Suicide Prevention Across the Educational Continuum Series
Part 4: Crisis Response Planning for Suicidal Patients

Video Transcript:

>> We are so excited to welcome you to today's presentation, Crisis Response Planning for Suicide Patients: An Introduction.

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>> It is my pleasure to introduce our presenter today. Dr. Craig Bryan, is a Board Certified Clinical Psychologist in Cognitive Behavioral Psychology, and is currently the Executive Director of the National Center for Veterans Studies at the University of Utah. Dr. Bryan is an Iraq war veteran who currently researches treatment for suicide prevention and PTSD, especially among military personnel and veterans, Dr. Bryan has published over 200 scientific articles and several books, including brief cognitive behavioral therapy for suicide prevention, and is considered a leading national expert on military and veteran suicide. It is now my pleasure to turn the time over to Dr. Bryan. Welcome.

>> Well, thank you for the introduction. Thanks for having me here. And Good morning or good afternoon, depending on where you're at in the US right now. What I'll do over the next hour, I guess, well, a little bit less than an hour is provide you with an overview of one particular intervention that we have been researching and developing now for several years. It's referred to as the crisis response plan. The crisis response plan we start to talk about it, many of you may be familiar with another version or iteration of this intervention referred to a safety planning. Safety planning was based off of crisis response planning. And so, if you work for an agency or you've been in trainings or seen any presentations on safety planning before, you know, you'll see, in many ways, kind of some of the overlap and the similarities between the approaches. My hope today is to provide you with a little bit of information about the conceptual foundations for this particular intervention, as well as, you know, suicide prevention interventions more broadly. And then we'll spend some time talking about the specific techniques and the specific steps involved in developing a crisis response plan with high risk individuals.

>> So, some of the key questions that I'll certainly do my best to answer for you today include these. First off, we'll begin by talking about the ways in which a crisis response plan differs from a no suicide contract or a contract for safety. A couple other terms that

get up this concept will begin there. We'll also then talk about some of the essential ingredients for suicide prevention interventions in general, based on several decades of research. So that way, you can see not only how the crisis response plan has evolved over time, but also that I think could also provide some additional information about when we think about treatment planning more generally. What are some of the elements of the more effective treatment strategies? We'll highlight the effectiveness of the crisis response plan, what we've learned from now a number of studies investigating this as a suicide prevention technique. And then we'll talk about some of these conceptual ideas about like, why and how we think the crisis response plan works, and how it targets some of the primary drivers and motives that underlie suicidal behavior. And then we'll conclude by going through the different pieces and elements of the crisis response plan.

>> And so to get started, I just want to provide you with sort of a visual depiction of a crisis response plan. These are two actual plans that I've developed over the past few years with patients that I have seen, and we've, of course, rewritten them to protect privacy and confidentiality. But, these are two that come from actual clinical cases. So on the left hand side here, what you'll see is that we start off with warning signs and then you'll see underneath that several items, several bullets that identified different self-management coping strategies that can be employed by an individual that are highly customized to this particular case on the right hand side from a separate patient, you see the same structural features, the same components, although what you'll notice is that the specific items, of course, are a little bit different. And that's because what we do in a crisis response plan is a very patient-centered intervention. And we focus on customizing the techniques and strategies to the unique needs and the unique context of each individual, suicidal individual. The other thing I'll highlight is that, you know, we write plans, typically on index cards. We don't use forms. There are a number of reasons for that. We'll maybe talk about them later if we have time for that. But what we found is that handwriting these plans on index cards has a lot of benefits. One of which is that they seem to be less likely to be lost. They're more convenient for individuals, but they're also -- It also seems to convey a sense of personalization to the suicidal individual, the patient that they kind of feel like a greater sense of ownership that the plan has been developed for them that it's not just an administrative procedure, where we're just kind of filling in the blanks. So this will -- we'll circle back to these two plans as we go through the presentation. But this is mostly again to at least give you sort of a visual idea of what we're talking about here.

>> So at its core, a crisis response plan serves several purposes. First, it's a problem solving tool. It's a reminder of how to effectively manage stressful situations. These list of activities or ideas are personalized to the individual. The underlying basis behind this is that when a person is experiencing intense emotional distress, the person will lose the ability to problem solve or to plan ahead. And most of us have experienced this to some extent within our lives. And if you reflect upon a time in your life where perhaps you were experiencing a crisis or an intense stressor, you may have found it harder than usual to kind of think through options to plan ahead, to organize your thoughts, to approach things. And then maybe later on after that crisis had passed, there might be an experience that you had of reflecting back on it and wondering or asking yourself.

You know, why was it so hard to get through that? Or, why do the answer seems so obvious to me now, but at that time, it did not seem quite so obvious. And that reflects this sort of neural impact of acute stress on problem solving, planning ahead, making decisions, and so a crisis response plan at its core is really designed to compensate for that. It helps to kickstart those problem solving executive functions that are otherwise restricted during intense extreme emotional distress.

>> I want to distinguish the crisis response plan from other interventions that have been used for a long time amongst the mental health and behavioral health fields and actually are still very widely used within the mental health field. These sort of alternative approaches are things like no suicide contracts are sometimes referred to as no harm contracts or even contracts for safety. At the core, whatever you call it, the idea is that we asked a suicidal individual or a person in crisis to make some sort of commitment or promise whether verbally or in writing to not kill themselves or to keep themselves safe. There's -- even though this has been used for a long time and it's still widely used, it's actually discouraged for use in the clinical and research data, don't really actually support its effectiveness. Interestingly, there's been some research as well, looking at patient perspectives of different suicide risk management strategies and, you know, what we've learned is that suicidal individuals actually really don't like these particular approaches. They're seen as not really motivated or designed to help the patient. The patient recognizes that these are often driven by clinician concerns to protect themselves or to manage their own liability risk. And so it can often, you know, sort of paradoxically interfere with effective collaboration with our patients, even though we typically have employed these strategies as a way to kind of assess the strength of the relationship or try to impose or put into place various management strategies. And so I put this out, because there's something that many of us are noticing is that a lot of clinicians are continuing to use contracts for safety or no suicide contracts, but they have changed the name when they documented. They're calling these intervention safety plans, even though they're not actual safety plans. And so what ends up happening is we're not necessarily providing a useful empirically supported intervention, we're actually doing something that doesn't work, but just calling it something that might actually work. And so what ends up happening is we're not actually providing the level of services to patients and suicidal individuals that we often believe that we are.

>> The crisis response plan is based off of several decades of research focused on developing and testing interventions designed to reduce suicidal thoughts and behaviors. About 10 years ago, David Rudd conducted a review of all of the published studies up until that point that were designed to test various ways of intervening with suicidal individuals and what he was primarily concerned with is trying to figure out why is it that some interventions and some treatments seem to do a better job of reducing and preventing suicidal behaviors than others. And if we can look at all of those treatments that work better for reducing suicidal behaviors, perhaps we can identify some patterns or some consistencies across them, that might give us some clues as to what is most important for suicide prevention. And likewise, if we compare those types of treatments and interventions to other forms of therapies and interventions that are less useful or do not seem to prevent suicidal behaviors to the same degree, perhaps those less effective treatments, they might also not -- or not only lack certain

ingredients, but they might be characterized by certain patterns as well, that could give us some clues as to what's not as useful for preventing suicide. And what he found was that there indeed are patterns across those more effective interventions. And he was able to sort of boil those patterns down to six general areas and concepts. The first is that treatments that work are based on simple empirically supported models or theories of suicide. And this seems to work because, in essence, if you can't explain why people want to kill themselves, when you're developing, or trying to implement a treatment strategy, you're less likely to target and hit upon a mechanism or a variable that is actually core and central to the problem of suicidal behaviors. Good models and good theory also matters for the patient, because it helps them to understand why am I feeling this way? Why am I doing these things? And it provides them with a rationale and justification then for understanding why we as clinicians are encouraging or recommending that they do certain things. Second key ingredient is that treatments that work have high levels of fidelity by the clinician. What this basically means is that clinicians reliably administer the treatments prescribed procedures in certain ways. And so another way of thinking about the second critical ingredient is that clinicians are reliable and consistent not only within a single suicidal patient over time, but also across multiple different suicidal patients. Now, one of the ways that we have found most effectively leads to high fidelity by clinicians, is to use manuals and protocols that specify in advance. Here are the things that you probably should be prioritizing here, the things that are less important. And in some cases, here's the sequence in the amount of a particular procedure or intervention that should be used. And so, in essence, what we do as clinicians if we follow those protocols and procedures, we're more likely to apply and administer the things that matter the most in a consistent manner. The third key ingredient of treatments that work is adherence by the patient. And so, treatments that are most effective integrate strategies and methods that are designed to increase the motivation of the patient to comply and adhere to the treatment itself. And so you'll see in a lot of the therapeutic modalities, and this is certainly true of crisis response planning. And we see a lot of motivational interviewing concepts and other motivational strategies that are explicitly focused increased buying and to increase the probability that the person in crisis will do the things that have been proven to help them reduce their suicide risk. The fourth key ingredient is an emphasis on skill stream. What this means is that within behavioral and psychosocial interventions, of course, it's a very verbally-based interaction, but talking about strategies and talking about a person's distress and their symptoms is not enough. There actually has to be a much more active skills based focus where in we show, we teach, and we practice the specific things that we want that suicidal individual to do, that can then lead to reductions in their risk and improve the quality of life. The fifth key ingredient is prioritizing self-management. So the treatments that work best differ in a kind of a interesting qualitative way from our more traditional treatment approaches. The traditional way that we've approached working with suicidal individuals is to place a heavy emphasis upon the clinician where the clinician then is seen as being responsible for treatment outcomes. And then if a suicide attempt or suicidal behavior occurs, there's an assumption that the clinician did not do something correctly, or failed to do something appropriately, which then led to or cause the suicidal behavior. And because of that traditional sort of philosophical orientation, the way that we have often approached working with suicidal individuals is

to emphasize external sources of support and control. So we hospitalize, we encourage suicidal individuals to contact hotlines to contact professionals basically go somewhere else, reach out to others, and use these external constraints to remove or otherwise inhibit the person's ability to engage in suicidal behaviors. Treatments that work, however, have a very different approach, wherein it basically says no, the patient is responsible for their behaviors, the patient can manage their own crises, can solve their own problems. And therefore what we do is we prioritize strategies that increase their ability to effectively employ those strategies and solve their problems in their own life. And so it's a very empowerment-based approach that seems to work best. Now, it doesn't mean we leave patients hanging. And this is where that sixth and final essential ingredient comes from. It's a treatments that work do ensure that suicidal individuals have easy access to professional crisis services, such as hotlines, access to mental health care, things like that. And so, all of these things are wrapped up together, but instead of an essence, telling someone we'll call a hot -- or go to a hospital, call a hotline, what the treatments do is say, what are the things that you have the ability within yourself to control and to manage? And then if those things don't work, or if they're not enough, then we fall back on these external sources of support as the backup system as opposed to the primary intervention. And so the crisis response plan then is based on all of these six principles. We'll talk a little bit about the empirically supported model that it's based on. We're finding in our research that clinician reliability is actually really important. The way in which a clinician does things matters a lot. We're finding out surprisingly, that when patients use the crisis response plan, they experience faster reductions in suicide risk. Now, the crisis response plan is also designed to first help a person identify their own unique indicators of a crisis. And then the first step after that are the self-management strategies, the specific concrete tangible things that a person can do to use the skills already available to them into self-manage, and then later steps of the crisis response plan focus on professional sources of support and other external-based interventions.

>> So let's talk a little bit then about does it work?

>> The short answer is yes, it does work. It's actually quite effective for preventing suicidal behaviors. We have evidence now from several various studies and several threads of research. The first line is actually a study that I conducted and published several years ago. This is a randomized controlled trial testing two different versions of crisis response planning as compared to treatment as usual. So we just use kind of standard existing crisis management services available in emergency departments and outpatient behavioral health clinics. And what we found was that although the two versions of crisis response planning one didn't necessarily seem to be better than the other, the crisis response plan in whatever iteration the clinician used was significantly better than treatment. As usual, we found specifically that patients receiving a crisis response plan where 76% less likely to make a suicide attempt in the next six months. And then shortly after that, two other quasi experimental studies were published. The first was Ivan Miller study. This was conducted in several emergency departments across the country and used an intervention called CLASP. In CLASP, one of the key features of CLASP is a self-guided safety plan where in essence patients in the emergency department were given the safety planning template, and directed here, fill

this out, it will come in and we'll see how you're doing in a few minutes. And then if we just -- if we discharge you, we'll then follow up with several phone calls to check in with you to see how you're doing and encourage you to receive outpatient mental health care. They found that this intervention will reduce suicidal behaviors by 20% during the 12-month follow up. And then the third study, another quasi experimental study was done by Barbara Stanley testing safety planning. And what they did here is this was done in the VA, veterans would come into different EDs, some of the EDs use safety planning, some did, again, treatment as usual. And what they found was that after a veteran received a safety plan was discharged home and then they would do some follow up contacts as well, they check in, they found that those veterans were approximately 50% less likely to have suicidal or suicide-related events in the next six months. So we now have three lines of evidence, including one randomized controlled trial, all suggesting that crisis response planning or other interventions that are based off of the core concepts of crisis response planning consistently lead to reductions in suicidal behaviors.

>> We also have some indirect evidence coming from different psychotherapy trials where in crisis response planning was an integrated part of the psychological treatment. And so, here are three different randomized controlled trials from the past decade or so showing that in some cases, treatments as short as even a three-session outpatient therapy, up to 12 sessions of outpatient therapy. All of these included crisis response planning as a central core component of the therapy. And all of them are associated with anywhere from about a 50 to 80% reduction in suicide attempts during the 18 to 24-month follow up. What this suggests is that in outpatient settings when crisis response planning is integrated into a psychotherapeutic package, it seems to lead to large reductions in suicidal behaviors as well. And interestingly, we have not only from these studies, but some secondary analyses from the Rudd study. What we found is that the crisis response planning seems to carry a lot of weight within treatment, regardless of whether a person only attends a few sessions or if they attend a lot of sessions. And so, we're now -- we're kind of seeing over and over again, that there's something about the ideas and the procedures using Crisis Response planning that seemed to be incredibly potent and incredibly effective for preventing suicidal behaviors.

>> (*Slide 12: Understanding Suicidal Behaviors)*

>> So let's spend some time talking about the conceptual model since I made a case that theory matters a lot. One of the theoretical ideas that I think has been really key to developing the crisis response plan as well as other empirically supported treatments for suicidal behaviors is what's referred to as the functional model of suicide, or the four function models, another term for this. The idea behind this it's based off a learning theory of the notion of punishment and reinforcement. And, of course, if we understand why behavior occurs, then we would want to look at the ways in which that behavior is reinforced. And so there are now numerous studies that point to negative internal reinforcement, the top right box as being especially key for understanding the emergence and maintenance of suicidal behaviors. And so why do people try to kill themselves? Well, they believe that it will help them to not experience intense emotional pain or suffering. Individuals who believe that are more likely to attempt suicide. And

then for those who attempt suicide, if afterwards, they do experience some kind of relief from these negative internal states, they're significantly more likely to attempt suicide again. And so it can become this learned pattern over time. And so understanding the core reasons and motives for engaging in suicidal behavior then is key for making sure that we're targeting the right thing. And so, crisis response planning at its core is designed for identifying strategies that alleviate emotional distress without having to engage in suicidal behaviors.

>> And so this is just sort of a visual depiction of that concept where a person becomes increasingly distressed over time. They try not to be suicidal. They try not to be upset, but for a variety of reasons, their strategies may not be effective and may not work, and so they experience an increase in their emotional distress. At a certain point in time, the person may decide, you know, I could kill myself that's a way for sort of coping with this problem. And what we often see here is that this will stabilize a person's emotional distress because it sort of gives them like an exit strategy. And then if that individual engages in suicidal behavior, they make the actual suicide attempt, as I alluded to before, about 33 to 40% will experience a reduction in emotional distress afterwards. If they experienced that reduction in distress, they're significantly more likely to make another suicide attempt, it becomes sort of its reinforced learned coping strategy.

>> So the challenge that we face as clinicians and as individuals trying to prevent suicidal behaviors is that suicide risk fluctuates, sometimes very rapidly. There's research now showing that within the span of just a few hours, suicidal ideation can, you know, go from a very low level to very intense severe level, and then a few hours later, come back down again. And so, suicide risk is this inherently dynamic construct. Now, what a lot of people think about, or how they assume crisis response planning works is that if a person is in crisis, they're experiencing a suicidal episode, then the crisis response plan is designed to calm them down to get them out of that crisis. And we do have data supporting that that the crisis response plan does work in that capacity. But we also have data suggesting that the better -- and I think more robust way of thinking about how a crisis response plan works is that it prevents future crises from emerging. And it seems to do this by helping the individual to recognize when they are heading down the road towards a crisis, and then they can employ a variety of self-regulatory strategies much, much earlier in the process, which then sort of averts or changes their course and in many cases can avoid the emergence of a new suicidal episode. And I think it's through that process that we're actually seeing the reductions in suicidal behaviors because they're not getting into that high risk state as often. And so, they're -- they have a reduced probability of engaging in suicidal behaviors.

>> So what are sort of the key features of the crisis response plan? Let's highlight some of those.

>> Now, something that we're starting to understand a lot more is that how we sort of lead into the crisis response plan really makes a big difference. And so something that my life has been increasingly interested in is the assessment process, you know, because in most of our settings, whether we're in EDs or inpatient facilities or an outpatient, you know, we're expected under standard of care requirements to conduct a suicide risk assessment. And then theoretically, based on our formulation of risk, based

on what we've learned in that assessment, we then will develop and determine the most appropriate level of treatment. Now what most of us do, what most of us have been taught to do, whether it happened while we were in professional school training to become mental health professionals, or through mechanisms like this, where we've had training workshops, continuing education, opportunities, things like that. When we talk about suicide risk assessment, we typically think of interviews where we have like forms or checklists of risk factors, and then we go through and we asked, you know, a patient, do you have this respect or do you have that risk factors and so on. And so, for most of us, the suicide risk assessment often follows some sort of a format where we ask things like, have you been feeling hopeless? Have you had thoughts about suicide? How often do you have those thoughts? How severe are the thoughts? What do you think about? Do you have a plan? What is your plan? Do you have a method? Do you have access to that method? Do you have some protective factors? What are those protective factors? So it becomes this -- in some cases, we've heard from some patients, it's almost like an interrogation that occurs while they're in an ED, or while they're in some other mental health setting. And so what we've started researching is an alternative approach to suicide risk assessment that we refer to as the narrative assessment. And so this is more of a storytelling approach where we sit down with someone in crisis, for instance, like in an emergency department, we say, could you tell me the story about the things that happened leading up to us meeting today? Or, could you tell me the story about the day that you tried to kill yourself or you wanted to kill yourself? And what this does is it seems to change the patient's experience of the assessment process where it empowers them to convey information in the way that's most important to them. And that allows them to sort of take ownership of the experience that they've had. And so you'll see here a few example questions that we use for the assessment approach. You know, let's talk about your suicide attempt, what's been going on lately. Can you tell me the story of what happened? And then as the patient starts to describe their story, what we do is we listen for risk factors, all the stuff that we would normally be listening to in an interview. And we can ask these more probing follow up questions like well, what happened next? And then what happened? What did you say to yourself at that point? What did you notice inside of your body? And so it becomes much more of a patient-centered approach to the assessment process. And what we find is that patients often will disclose their thoughts and their feelings voluntarily. They tend to provide more nuance, more detail about the various risk factors. And in the end, we can ultimately collect all the same information that we need to for a documentation suicide risk assessment, but it does it in a way we're even able to show it facilitate some builds rapport and therapeutic alliance, and patients tend to feel more listened to and more heard.

>> Again, I've got plenty more I can say about that like we've done some pretty interesting research on that and even working with like engineers who do acoustic analysis, verbal analysis using machine learning, look at what are we saying and what are we doing, and they're finding some very intriguing patterns that the narrative assessment probably provides us with a whole lot of benefit as compared to that more interview-based approach. So once we are understand sort of the context of what has happened in the person's life, the story about their suicidal crisis, we then transition to

the crisis response plan itself. There's another benefit of the narrative approach is that, you know, a lot of times maybe you've experienced this as a clinician, I certainly experienced it in the past when I was using my, you know, agency required checklist of things that I had to circle and check off and risk factors and things like that, where I would finish the form, but I often felt afterwards like I didn't actually understand what had happened to the person, I just knew that they use a particular method that they said they were thinking about certain things, and that happened at home. But it didn't -- It was like sort of my understanding of like what actually led up to the suicide attempt of this crisis, I often felt lacking. And so sometimes that makes it hard to transition to that next step, which is, well, what are we going to do about it? Like how are we going to actually intervene and help this person in order to reduce the probability that they engage in suicidal behaviors again. And so, that narrative assessment then lends itself really nicely into intervention where, in essence, almost everything you need to develop a good crisis response plan has already been handed to you. And so, we'll introduce the concept of a crisis response plan. I'll note at this point, you know, I've been doing this now for years. I actually very rarely even use the term crisis response plan, I just oftentimes just refer to it as a plan. Let's come up with a plan that could help address some of these concerns and these problems that brought you in to meet with me today. Provide them with an index card as well, and explain that this plan can help them to address their unique risk factors or problems, which in some cases, might preclude another suicide attempt. Or, for some patients -- I've worked with some patients who attempted suicide during the ED and they're saying I'm not here because I'm suicidal, I'm here because I can't sleep and I'm stressed out and have these relationship problems. I drink too much, I need to help with that. And so, I've learned to actually stop referring to these plans as the suicide prevention plan is the suicide safety plan is a crisis response plan. You just refer to it as the plan or a plan to help you with whatever it is that you need help with. Now, if you read my documentation, it's all about suicide prevention. But in that moment, with that person of acute distress, I use the language and the terminology that they're presenting with so that it increases motivation and more likely to use the plan because they feel like now I've listened to them and we've customized something for their unique needs. So we begin with warning signs, where I'll ask what are the -- what are sort of indicators that you are heading to this place? How would we know that you're getting really stressed out? Not just everyday stress out, but like really intensely, potentially dangerous stress. And how can we distinguish between not dangerous stress and potentially dangerous stress? And so, we'll identify thoughts, behaviors, physical sensations that can serve as these objective indicators that they're -- the person is becoming upset and heading towards a crisis. And that's key for a number of reasons. Number one, what I find is that many of the patients I work with, they're not really very adept at this. They're not very good at recognizing their feelings and their emotions and distinguishing between sort of true crises from other stressful situations that might feel like a crisis but perhaps it's not an actual crisis. And so now we have several indicators of how to know when to use the plan. A plan is useful if you don't know when to use it. And so we've started now with knowing when to use a plan. We then transition to those self-management strategies. What are the things that you found helpful in the past, when you're stressed out, when you're overwhelmed, when you feel like you can't take it anymore? What are things that you used to do, or things

that have been helpful for you before? And so now we tap into their existing strengths, and we can harness them and use them for prevention of future crises. We then transition to reasons for living. This is something we've also been doing a ton of research on now. And we're finding that this seems to be a really valuable conversation even for people who are acutely suicidal. Though, you know, when I ask them what are your reasons for living or for not killing yourself, it's very common for them to say, well, I've got no reason for living that's why I tried to kill myself. And what we've found is that if we can reframe that question towards what has held you back from suicidal behavior? I mean, you felt this way a long time even thinking about killing yourself maybe a lot. But you've stopped yourself, you've not tried to kill yourself. What is getting in the way of that? Well, those are your reasons for living. And what we find is that when we have a frank conversation about the reasons for living, it increases their positive emotions and leads to faster reductions and suicidal intent. So identify those talk about them for a bit and we add that to our written plan. We then identify sources of social support, friends and family members that they can reach out to. In some cases, it's to obtain support. You know, I need some emotional assistance, a shoulder to cry on. Other times, however what we focus on is that this is -- you know, sometimes just spending time with people that we enjoy, having lunch or having dinner, going and watching a movie, things where we just experience positive emotions in the presence of other people. So it doesn't have to be a secret bearer, that person that you entrust and are highly vulnerable with. In some cases, it's just going out and enjoying the presence of other people and taking your mind off of things that can be very valuable. And then the final step are those crisis and emergency procedures, providing them with our contact information, making sure that they have the phone number for the national suicide lifeline. And then I always include as well emergency services calling 911 going to the emergency department. Once we have the plan written on that index card, we'll verbally review it, kind of go from the top down. And then we'll ask patients, how likely they are to use it. There's a motivational interviewing strategy. And if we've created a crisis response plan in this collaborative spirit, what we find is that at the end, they're very likely to say, yes, I can do this. I like it. I'm able to use this plan and I'm motivated to do so.

>> And so that brings us back to where we started. Now, you -- you'll kind of see these two plans that were written with actual patients that I've treated over the past few years. The one on the left was a young Hispanic male who had an argument with his spouse and grabbed the shotgun and contemplated shooting himself with it. When I first met with him, his warning signs were pacing, feeling irritable and thinking that it'll never get better. And we identified several self-management strategies going for a walk, watching friends episodes, because he enjoyed that, he would laugh and enjoy watching that particular programming, also playing with his dog. His dog was also a reason for living. And incidentally during his crisis, as he was sitting at the shotgun thinking about whether or not to kill himself, it was his dog who came up as a little Pomeranian, came up and started like licking his hand. And he said that kind of snap them out of the moment. And so we included playing with his dog on his plan. His reasons for living also were his kids. And I asked him, well, tell me some stories about your kids and your family, like what's your favorite memory? And so, he relayed this vacation, as well as

Christmas Day, 2012, which is a very emotionally powerful memory for him. His social support includes mom and his spouse, Jennifer. And in the final section there are the professional sources of support. So my phone number hotline going to the hospital 911. On the right hand side, this was a middle aged white male who had a very heavy substance use disorder. He actually had a lot of respecters. He was, you know, sort of underemployed. He'd been kicked off of the police force, was drinking constantly, kicked out of the home by his wife, incredibly angry, drinking constantly, sleeping with a loaded weapon, you know, kind of like the full gamut. And so, we identified his key warning signs. We see that his initial of -- in that first appointment, his initial self-management strategies for video games would work in the garage, going for a walk. Do some breathing exercises. His social support was a friend Bill. You see the crisis options at the bottom. And then his reasons for living were included on the right hand side. Now, over the course of therapy, we work together for a few months. We cross out video games because he found that wasn't as helpful. And then we added new things, photography, writing, playing games on the phone, listening to music, those are things that he learned were helpful over the course of therapy. So the crisis response plan is a living document. It's something that becomes the foundation of enhancing their ability to manage stress within their lives. And then we even qualified it, number eight there, listen to music and then you see we kind of adjusted it to say uplifting music, because he came during a session and said I had a bad week. I started listening to music because it was on my plan, but I felt worse. And instead of crossing it out, I simply asked, well, let's talk about what happened and we found out that for him, you know, death metal does not reduce his anger, it heightens his anger and his frustration. And so we decided, well, we need to clarify. We got to listen to certain types of music, uplifting music, not anger inducing music. And so now, we customize and we've learned as we go, which is all a part of the treatment process.

>> So to conclude some additional resources, we have a YouTube page. If you go to YouTube and search for National Center for veterans studies. We actually have some demonstration videos with some of us role playing our various patients that we've seen over the years. And so you can get some examples of what narrative assessment and what it looks like to create a crisis response plan. We also have a website CRP for suicide.com where again, you can link to those videos and watch some of those and potentially even look at some scheduled workshops like full day workshops on that. We don't have any obviously at the moment due to COVID, but we're hoping to start those up again a few months. And on the right hand side, this is the full treatment manual, Brief Cognitive-Behavioral Therapy for Suicide Prevention. And the CRP is the primary kind of feature of this particular therapy. So if you want to learn more about the full psychotherapeutic process that reduces suicidal behaviors, you can get a hold of that book.

>> And so if you have any questions or follow up, let me know. But otherwise, I'll pause there and we'll take any questions that might have come up during the presentation.

>> Craig, thank you so much.