South Central MIRECC

MICHAEL E. DEBAKEY VETERANS AFFAIRS MEDICAL CENTER

Baylor College of Medicine

COLLABORATIVE **SAFETY PLANNING** FOR OLDER ADULTS

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This manual is based on the "Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version" by Stanley and colleagues (2008). It has been customized and enhanced for use with older adult Veteran patients. This manual is designed to be used by nurses, social workers, physicians, and other professionals who may or may not have extensive training in psychotherapy.

The goal is to improve the ***quality*** of safety plans, to make them more ***useful*** for Veterans. We are focusing on older Veterans (generally 65+) in this manual. However, most of the information is useful for younger Veterans, too.

Basic Ideas

1. Safety Plans are only effective when Veterans know why, when, and how to use them.
2. Creating a Safety Plan is a collaborative, therapeutic task. If it feels like paperwork, the Veteran will treat it like paperwork.
3. The "magic ingredient" in a Safety Plan is that you do it together.

INGREDIENTS FOR SAFETY

1. Collaboration with Veteran

2. The Veteran's cell phone (for looking up phone numbers)

3. 1:1 time with Veteran, approximately 20-30 minutes total

4. Veteran agreement and ability to participate (consider dementia, psychosis, etc.)

5. Comfort asking and talking about suicide

6. Know how to
* Use reflections (repeat what they say)
* Ask open-ended questions (get more information)
* Troubleshoot barriers (make sure the plan is possible)

Reference appendixes for more information

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Key Considerations for Suicide Prevention and Safety Planning in **Older Adults**

- Older people are much more likely to die on their first suicide attempt than younger people.
- Older adults may also be less likely than younger people to admit to thinking about suicide.
- Older adults, especially men, often have a harder time asking for help and may have fewer close family members and friends.

- **The safety plan should be seen as a menu of options, not one-by-one steps.**
- **Reaching out for support can be done first, before thoughts become intense.**
- **Talk about how the Veteran might increase their social support.**

Special Risk Factors for Suicide in Older Adults

Other risk factors are important, but these may be more common or obvious in older people.

- Feeling isolated, lonely, or without a purpose.
- Feeling like a burden on those around them.
- Disability or changes in ability. Not being able to write, hear, talk, move, bathe, toilet, etc.
- Pain of any type or place in the body.
- Poorer memory, thinking, feeling "slow," trouble thinking through options to make decisions.
- Being rigid, inflexible, unable to think of solutions, stubborn, not wanting to try something new to cope or help.
- Grief and loss, especially of close relationships.

With these risk factors in mind, as you create the Safety Plan

- **Get the older adult connected to others, helping others, doing social activities, etc.**
- **Consider what the person is actually able to do (disabilities) when choosing activities.**
- **Think "outside the box" when choosing activities or coping techniques.**
- **Include medical providers on the safety plan, and talk to them as allowed.**

Involving Family

With the Veteran's permission, involving the Veteran's family in the creation of the safety plan and carrying it out can be very helpful. Family members or people who know the Veteran well can identify warning signs, coping strategies, numbers to call, and can help remind the Veteran to use the Safety Plan. Sometimes older adults have other types of care providers such as power of attorney or guardians, who help make medical, financial, and other decisions for the person. These individuals may also be included, depending on their relationship with the Veteran. Encourage the Veteran discuss their Safety Plan with people in their life who can support them in their use of the Safety Plan. For more details about Safety Planning for Veterans with dementia, see Appendix B.

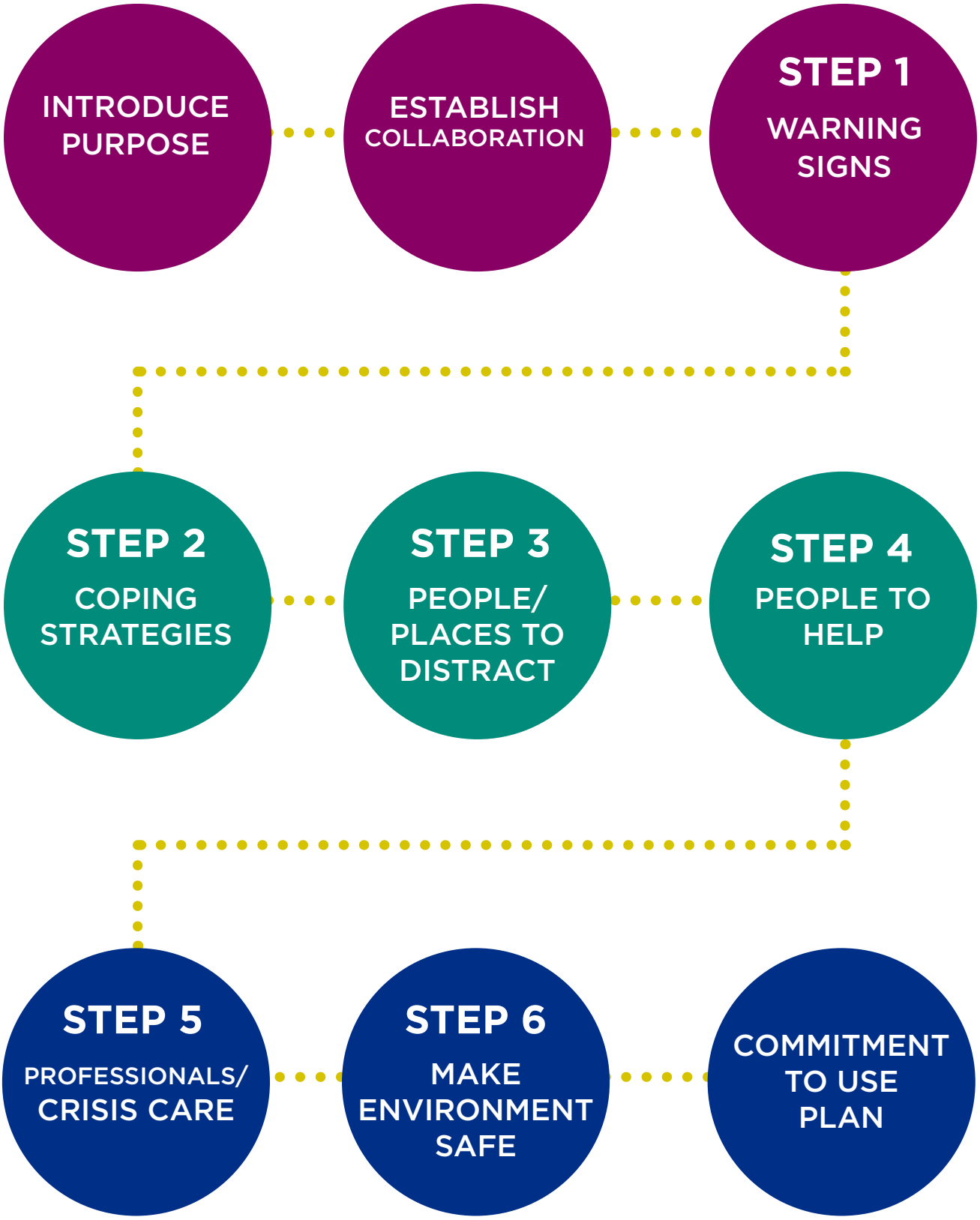
Involving Other Providers

Primary care providers are excellent allies in suicide prevention. Many people who kill themselves have recently been in contact with primary care. Regular check-ins (for example, weekly) by a medical or mental health provider is best practice for any person at risk for suicide.

Special Settings for Older Adults

Older adults who live in a nursing home, a hospital setting, assisted living, or a personal care home might seem to be safer from suicide. People in these settings will not usually have access to firearms (although sometimes they might!). However, older adults can and do die by suicide in these places. The most common methods are jumping from a building, hanging, cutting, and taking an overdose of medication. Living in one of these facilities might make the person feel more lonely or less useful. Veterans living in these settings often have more limits in their daily activities or problems like dementia. With proper authorization, it's very important to contact the staff at the place where the Veteran is living to share the safety plan, and especially a plan for limiting access to ways the person might hurt themselves.

Safety Planning: THE STEPS

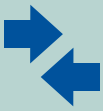


Other Key Strategies

The safety plan can be started anytime the Veteran is stable. Don't wait until the Veteran is ready to be discharged from an inpatient unit. Enlist competent students or interns, or a psychologist, to complete the safety plan. Ask for help! It's better to delegate the plan rather than have it be completed by the Veteran alone or not at all.

If the Veteran does not agree that he/she had suicidal thoughts or behaviors, continue with the plan, being careful to frame it as a plan for "crisis."

If possible, sit next to the Veteran instead of standing or sitting across a table (ask first). If physically able (even if extra time is needed) the Veteran should write on the form and/or card.



Use a lot of reflections, more than questions. Just reflect what the Veteran says. This builds rapport, shows empathy, and gets the Veteran "arguing for change." *See appendixes for more information.*

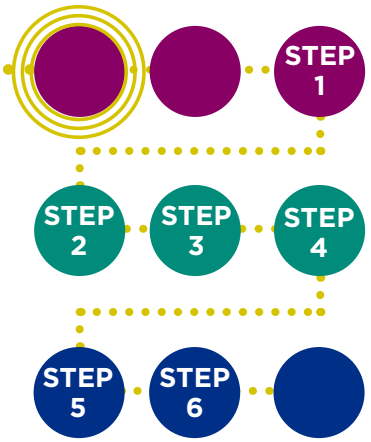
Although means safety ("making environment safe") is last on the plan, it may be the most important. Means safety is an effective way to prevent suicide. Leave at least 5 full minutes for that conversation.

You or the Veteran should write the plan on a card so that the Veteran can carry it with them. See page 14.

You don't have to use every strategy or question in this manual. Text in quotations is meant as an example, not a strict script. The most important thing is that the safety plan comes from a meaningful, therapeutic conversation.

Each item on the plan should be personally meaningful and specific. For example, instead of "depressed," Veteran might write "crying for hours" or instead of "anxiety" Veteran might write "sweating and heart racing." Instead of "listen to radio" they might write "listen to KBCO" or "listen to my play list."

Introduce Purpose of Safety Plan



1. **Provide context personalized based on the Veteran's situation**
   For example: "You were hospitalized because you had a crisis [OR some serious thoughts about ending your own life]. Usually people find themselves in crisis because whatever is going on around them is just unbearable. The purpose of the session today is to develop a plan for what to do if you feel that way again in the future. The goal of this plan is to reduce the emotional pain [or other appropriate term] for long enough that you can get help or get through the crisis. As you may have experienced, suicide crises/thoughts do come and go. We want you to be able to survive the next one."

2. **Other ways to explain safety plans**
   "You've been prescribed medication to make your mood and body feel better, but people often still need a plan for what they're going to do in a crisis."

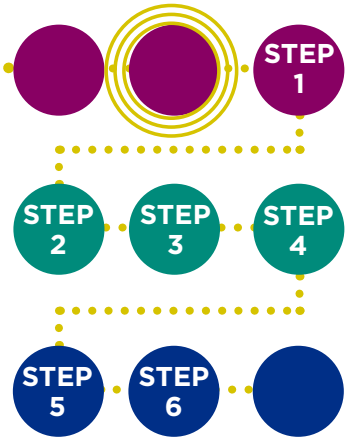
   "When you're feeling very distressed/upset/suicidal, it might seem like you have few options. The safety plan just reminds you of what you would do if you were in your calm mind, like you are now."

   "You've learned some strategies such as deep breathing or using distraction. Today we're going to put it all together so you know when and why to use those tools."

   "It's like a map to navigate challenging, unfamiliar and rugged terrain."

   Military Standard Operating Procedure (SOP) analogy: "You can think of the safety plan as similar to SOPs you would use in the military. You would never enter into a dangerous situation without a plan about what to do. The safety plan is the same type of thing; we just apply it to your emotional life."

Establish Collaboration



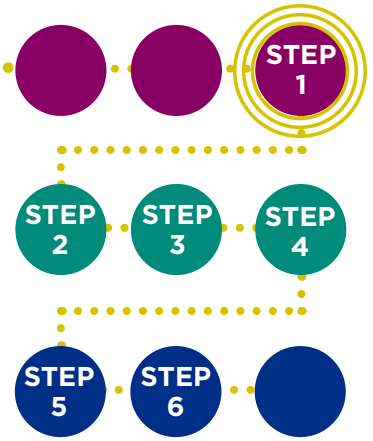
EXAMPLES

Ask: "How does that all sound to you?" or "What are your thoughts about that?"

Ask for permission to continue: "I'm wondering if we could talk a bit about how we can work together to come up with a plan to keep you safe during crises. Would you be willing to talk with me about a plan for safety?"

"You are the coauthor of your plan – with the goal of keeping you out of the hospital and getting you through difficult times."

If Veteran is not sure, talk about reasons for staying safe: "What are some reasons for living? What keeps you from making a suicide attempt despite some desire to do so?"



STEP 1

RECOGNIZING WARNING SIGNS

Inform "It often seems like suicidal thoughts or crises come out of nowhere. But usually there are warning signs that you or other people might notice before you get to that point. By noticing these warning signs, you'll know when to use this plan."

Ask "What's it like for you to 'become suicidal (or in crisis)'?" "What is usually going on?" "What would others notice?"

List warning signs using the Veteran's own words.

Reflect (repeat back) to make sure the Veteran knows you understand and the plan is accurate.

Ask about alcohol or other drug use. For older adults and others, alcohol use can be a major warning sign.

EXAMPLES OF WARNING SIGNS

PHYSICAL

Racing heart, not sleeping, fatigue, headaches, stomach problems, pain, lack of energy, lots of ongoing health issues, not being able to take care of self, worsening eye sight, hearing, memory, or mental speed...

MOOD/THOUGHTS

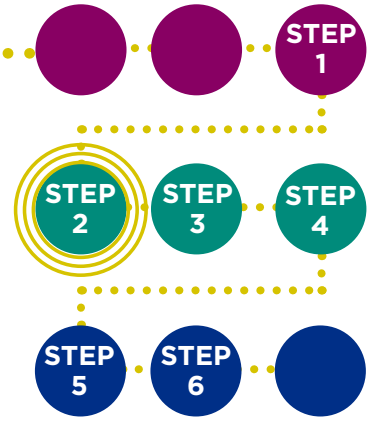
"I am a failure," "I can't cope," "I am a nobody," "I'm a burden," "I have no one," feeling hopeless, irritable, loneliness, angry, very depressed, unable to concentrate, careless, intense worry, difficulty controlling worry, feeling overwhelmed, thoughts of self-harm, thoughts of hurting others, thoughts of suicide, thoughts of using substances/craving...

BEHAVIORS

Isolating, crying a lot, not taking care of self, not eating, not sleeping, less involvement in pleasant or social activities, cancelling treatment sessions, not taking medications, rejecting others and their advice, using drugs or alcohol to cope...

TO CHECK UNDERSTANDING

ASK: "How will you know when the safety plan should be used?"



STEP 2

INTERNAL COPING STRATEGIES - THINGS I CAN DO TO TAKE MY MIND OFF MY PROBLEMS WITHOUT CONTACTING ANOTHER PERSON

Inform "Because suicidal thoughts/crises come and go, having a few tools to get through those moments can be really helpful. These help you reduce uncomfortable feelings to a level where you can think, plan, reach out, or get involved in something positive."

Ask "What can you do, on your own, if you become suicidal again, to distract or occupy yourself so that you do not act on your thoughts or urges in the moment?"

Ideally, Veteran has been to therapy or groups that focus on coping strategies.

Ask "How likely do you think you would be able to use this during a time of crisis?"

For older people, connecting and contributing to others may be especially important, for example, walking a neighbor's dog or writing a letter or card to a friend.

EXAMPLES OF INTERNAL COPING STRATEGIES

Deep/diaphramatic breathing
Meditate or use mindfulness
Go for a walk
Watch TV
Turn up loud music
Watch funny videos
Hold ice in your hand
Lift weights, walk up and down stairs
Concentrate on colors & sounds around you
Squeeze a ball, focus on the feeling
Repeat a special calming phrase, for example, 'I can get through this'
Read
Listen to audiobooks
Put on makeup, favorite clothes
Shave
Do your hair
Dance
Craft, whittle, any hobby
Take a shower
Eat if hungry
Drink if thirsty (non-caffeine, non-alcohol)
Nap
Make a list, write down to-do's
Pray, read the Bible, sing hymns
Play a game, do a puzzle
Visualize being in the forest or beach
Look at photos of happy memories
Re-read notes, emails, cards from loved ones

IN THIS STEP

Ask "What might stand in the way of you thinking of these activities or doing them if you think of them?"

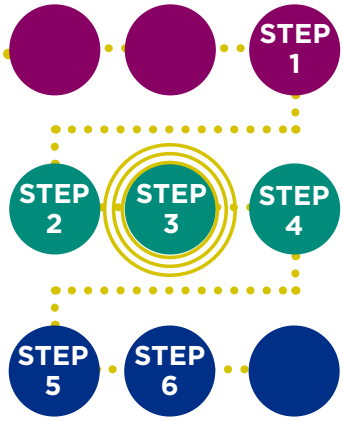
Talk through things that might get in the way. For example, a person might not always be able to go fishing, even though that's a great distraction tool for them. Try to get Veterans to think of things they can use anywhere, at any time.

Older people may have different levels of impairment or disability. Ask the person what they are able to do and consider what is realistic.

TO CHECK UNDERSTANDING

Reflect answers to improve understanding and commitment to using these coping strategies.

STEP 3



PEOPLE AND SOCIAL SETTINGS THAT PROVIDE DISTRACTION

Ask "Who can help you take your mind off your problems at least for a little while?" "Who helps you feel better when you're around them?"

"Are there places you can easily get to where you feel safe and calm, or would distract you?"

Ask patients to list several specific people and places (with names and phone numbers), in case the first option is unavailable.

Older adults may have fewer social contacts or places they go. Let them know that's OK and that it is something to work on in the future.

EXAMPLES OF PEOPLE AND SOCIAL SETTINGS

IF RELATIONSHIPS ARE STABLE:

Friend who always has something to talk about or something going on

Buddy to talk about sports with

Brothers, sisters

Parents

Children

Neighbors

Pastor, clergy

Nieces, nephews

IF ACCESSIBLE AND SAFE:

Coffee shop

Grocery store

Library

Shopping mall

Friend's/family member's house

Senior center

Religious gathering place

VA Canteen

Chapel

VFW

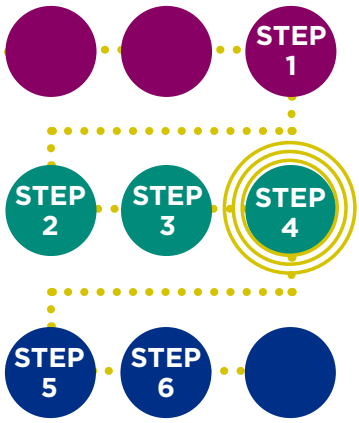
Barbershop/salon

IN THIS STEP

Suicidal thoughts and feelings do not have to be revealed to the people contacted.

TO CHECK UNDERSTANDING

Reflect and summarize when and how they will access these people or places.



STEP 4

PEOPLE WHOM I CAN ASK FOR HELP

Ask "Among your family or friends, who do you think you could contact for help during a crisis?" or "Who is supportive of you and who do you feel that you can talk with about your suicidal thoughts/when you're under stress?"

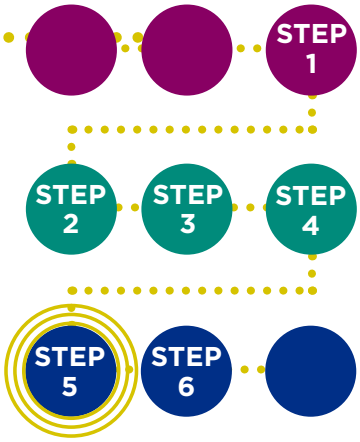
If possible, ask patients to list 2-3 people with names and phone numbers, in case they cannot reach the first person on the list. In this step, unlike the previous step, patients reveal they are in crisis.

Ask "How likely would you be willing to contact these individuals?"

If doubt is expressed about contacting individuals, identify potential obstacles and problem-solve ways to overcome them.

Again, older adults may have fewer social supports. Let them know that's OK and that it is something to work on in the future.

TO CHECK UNDERSTANDING
Reflect and summarize pros and cons of contacting these individuals.



STEP 5

CONTACTING PROFESSIONALS AND AGENCIES

Ask "Who are the mental health professionals that we should identify to be on your safety plan?" and "Are there other health care providers?"

LIST NAMES AND NUMBERS OF PROVIDERS IN ADDITION TO:

VA Suicide Prevention Hotline: 1-800-273-TALK (8255), press 1

Older persons' Friendship Line: 800-971-0016

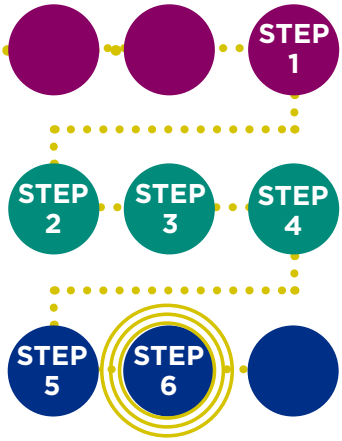
Local urgent care services: For example: MEDVAMC Emergency Dept. 2002 Holcombe Blvd.

911: If there is a life-threatening emergency, the Veteran should call 911

Identify 2-3 options with which Veteran is comfortable, troubleshoot concerns.

TO CHECK UNDERSTANDING
Reflect and summarize pros and cons of using these resources.

STEP 6



STEP 6: REDUCING THE POTENTIAL FOR USE OF LETHAL MEANS (MAKING THE ENVIRONMENT SAFE)

Inform: "As we discussed before, it's common for people to feel suicidal very quickly, without much warning, sort of like they're suddenly overwhelmed and just can't take it anymore."

Inform: "When you're upset, thinking of alternatives or solutions is very hard to do. Having access to lethal means for suicide can be dangerous when in this state of mind. If you don't have access to a lethal method, chances are good that you'll find another way to manage that doesn't result in physical harm or death."

Inform: "So, making a plan to limit your access to [method] for now is an important and straight-forward way of reducing the likelihood of you dying before you can receive the help you need or feel better."

Consider or ask what means (for example, guns, pills, razor blades etc.) were used during previous suicide attempts. If no previous attempts, ask what methods the Veteran has thought about using, even if they didn't make a plan.

Tailor plan to previous methods used, preferred methods, and guns if present (even if not preferred).

Guns

Ask about guns in the home and where they are stored. Usually if there is 1 gun, there is more than 1.

Avoid perception of "taking guns away" by letting Veteran problem-solve.

Make it clear that limiting means is TEMPORARY.

Most older adults who die by suicide use firearms.

Pills/Medications

Ask the Veteran how they take and store their medications. Ask if they have extra medications in their home from leftover prescriptions. Listen for medications that are dangerous when taken in large quantities.

For All Methods

Identify a menu of options: "What are some ways you could reduce the likelihood of you using [method] when you are upset?"

Ask "Is there anyone in your life who might be able to help you carry out this [means safety] plan?"

Ask about reasons for using a plan (If not asked earlier): "What are some reasons for living? What keeps you from making a suicide attempt despite some desire to do so? What benefit might there be to limiting your access to [method] for now?"

Other ways to Make Environment Safe

The Veteran could make their home more safe and comforting by placing pictures/mementos of their reasons for living around the house or in a special box or envelope. Encourage them to keep the safety plan on the refrigerator or easily accessible. Limiting alcohol in the home could also be helpful.

EXAMPLES OF OPTIONS FOR MEANS SAFETY

Give means to family member/friend who does not live with Veteran, "let them hold it for now"

Keep gun unloaded in a tamper-proof safe, have significant other change code or lock

Lock ammunition separately, have significant other change code or lock

Dismantle gun, give a piece to a friend/family member not in the home

Use gun lock (Free from VA), give key to friend/family member

Throw extra medications in the trash (not in the toilet) or bring to Medication Take-Back event

Throw/give away noose, razor blades or other means

"Hiding" is not sufficient, acknowledge this suggestion and ask for other possibilities.

If session occurs during inpatient stay, follow up close to discharge to remind patient of Means Safety plan. With permission, enlist the help of patient-identified family members or friends.

IN THIS STEP

After making decision, write on plan.

TO CHECK UNDERSTANDING

Reflect, summarize, and confirm a time/date to plan for means safety.

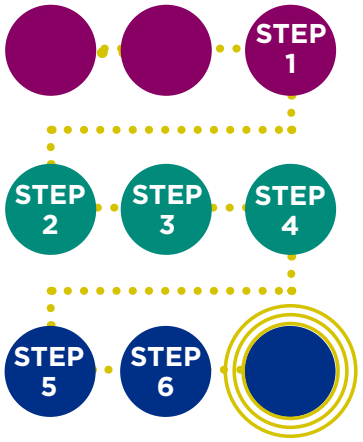
QUICK GUIDE

LETHAL MEANS: method that Veterans might use to kill themselves. Examples: firearm, pills, noose, razor blades.

MEANS SAFETY: plan to reduce access to lethal means, or to make them less deadly.

MEANS RESTRICTION: same as means safety, but may sound more negative to Veterans.

Assess commitment to use plan



Ask "How likely, on a scale of 1 to 10, are you to use the plan?"

"What would make it easier/more likely for you to use it?"

Troubleshoot issues.

Invite Veteran to complete card (example below). Involve family or close friends as much as possible in developing and finalizing the plan.

SAFETY PLANNING

COPING:

PEOPLE/PLACES:

SAFETY:

FOR EMERGENCIES:

FRIENDSHIP LINE: 800.971.0016

SUICIDE PREVENTION HOTLINE:

800.272.TALK (8255) Press "1" for Veterans

YOUR VA HOSPITAL EMERGENCY DEPARTMENT:

911

SAFETY PLANNING

COPING:

Focus on breathing, play with dog, pray

PEOPLE/PLACES:

Go to coffee shop, call friend (Bill 777-7777)

Text daughter Melissa

SAFETY:

Bill will keep my rifles until I feel better

FOR EMERGENCIES:

Call wife Linda (888-8888)

Call Dr. Price (999-999-9999)

FRIENDSHIP LINE: 800.971.0016

SUICIDE PREVENTION HOTLINE:

800.272.TALK (8255) Press "1" for Veterans

YOUR VA HOSPITAL EMERGENCY DEPARTMENT:

MEDVAMC - 2002 Holcombe

911

APPENDIX

A. SAFETY PLAN

SAFETY PLAN

Step 1: Warning signs:

1. _____
2. _____
3. _____

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

1. _____
2. _____
3. _____

Step 3: People and social settings that provide distraction:

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

Step 4: People whom I can ask for help:

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

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

1. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
2. Clinician Name_____ Phone_____
   Clinician Pager or Emergency Contact #_____
3. Suicide Prevention Lifeline: 1-800-273-TALK (8255)
4. Local Emergency Service _____
   Emergency Services Address_____
   Emergency Services Phone _____

Making the environment safe:

1. _____
2. _____

From Stanley, B. & Brown, G.K. (2011). Safety planning intervention: A brief intervention to mitigate suicide risk. *Cognitive and Behavioral Practice. 19*, 256–264

B. DEMENTIA

If the Veteran has mild-moderate dementia, attempt the safety plan.

Example: Veteran is oriented to person, place, situation, and time, but is forgetful and has difficultly doing complex tasks such as paying bills. The Veteran may mostly take care of him or herself but needs some help.

Complete as much of the plan as possible while avoiding frustration. Be encouraging and patient. You can make it a "plan for what to do when you feel really bad."

It's OK if you just agree on 1-3 strategies, people, or numbers to call.

For Veterans with mild dementia, a card with these numbers/strategies written on it could be really helpful.

Note in the chart that the Veteran has dementia so a modified safety plan was completed, to the best of their ability.

Involve family, nursing home or personal care home staff in means safety by calling them (with appropriate authorization) and telling them about the plan.

For Veterans with severe dementia

Example: Veteran is confused most of the time, and needs to be supervised by family or staff. Veteran may live in a personal care home or nursing home.

Means safety is most important.

Family and staff at the place where the Veteran lives must be involved.

Unfortunately, people with dementia do kill themselves. All guns and other means should be kept locked up from the Veteran.

Note in the chart that a plan for means safety was complete, though a full safety plan could not be completed.

Talking to families about safety plans

Inform: "While your loved one was in the hospital, we developed a safety plan he/she can use if he/she feels suicidal [or in crisis]. Because the Veteran has problems with memory, he/she will need your help. The most important thing is that there are no guns or other things in the home that the Veteran can access (large numbers of pills, etc.)."

Ask: "Do you have guns or large numbers of pills in your home? How could you lock those up or remove them from the house in order to keep the Veteran safe?" "Did the Veteran talk about or use another method to attempt suicide?" (Make sure those means are secure.)

Develop a specific plan for means safety. Also discuss content of safety plans and brainstorm with family about other pleasant activities or people who can help improve mood.

C. TROUBLE-SHOOTING

There's nowhere to sit with the Veteran

If inpatient, try his/her room, visitor/family/telephone room, pull up a rolling chair from the nurse's station, get comfy so you can be as relaxed and focused as possible.

I don't have time to do the safety plan with the Veteran

The safety plan can be started anytime after admission if the Veteran is stable. Don't wait until the Veteran is ready to be discharged. Enlist competent students or interns, or a psychologist, to complete the safety plan. Ask for help! It's better to delegate the plan then have it be completed by the Veteran alone or not at all. It's also OK to do the safety plan in more than 1 session (e.g., two 10-minute sessions). Ask the Veteran if they have done one in group. Print out an older safety plan from their chart and make edits/changes. Make sure they know when/why to use it, though! Just think: if an extra 10 minutes of safety planning could help avoid just 1 admission, you've saved hours of work.

The Veteran doesn't want to do the safety plan

Ask why, using some motivational interviewing strategies (see appendixes E-G). Maybe they need more reading or information, or maybe they've done safety plans in the past and it wasn't a good experience or helpful. Listen to their concerns and try to get as much done as possible. They may just want to be heard instead of "doing paperwork."

The Veteran doesn't understand the safety plan

If the Veteran has dementia, see Appendix B. These also apply if the Veteran is psychotic or manic. Try to explain that crises come and go, and that it's helpful to have a plan just in case. Say that it's hard to think straight when you're very depressed (or anxious, disorganized, etc.) and that having a plan can help the Veteran know where to turn. Use other explanations listed on page 7.

The Veteran does not have dementia, but his/her behavior is challenging

Reflect, reflect, reflect! In other words, repeat their concerns back to them. Once the Veteran feels heard, they may be more likely to cooperate. Gently but firmly keep them on task. Remind them you only have a certain amount of time. Say that you care about keeping them out of the hospital and keeping them alive. Let them know you are on their side. If all else fails, politely end the session and try again later.

The Veteran refuses to give up his/her guns

Usually this happens because there is a misunderstanding about "means restriction" (we're calling this "means safety" now). Securing lethal means is temporary, and there are several ways this can be done without the Veterans losing possession of the firearm (see box on p. 13). Try "would you be willing to let your friend or family member hold your firearms for now, until this depression has passed?" or another option. If the Veteran is concerned about personal protection, you can say "right now, you are actually a pretty big threat to yourself. I know you want to protect your home and family, but we have to protect you/keep you around, in order to do that." If the Veteran is upset that you even ask about guns, you can also try, "I only ask about guns because most Veterans who die by suicide use guns." At a certain point, you can't force the issue and should just listen to concerns. It's much better if the Veteran comes up with a solution that's OK with them, even if it's not "perfect."

D. TALKING ABOUT SUICIDE

Talking about suicide can be very difficult, especially if you aren't used to it. One important thing to know is that research shows that just talking to someone about suicide does not "put the idea in their head" or make them more suicidal. People with mental illness often have thoughts of suicide, even if they do not intend to act on them. These thoughts are distressing and often kept secret. They may appreciate you asking about suicide in a real way. We also know that people are not offended when their providers ask about suicide. If you follow this manual, you might be providing the most extended conversation about suicidal thoughts that the person has ever had.

Throughout this manual, we've provided questions that ask about suicide in an open and frank way. We encourage you to use the word "suicide" or "suicidal" when appropriate. We want our Veterans to be comfortable talking to us about their suicidal thoughts, so that we can better help them. We can prove to them that we are comfortable with the topic.

Note that the term "suicide death" or "die by suicide" is preferred over "commit suicide" or "complete/successful suicide." This is because "commit" can make it sound like a crime and "complete/successful" makes it sounds like an achievement, which is not the message we want to send. You can also use the phrase "end your life." The phrase "hurt yourself" is vague and can mean several different things. If you or the Veteran uses this phrase, you'll want to clarify exactly what this means.

E. MOTIVATIONAL INTERVIEWING (MI) BASICS

Most people in the healthcare profession want to help others. This is great! But we know that telling someone to change or do something often doesn't work. The person has to want to change, right?

Motivational interviewing is a popular technique in healthcare settings because it helps to increase motivation for change by using the Veteran's own words and opinions to nudge them towards change. In this case, the change we are focused on is an agreement to use the safety plan. In other words, we want them to do things differently the next time they are in crisis.

Key MI techniques are reflections and open-ended questions, which are described in the next two sections and included throughout this manual.

The spirit of MI revolves around the idea that people must feel understood and heard before they will change:

COLLABORATION: We'll do it together, at your pace. You are the expert on you.

ACCEPTANCE: I accept where you are right now.

COMPASSION: I am sensitive to what you're feeling.

EVOCATION: You have what you need, and together we'll find it.

One key MI technique is to have the Veteran talk through what it would mean to make the change. Listen for moments when the Veteran talks about wanting to change. When you hear that, reflect and encourage it.

Example:

Staff: "What might get in your way of using this plan the next time you're in crisis?" (open-ended question, emphasizing collaboration)

Veteran: "Well, I'm not sure...to be honest, I'd have to remember it, have it on me, get it out..."

Staff: "So you're not sure if you'd be able to have it on you at all times, and other people might see it if you get it out" (reflection, showing compassion)

Veteran: "Yeah, but I guess I could put it in my phone."

Staff: "Having the safety plan on your phone would be a way to always have it with you, and might make it less obvious to other people." (reflection) What else might prevent you from using the plan we made today?" (open-ended question, evocation)

Veteran: "Well, I can't always be watching TV or doing other distracting things when I'm out and about."

Staff: "Good point, let's make sure there are some coping skills on your list that you can do anywhere, anytime." (collaboration and affirmation)

There's a lot more to MI, but if you keep these basic strategies in mind, you can foster a more collaborative conversation that could make "real life" change more likely.

F. REFLECTIVE LISTENING

Reflective listening shows that you are actively engaged in listening. The most simple way is to just repeat some of what the Veteran says back to them. You might be surprised how powerful this is.

Example:

Veteran: "I'm sometimes feel like my kids think I'm a burden"

Staff: "Sometimes you wonder if your kids think you're a burden."

You can also summarize what the Veteran says.

Example:

Veteran: "Some days I don't even get out of bed. And the pile of dirty clothes gets bigger and bigger, and I just hide and try to forget about everything. I don't even have the strength to go to the mailbox."

Staff: "Some days you're just exhausted."

Or try making an educated guess or "reading between the lines."

Example:

Veteran: "Some days I don't even get out of bed. And the pile of dirty clothes gets bigger and bigger, and I just hide and try to forget about everything. I don't even have the strength to go to the mailbox."

Staff: "It sounds like you're really unhappy with how things are going."

When in doubt, reflect!

G. OPEN-ENDED QUESTIONS

Open-ended questions are questions that cannot be answered with "yes" or "no." They let the Veteran tell you what is really going on with them. You should use these as much as possible, especially if the Veteran isn't talking very much.

Example of Closed (Yes-or-No) Questions:

Are you going to use the safety plan?
Do you understand what to do?

Examples of Open-Ended Questions:

What are some reasons for living?
What do you think might get in your way of using this plan?
What makes this person a good person for you to call in a crisis?
What are your thoughts about that?
What questions do you have?

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