes, describe:*
4. Over the past month, have you had these thoughts and some intention of acting on them?	☐ Yes *Proceed to question #5 regardless of response.* ☐ No	*If yes, describe:*
5. Over the past month, have you started to work out or worked out the details of how to kill yourself? *(If no, go to question 6)*	☐ Yes ☐ No	*If yes, at any time in the past month, did you intend to carry out this plan?*
6. In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life? (*If yes, complete the following Comprehensive Suicide Risk Evaluation; If no, proceed to Assessment of Needs)*	☐ Yes ☐ No	*If yes, describe:*

Proceed to scoring.

C-SSRS Screener Scoring:

A positive C-SSRS (Columbia) score is a 'Yes' response to items 3, 4, 5, or 6.

STEP 2: IF THE C-SSRS SCREENER IS POSITIVE, UTILIZE THE FOLLOWING COMPREHENSIVE SUICIDE RISK EVALUATION

The CSRE Guide (CSRE; Matarazzo et al., 2020; U.S. Department of Veterans Affairs and Department of Defense, 2019) below provides sample questions to help obtain information needed to complete the CSRE and inform the Veteran's care. **Not all questions need to be asked.**

Edit this document as needed to best facilitate completing the CSRE in your clinical setting. A worksheet is included for you to record the Veteran's responses.

Comprehensive Suicide Risk Evaluation (CSRE) Guide

General tips

- Administer the CSRE in a therapeutic and collaborative manner. These questions serve as a guide. The actual interview will vary for each Veteran.
- Allow the Veteran to share their narrative around their suicidal thoughts or previous suicidal behavior. This information will help you understand their experiences and will guide your formulation of risk level and risk mitigation strategies.

Introduction

For cases where you are completing the CSRE following a positive Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011):

- *Thank you for those responses. I would like to learn more about the suicidal thoughts you have been having and also get a sense of any past suicidal thoughts or behaviors you have experienced. This will help me better understand what is going on for you so we can develop a plan to build up your strengths and keep you safe. Our work today will also help guide our next steps in treatment.*
- *This should take approximately 15-20 minutes. Do you have any questions before we begin?*

For cases where you receive a referral from a provider after a positive C-SSRS:

- *I understand from Dr. Smith that you have been having thoughts of suicide. It sounds like you're having a tough time. I would like to better understand what is going on for you. These questions will help us develop a plan to build up your strengths and keep you safe. Our work today will also help guide our next steps in treatment.*
- *This should take approximately 15-20 minutes. Do you have any questions before we begin?*

For cases where you start by administering the CSRE:

- *As part of our time together today, I would like to review your current and past experiences with suicidal thoughts and behaviors. This will help us develop strategies to bolster your strengths and keep you safe. Our work today will also help guide our next steps in treatment.*
- *This should take approximately 15-20 minutes. Do you have any questions before we begin?*

Section 1: Suicidal Ideation

- *Tell me about any suicidal thoughts that you have been having lately.*
- *I understand that you have been having suicidal thoughts lately. Tell me a bit more about what has been going on for you.*

How recently thoughts occurred:

- *When is the last time these thoughts crossed your mind? Today? Yesterday? This week sometime? (Continue to probe based on response)*

Details including frequency of thoughts:

- *Tell me more about the actual thoughts you have – what runs through your mind?*
- *How frequently do you have those thoughts? For some people, it is multiple times per day, for others it is weekly or every couple of days. There is no right or wrong.*

Presence of intent:

Note: Presence of intent can use past or present (implicit or explicit) evidence that the Veteran wishes to die, means to kill him/herself, and understands the probable consequences

- *And do you have any intention of acting on these thoughts?*
- *Are you planning to act on your thoughts and plans? If yes, tell me more about this.*

Details related to the plan:

If applicable, incorporate specifics based on what the Veteran has already disclosed as you proceed with your interview.

- *Have you thought about specific ways to harm or kill yourself? If so, tell me more about those thoughts.*
- *Let's discuss any plans you have considered as a way to kill yourself.*
- *What plans do you have to act on the thoughts of suicide that you described?*

Access to lethal means:

- *Describe how easy or hard it would be to act on your plan.*
- *Your plan involves using (e.g., gun, knife, rope, medication, bleach, car) _____. Do you have easy access to (fill in their selection) _____? If not already asked about, tell me about any guns that you have access to.*
- *If these are in the home, how many do you have? Where do you store them and how do you store them?*
- *Tell me about other weapons or tools that you have considered using to harm yourself. (e.g., knives, ropes, etc.)*
- *About how much medication do you have stored in your home that belongs to you or someone else? Where do you store the medication?*
- *Do you have plans to obtain (e.g., gun, knife, medication) _____?*

Section 2: Suicidal Behavior

History of attempts (including number, general dates, and potential patterns):

- *Have you ever made a suicide attempt before?*
- *If yes, how many times have you attempted suicide?*

For each attempt not previously documented, consider asking the following questions. Elicit specific information about methods used to help inform the lethality of the attempt, including estimates of the number of pills taken, amount of substances consumed, seriousness of the cuts or wounds, etc.

- *Please describe what happened during that attempt. How did you try to kill yourself?*

- *Approximately when did that attempt occur?*
- *Looking back, what do you think led to that attempt?*

Most recent attempt (ask the following if not already known):

- *Tell me about your most recent attempt.*
- *What did you do to try to kill yourself?*
- *Were you injured as a result of the attempt?*
- *Did someone or something interrupt you?*
- *Where were you when you made the attempt?*
- *Describe the care you received after the attempt, if any.*
- *Were you admitted to a CLC, residential, or inpatient program at the time?*
- *Where did the event occur?*
- *Did you happen to be recently discharged from an inpatient or residential stay?* (If yes, gather more information about dates to clarify if the attempt occurred within 7 days of discharge.)

Note: If there was only one attempt, you can skip the question below.

- Lethality can be determined by the provider, with input from the veteran.
- *Thank you for that information. Do you consider that attempt to be the most lethal – or the most likely to result in your death – or was there another one that was more lethal?* (If the most recent was the most lethal, move on to the preparatory behavior section. If there was a more lethal attempt, the same questions for the most recent attempt can be used to assess the most lethal attempt.)

History of Preparatory Behavior:

Note: Inquire about preparatory behavior even if the Veteran has never engaged in a suicide attempt. Examples include writing a suicide note, giving away belongings, researching means/methods, and seeking access to lethal means (e.g., buying/obtaining a firearm, stockpiling medication).

- *Have you ever done anything other than what you have already told me to prepare to kill yourself, such as writing a note or collecting pills?*

For behaviors aside from those associated with prior attempts or those previously documented in a *Suicide Behavior and Overdose Report* (SBOR) or CSRE, ask the following:

- *Were you admitted to a CLC, residential, or inpatient program at the time?*
- *Did the event occur on VA property?*
- *Did you happen to be recently discharged from an inpatient or residential stay?* (If yes, gather more information about dates to clarify if the attempt occurred within 7 days of discharge).

Section 3: Warning Signs

Individual factors that signal an acute increase in risk.

- *It can be helpful to identify thoughts, feelings, or behaviors that you tend to have when your suicidal thoughts are getting worse or when you made an attempt previously.*
- *This helps us know when it is time to use some coping skills or get some help.*
- *What kinds of things do you do, think, or feel when that is happening for you?*

If the Veteran is having a hard time identifying these:

- *Think about the last time you attempted suicide or had an increase in suicidal thoughts. Please describe the thoughts or feelings that were present leading up to this.*

After you have collaboratively identified warnings signs:

- *Have you been having any of these warning signs recently?*

Section 4: Risk Factors

Factors that may increase the likelihood of engaging in suicidal self-directed violence:

- *I am going to ask you a few questions to get a sense of what might increase your risk for suicide and what might be protective for you.*
- *From what you've told me, you have_____ stressors that make it more likely to want to kill yourself.* (Fill in with what you know about the Veteran's risks including financial stressors, relationship stress, and recent hospitalizations.)
- *Is there anything we are missing?*

Section 5: Protective Factors and Reasons for Living

Personal qualities and resources that promote recovery, health, wellness, growth, AND may reduce the risk for suicide.

- *I am also very interested in hearing about your reasons for living and other things that keep you from killing yourself. Please tell me more about why you still want to live.*
- *What keeps you going?*
- *What are some things in your life that help motivate you to live?*

Clinical Impressions:

You do not need to ask further questions here, but it is helpful to think about stratifying risk to (1) ensure you have enough information and (2) inform your risk mitigation strategies. Please refer to the therapeutic risk management – risk stratification table for assistance (see Appendix 2B).

- Identification of **acute risk** (minutes to days): Low, Intermediate, High
- Identification of **chronic risk** (long-term): Low, Intermediate, High
- Provide a rationale for your selections.

Section 6: Disposition/Risk Mitigation Plan

- *Let's focus on some things we can do to increase your sense of hope and desire to live.*
- *Let's review your safety plan together.*
- *What are things that you can do outside of my office to help alleviate the heaviness that you feel right now? Are there people you can contact? Places you can go? Activities you can do on your own that will help?*
    - Draw from what the Veteran has identified thus far in the protective factors and reasons for living section as well as his/her existing safety plan.
- *Let's discuss the crisis resources that are available to you. The Veteran's Crisis Line # is 1-800-273-8255; press 1 for Veterans. You can also go to your nearest ED or come to your local crisis center/urgent care/psychiatric emergency service* (fill in what's applicable in your area).

- *I'd like you to schedule your next appointment in about _____ days/weeks. Please do the following to schedule that appointment.* (Give site-specific instructions for scheduling.)
- *Let's discuss the following referral* (Such as a referral to psychotherapy, group, or evidence-based psychotherapy).
- *Let's discuss the following medication that can help as well.*
- *Thank you so much for taking the time to discuss these personal and important topics with me. I am sure it was hard. I am hopeful that we can work together to help things improve.*

Comprehensive Suicide Risk Evaluation (CSRE) WORKSHEET - Printable

For some items, spaces are provided to add details. **Appendix 2-A**- includes definitions (e.g., suicide attempt vs. preparatory behavior) and tips. **Appendix 2-B**- includes risk stratification guidance. Appendix 2C- includes a full list of risk mitigation strategies.

QUESTION	ANSWER	DESCRIBE
1. Does the Veteran appear to be willing and able to answer questions related to the CSRE (consider intoxication, delirium, or other factors that may impact responding)?	☐ Yes *If yes, proceed with worksheet* ☐ No *If no, indicate reason and proceed with worksheet, documenting all available information, which will be used to make a final risk determination.*	*Reason:*

SECTION 1: SUICIDAL IDEATION

QUESTION	ANSWER	DESCRIBE
2. How recently did thoughts occur?	*Answer here*	*Details of the ideation, including frequency:*
3. Presence of intent:	☐ Yes ☐ No ☐ Unknown/Unclear	*Describe:*
4. Plan:	☐ Yes ☐ No ☐ Unknown/Unclear	*Describe:*
5. If most recent ideation is not the most severe ideation in the past 30 days, comment on details of the most severe ideation in the past 30 days, including frequency, intent and plan.	*Details:*	*Describe:*

QUESTION	ANSWER	DESCRIBE
6. Does the Veteran have access to lethal means?	• Firearms • Other lethal means • If Veteran's access to lethal means is unknown, indicate why this is information is not known	• (Indicate number and describe storage practices): • (Indicate type and describe storage practices): • (e.g., Veteran declined to answer, Veteran unable to answer, other):

SECTION 2: SUICIDAL BEHAVIOR

Suicide Attempts

Note: If any suicidal behavior is already documented in a Suicide Behavior and Overdose Report (SBOR) or past CSRE, you will not have to document it again in the CSRE.

QUESTION	ANSWER	DESCRIBE
7. Describe history of attempts, including #, general dates, and potential patterns (e.g., following argument with loved one, while intoxicated, after relapse, etc.)	*Details:*	*Describe:*
8. For the most recent attempt:	• Date and method used: • Was it interrupted: • Was there any injury: • Any care received afterwards: • Outpatient vs inpatient at the time, whether occurred on VA property and whether it occurred within 7 days of discharge from a VA inpatient or residential facility:	*Describe:*
9. If the most recent attempt was not the most lethal, document the following for most lethal attempt:	• Date and method used: • Was it interrupted: • Was there any injury: • Any care received afterwards: • Outpatient vs inpatient at the time, whether occurred on VA property and whether it occurred within 7 days of discharge from a VA inpatient or residential facility:	*Describe:*
10. ***Preparatory Behavior*** *Note: Describe any preparatory behavior (1) not associated with any suicide attempts reported or (2) not previously reported in an SBOR or CSRE.*	• Describe any preparatory behavior reported: • For most recent preparatory behavior:	• Date and method the behavior was related to: • Outpatient vs inpatient at the time, whether occurred on VA property and whether it occurred within 7 days of discharge from a VA inpatient or residential facility:

SECTION 3: WARNING SIGNS

QUESTION	ANSWER	DESCRIBE
11. Warning signs currently present:	☐ Suicidal communication ☐ Preparations for suicide ☐ Seeking/recent use of lethal means ☐ Anger ☐ Anxiety ☐ Guilt or shame ☐ Hopelessness ☐ Increased isolation ☐ Recklessness ☐ Sleep disturbance ☐ Escalating substance use ☐ Other:	Past warning signs (may inform safety planning):

SECTION 4: RISK FACTORS

QUESTION	ANSWER	DESCRIBE
12. Risk factors currently present:	☐ History of suicide attempt ☐ Recent psychosocial stressors (e.g., homelessness; legal, financial, relationship problems) ☐ Access to lethal means (e.g., firearms, large quantities of medications) ☐ History of mental health hospitalizations (dates, reasons, duration) ☐ Psychological conditions or symptoms (e.g., mood/affective disorder, personality disorder, psychosis, insomnia, agitation, hopelessness) ☐ History of non-suicidal self-directed violence (e.g., cutting, burning) ☐ Losses (e.g., loss of a loved one or relationship) ☐ Medical conditions/health-related problems (e.g., TBI, HIV/AIDS, chronic pain) ☐ Member of minority group at risk for suicide (e.g., LGBT)	*Describe:*

QUESTION	ANSWER	DESCRIBE
	☐ Preexisting risk factors (e.g., history of trauma, history of suicide attempt) ☐ Recent transition from military to civilian life ☐ Other: ☐ None noted	

SECTION 5: PROTECTIVE FACTORS AND REASONS FOR LIVING

QUESTION	ANSWER	DESCRIBE
13. Protective factors and reasons for living currently present:	☐ Access to and engagement with health care (e.g., supportive medical care relationships) ☐ Motivation for medical treatment ☐ Access to and engagement with mental health care (e.g., supportive mental health care relationships) ☐ Motivation for mental health treatment ☐ Meaningful family relationships ☐ Significant other ☐ Child or other person-related responsibilities (e.g., elder) ☐ Hope for the future ☐ Protective personal traits or beliefs (e.g., pattern of help seeking, beliefs against suicide, cognitive flexibility) ☐ Religious or spiritual beliefs/connections ☐ Connections to cultural group (e.g., ethnic, religious, community, etc.) ☐ Social context support system (e.g., friend(s), community support) ☐ Strong desire to live ☐ Other: ☐ None noted	*Describe:*

Clinical Impressions (see Appendix 2-B for Risk Stratification guide)

QUESTION	ANSWER	DESCRIBE
14. ACUTE Risk for Suicide:	☐ Low ☐ Intermediate ☐ High	*Rationale:*
15. CHRONIC Risk for Suicide:	☐ Low ☐ Intermediate ☐ High	*Rationale:*

SECTION 6: RISK MITIGATION PLAN (SEE APPENDIX 2-C FOR FULL LIST OF RISK MITIGATION STRATEGIES)

QUESTION	ANSWER	DESCRIBE
16. Plan was developed in collaboration with:	☐ Veteran ☐ Veteran's Guardian ☐ Family ☐ Additional health care providers	*Additional Details:*
17. Clinical setting in which CSRE was completed:	☐ ED/Urgent Care Center ☐ Inpatient ☐ Outpatient (includes home, community) ☐ Residential (includes CLC)	*Additional Details:*
18. Provide details of the plan:	*Describe:*	*Additional Details:*

Appendix 2-A: Definitions

Suicidal Ideation: Thoughts of engaging in suicide-related behavior.

Suicidal intent: Past or present evidence (implicit or explicit) that an individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions. Suicidal intent can be determined retrospectively and in the absence of suicidal behavior.

Suicide Attempt: A non-fatal self-inflicted potentially injurious behavior with an intent to die as a result of the behavior.

Preparatory Behavior: Acts or preparation towards engaging in Suicidal Self-Directed Violence, but before potential for injury has begun. Examples include writing a suicide note, stockpiling medications, etc.

TIP: If there is potential for injury (e.g., pills have been ingested), the behavior is a suicide attempt; otherwise, it is preparatory behavior (e.g., pills are in the Veteran's hand but have not been taken)

Warning Signs: Factors specific to the individual which when exacerbated or increased, signal an acute increase in risk of suicidal behavior in the immediate future (i.e., minutes and days). These can be assessed by asking the Veteran to describe thoughts, feelings, and behaviors experienced prior to most recent exacerbation of suicidal ideation or behavior. This information may inform safety planning, if indicated.

Risk factors: These increase the likelihood of engaging in suicidal self-directed violence. They may be modifiable or non-modifiable and both inform the formulation of risk for suicide. Modifiable risk factors may also be targets of intervention.

Protective factors: Capabilities, qualities, environmental and personal resources that drive an individual toward growth, stability, and health and may reduce the risk for suicide. Enhancing protective factors can be a target of intervention. Select all that apply. Each comment is optional, except if 'Other' is selected.

Risk Stratification and Risk Mitigation Plan Tips

Stratify the Veteran's acute (minutes to days) and chronic (long-term) risk to inform disposition planning. Provide evidence for the acute and chronic risk levels, utilizing information obtained for the CSRE, and pay particular attention to the presence of warning signs and risk and protective factors.

In some circumstances (e.g., acute intoxication) acute and/or chronic risk may be difficult to determine. In these cases, consider a high-risk level and detail the relevant circumstance in the evidence section.

See **Appendix 2-B** for guidance on the risk stratification levels and associated risk mitigation steps to consider.

Appendix 2-B: Risk Stratification Guidance

ACUTE THERAPEUTIC RISK MANAGEMENT

High Acute Risk

ESSENTIAL FEATURES	ACTION
• **Suicidal ideation with intent to die by suicide** • **Inability to maintain safety independent external support/help**	Typically requires psychiatric hospitalization to maintain safety and aggressively target modifiable factors.
Common Warning Signs • A plan for suicide • Recent attempt and/or ongoing preparatory behaviors • Acute major mental illness (e.g., MDD episode, acute mania, acute psychosis, recent/current drug relapse) • Exacerbation of personality disorder (e.g., increased borderline symptomatology)	These individuals need to be directly observed until a secure unit and kept in an environment with limited access to lethal means (e.g., keep away from sharps, cords/tubing, toxic substances).
Common Risk Factors • Access to means • Acute psychosocial stressors (e.g., job loss, relationship dissolution, relapse on alcohol)	During hospitalization co-occurring psychiatric symptoms should also be addressed.

Intermediate Acute Risk

ESSENTIAL FEATURES	ACTION
• **Suicidal ideation to die by suicide** • **Ability to maintain safety, independent of external support/help** These individuals may present similarly to those at high acute risk, sharing many of the features. The only difference may be lack of intent, based upon an identified reason for living (e.g. children), and ability to abide by a safety plan and maintain their own safety. Preparatory behaviors are likely to be absent.	Consider psychiatric hospitalization, if related factors driving risk are responsive to inpatient treatment (e.g. acute psychosis). Outpatient management of suicidal thoughts and/or behaviors should be intensive and include: • Frequent contact, • Regular re-assessment of risk, and • A well-articulated safety plan Mental health treatment should also address co-occurring psychiatric symptoms.

Low Acute Risk

ESSENTIAL FEATURES	ACTION
• **No current suicidal intent AND** • **No specific and current suicidal plan AND** • **No preparatory behaviors AND** • **Collective high confidence** (e.g., patient, care provider, family member) in the ability of the patient to independently maintain safety Individuals may have suicidal ideation, but it will be with little or no intent or specific current plan. If a plan is present, the plan is general and/or vague, and without any associated preparatory behaviors (e.g., "I'd shoot myself if things got bad enough, but I don't have a gun"). These patients will be capable of engaging appropriate coping strategies, and willing and able to utilize a safety plan in a crisis situation.	Can be managed in primary care. Outpatient mental health treatment may also be indicated, particularly if suicidal ideation and psychiatric symptoms are co-occurring.

*Overall level of individual risk may be increased or decreased based upon warning signs, risk factors and protective factors.

CHRONIC THERAPEUTIC RISK MANAGEMENT

High Chronic Risk

ESSENTIAL FEATURES	ACTION
Common Warning Sign • Chronic suicidal ideation **Common Risk Factors** • Chronic major mental illness and/or personality disorder • History of prior suicide attempt(s) • History of substance abuse/dependence • Chronic pain • Chronic medical condition • Limited coping skills • Unstable or turbulent psychosocial status (e.g., unstable housing, erratic relationships, marginal employment) • Limited ability to identify reasons for living	These individuals are considered to be at chronic risk for becoming acutely suicidal, often in the content of unpredictable situational contingencies (E.g., job loss, loss of relationships, and relapse on drugs). These individuals typically require: • Routine mental health follow-up • A well-articulated safety plan, including means safety (E.g., no access to guns, limited medication supply) • Routine suicide risk screening • Coping skills building • Management of co-occurring psychiatric symptoms

Intermediate Chronic Risk

ESSENTIAL FEATURES	ACTION
These individuals may feature similar chronicity as those at high chronic risk with respect to psychiatric, substance abuse, medical and painful conditions. Protective factors, coping skills, reasons for living, and relative psychosocial stability suggest enhanced ability to endure future crisis without resorting to self-directed violence.	These individuals typically require: • Routine mental health care to optimize psychiatric condition and maintain/enhance coping skills and protective factors. • A well articulated safety plan, including means safety (E.g., no access to guns, limited medication supply) • Management of co-occurring psychiatric symptoms

Low Chronic Risk

ESSENTIAL FEATURES	ACTION
These individuals may range from persons with no or little in the way of mental health or substance abuse problems, to persons with significant mental illness that is associated with relatively abundant strengths/resources. Stressors historically have typically been endured absent suicidal ideation. The following factors will generally be missing: • History of self-directed violence • Chronic suicidal ideation • Tendency towards being highly impulsive • Risk behaviors • Marginal psychosocial functioning	Appropriate for mental health care on an as needed basis, some may be managed in primary care settings. Others may require mental health follow-up to continue successful treatments.

Training for TRM available here: https://www.mirecc.va.gov/visn19/trm/. No cost copies of the laminates can be requested here (by anyone): https://www.mirecc.va.gov/visn19/orderform/orderform.asp

Appendix 2-C: Risk Mitigation Strategies

RISK MITIGATION STRATEGIES

- Alert supervisor to Veteran's risk for suicide
- Complete or update Veteran's crisis response plan
- Increased frequency of suicide risk screening
    - Describe:
- Provide lethal means safety counseling
    - Provision of gun locks
- Obtain additional information from collateral sources
    - Describe:
- Address barriers to treatment engagement
    - Describe:
- Address medical conditions
    - Describe:

- Consult/Provide referral to additional services and support
    - Referral to evidence-based psychotherapy
    - Referral to psychiatry/medication assessment or management
    - Referral to chaplaincy/pastoral care
    - Referral to vocational rehabilitation/occupational rehabilitation services
- Discuss with Veteran to continue to see assigned Primary Care Provider for medical care
- Discuss with Veteran regarding enhancement of a sense of purpose and meaning
- Educate Veteran on supportive smartphone applications (i.e., Virtual Hope Box, PTSD Coach)
- Conduct medication reconciliation
- Involve family/support system in Veteran's care
- Provide Opioid Overdose education and Naloxone Distribution
- Provide resources/contacts for benefits information
- Provide Veteran with phone number for Veteran's Crisis Line: 1-800-273-8255 (press 1)
- Obtain consultation from Suicide Risk Management Consultation Program on ways to address Veteran's risk by sending a request for consultation https://www.mirecc.va.gov/visn19/consult/request-a-consult.asp

APPENDIX 3: SUPERCEDE ASSESSMENT OF NEEDS

SUPERCEDE Assessment of Needs

QUESTION	ANSWER
1. Where do you live? Who do you live with?	*Answer here*
2. [Possible follow-up if there are needs or concerns]: **Would you like help with that? How urgent is help needed?** ☐ Needs housing resources (e.g., emergency housing shelters, Habitat for Humanity, utility companies) ☐ Needs financial resources (e.g., public assistance, financial assistance programs, interest-free loans). Additional health care providers you like help with that? How urgent is help needed?	*Answer here*
3. What is your relationship with your family like? Do you have friends you would consider close friends?	*Answer here*
4. [Possible follow-up if there are needs or concerns**]: Would you like help with that?** ☐ Needs resources to build relationships (e.g., peer network referral, couples counseling) ☐ Needs community organization resources (e.g., church directory, community centers, volunteer placement agencies, seniors' groups, bulletin boards) ☐ Needs caregiving resources	*Answer here*
5. What is your method of transportation?	*Answer here*
6. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs transportation resources (e.g., Veteran transportation non-profit, transit district maps)	*Answer here*
7. What is your highest level of education?	*Answer here*
8. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs educational resources (e.g., Free GED prep class, student support services for college/university academic counseling, advising, tutoring, and financial assistance)	*Answer here*
9. Do you work? If so, where?	*Answer here*

QUESTION	ANSWER
10. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs work resources (e.g., Veteran job resources, career placement centers, career training centers)	*Answer here*
11. Do you have health insurance?	*Answer here*
12. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs health insurance resources (e.g., Medicare, Medicaid)	*Answer here*
13. Are you experiencing any financial hardships?	*Answer here*
14. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs financial resources (e.g., Unemployment assistance, social service centers, government-sponsored welfare centers, energy assistance centers, not-for-profit assistance centers, public housing agency (HUD) centers)	*Answer here*
15. Are you experiencing any legal problems?	*Answer here*
16. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs specific legal resources (e.g., free legal clinics, municipal libraries)	*Answer here*
17. Have you ever been diagnosed with any mental health conditions? Other than thoughts of suicide and symptoms we have already discussed, what other symptoms are coming up the most currently? Are you currently receiving any mental health treatment? *List if Veteran is experiencing: communication difficulties, anxiety, irritability, hopelessness, guilt/shame, grief, depressed/elevated mood, aggression, emotionality, fatigue, substance use, poor concentration, phobias, paranoia, panic attacks, mood swings, self-harm, dissociation, appetite disturbance/binging/purging, hallucinations, hyperactivity, etc.*	*Answer here*
18. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs mental health resources (e.g., referral to local hospital that provides care, mental health treatment centers)	*Answer here*
19. Do you take any prescription medications? Do you take them differently than prescribed?	*Answer here*

QUESTION	ANSWER
20. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs substance use resources (e.g., referral to local hospital that provides care, community mental health facility)	*Answer here*
21. How often do you drink alcohol?	*Answer here*
22. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs specific alcohol use disorder resources (e.g., substance abuse homes, addiction support groups)	*Answer here*
23. Do you use illicit drugs?	*Answer here*
24. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs specific drug use disorder resources (e.g., addiction support groups)	*Answer here*
25. Are you experiencing sleep problems?	*Answer here*
26. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs specific sleep resources or help addressing issue in sessions 2 or 3 if necessary (e.g., primary care clinics, sleep disorder clinics)	*Answer here*
27. Are you experiencing any medical issues?	*Answer here*
28. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs medical referrals	*Answer here*
29. Are you in the process of trying to get disability benefits from the VA?	*Answer here*
30. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs disability qualification information (e.g., social security disability, Veteran benefits offices)	*Answer here*
31. Are there ever times when you do not have enough food in your house?	*Answer here*

QUESTION	ANSWER
32. [Possible follow-up if there are needs or concerns]: **Would you like help with that?** ☐ Needs food bank referrals (e.g., faith-based centers, food stamps, WIC, food kitchens)	*Answer here*
33. What care are you receiving from VA?	*Answer here*
34. [Possible follow-up if there are needs or concerns]: **Would you like help with that?**	*Answer here*
35. What care are you receiving in the community?	*Answer here*
36. [Possible follow-up if there are needs or concerns]: **Would you like help with that?**	*Answer here* *[Therapist: Provide names and contact info of community providers]*
37. **Were you ever deployed to combat during your military service?** *[May qualify for additional benefits or programs]*	*Answer here*
38. **Do you identify as a survivor of military sexual trauma**? *[May qualify for additional benefits or programs]*	*Answer here*
39. **I see that in your VA chart, you have been diagnosed with XX mental health disorder (e.g., depression, PTSD). Are these symptoms impacting your day-to-day functioning? I see you [are receiving XXX mental health care OR are not receiving any mental health care]. Are you receiving any mental care in the community?**	*Answer here*
40. **Is there anything else you think I should know about**? Do you have additional needs? Are you experiencing current stressors?	*Answer here*

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