Cohen Veterans Network

# “A Lifesaving Find”: Client Experiences in CVN’s Suicide Prevention Ecosystem

## Summary of Key Themes and Recommendations

Cohen Veterans Network
Institute for Quality

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## Introduction & Background

Veterans and active-duty service members continue to be at elevated risk for death by suicide. In response to these on-going challenges, Cohen Veterans Network, Inc. (CVN) has built a robust suicide prevention ecosystem to identify and address suicidal thoughts and behaviors (STB) within the military community. This ecosystem includes universal screening via the Columbia-Suicide Severity Rating Scale (C-SSRS), implementation of measurement-based care (MBC), and integration of evidence-based, suicide-specific interventions, including safety planning. Prior research at CVN examined clinician experiences assessing and managing suicide risk within this ecosystem. Participating clinicians highlighted three important facilitators that addressed challenges encountered when providing suicide-specific treatment, including 1) the importance of direct and transparent communication with clients, 2) the utility of measurement-based care as an integral assessment and intervention tool, and 3) the role of network and supervisor consultation to provide robust training and case support (Cohen Veterans Network, 2023).

To maximize the efficacy of this ecosystem, we also need to understand the varied experiences and perspectives of our diverse client populations who receive suicide-specific interventions. In addition to veteran and military clients, we sought to understand the experiences of military family members and perspectives of clients belonging to racially minoritized groups, whose unique needs may be overlooked in clinical care. By cultivating representation across gender identity, ethno-racial background, and military affiliation, we sought understanding of individual differences in the context of identity, minoritized status, and intersectionality. To accomplish these goals, we endeavored to answer three questions:

1. What elements of CVNs suicide prevention ecosystem were perceived as beneficial by former clients?
2. What opportunities can we identify based on client experiences to improve the existing ecosystem?
3. How can the experiences and perspectives of racially minoritized clients help to enrich and inform our understanding of the client journey through suicide-specific care at CVN?

## Methods

Semi-structured interviews were conducted to better understand client experiences within CVN's suicide prevention ecosystem and identify strengths and opportunities. Interview topics focused on clients' general impressions of their care and their experiences with suicide-specific interventions, including weekly screening via the C-SSRS, safety planning, and lethal means counseling. Other suicide specific interventions, i.e., Collaborative Assessment and Management of Suicidality (CAMS), Cognitive Behavior Therapy for Suicide Prevention (CBT-SP), were also discussed based on the client's specific treatment experiences. Interviews were conducted virtually, were recorded, and transcribed verbatim. Each transcript was coded inductively by a

qualitative research expert, who proposed preliminary themes. Themes were then reviewed and revised by the research team based on coded excerpts from the transcripts.

Given the sensitive nature of the research topic, inclusion criteria were carefully developed to minimize risk to participants. Eligible participants included former clients of any Cohen Clinic who had been designated as "high-risk" for suicide during their care. To ensure participants had engaged sufficiently with their treatment, they must have completed a safety plan, attended at least four sessions, and successfully completed their treatment as determined by the clinician's characterization of the discharge reason, experienced a significant reduction in symptoms, or both. Additionally, participants were required to have completed their treatment at least 30 days but not more than 12 months prior to receiving an invitation to participate. Former CVN clients meeting these criteria were contacted via email and invited to complete a screening survey. This screening survey involved a series of questions to ensure eligibility, including verifying that the participant currently resided in a state served by a Cohen Clinic, had teleconference capability (for example, high speed internet), had not re-engaged in care, and was not currently experiencing suicidal thoughts. Clients who completed the screening survey and met inclusion criteria were offered an opportunity to sign-up for an interview and were provided with additional information and the informed consent document. Participants who completed an interview received a $25 e-gift card in appreciation of their time and effort. A summary of self-reported participant demographics is provided in **TABLE 1.**

**Table 1.**
**Demographic Summary of Participants**

| | *N* (%) |
|---|---|
| **Gender** | |
| Woman | 7(64) |
| Man | 4(36) |
| **Race/Ethnicity** | |
| Asian or Asian American | 2(18) |
| Black or African American | 5(46) |
| Multiracial | 1(9) |
| White | 3(27) |
| **Client Type** | |
| Veteran* | 6(55) |
| Military Family Member | 4(36) |
| Veteran/Family Member | 1(9) |

*Some veteran participants received care while on active duty

## Results

Eleven former clients participated in structured interviews, including individuals who received care as veterans, active-duty service members, and military/veteran spouses or adult children. Participants reported entering care with a desire to feel better and address their STB.


Despite intentions to seek help with STB, many participants reported difficulties and discomfort when sharing their experiences with their clinician, engaging in aspects of suicide-specific care, and, in some cases, confronting the severity of their symptoms. "The first time I went, um, I kind of had hesitations and trepidations…". Participants identified factors that addressed these difficulties and effective elements of care in two key areas: clinic atmosphere and implementation of suicide-specific interventions. Additionally, participants shared benefits and challenges at the network level that impacted their care.

### Clinic Atmosphere:
### Feeling Cared For Is Foundational to Effective Therapy

Connection and care were universally the most important part of the participants' experience at Cohen Clinics. Feeling cared for created a safe environment where they felt secure enough to be vulnerable and share their experiences with STB. Both office staff and clinicians contributed to creating a safe and welcoming space and fostering connection.

#### *A welcoming atmosphere begins at the front door*

Participants described Cohen Clinics as a "friendly" and "professional" space that "[makes] you feel like you are in good hands." Staff members were described as "thoughtful," "empathetic," and "compassion[ate]." Participants appreciated it when office staff greeted them by name and intake coordinators helped with paperwork. One participant shared that receiving a call from the clinic director while on the waitlist made them feel like they had not been "forgotten."

Connection with assigned clinicians made participants feel understood, allowing them to more comfortably share their STBs. Cultural competency and subject matter expertise contributed to beliefs that their clinician was "exactly who [they] needed to talk to." In some cases, participants

felt their assigned clinician had expertise relevant to their personal situation, including treating trauma and complex diagnoses or having extensive knowledge about family law. For veterans, knowing the clinician had a military background "just made it more comfortable,"–"you know, we're bros, I guess"–and facilitated communication through "relate[able]" references and familiar dynamics–"…she was kinda like a drill sergeant…". Meanwhile, some Black participants reported that it was important to work with a clinician with a shared cultural background, to know that "it's a safe space to talk" and to prevent cultural miscommunication, as some things "might come across a different way." When this was not possible, knowing the clinician had cultural competency training helped alleviate concerns.

Participants repeatedly described the importance of comfort and connection with their clinician and its role in their ability to be open and engage in difficult emotional work. "Showing a personal interest in somebody really helped facilitate those discussions and break down those barriers, so that, you know, when suicidal thoughts, or whatever, became more of an issue, then I could talk about it more easily."

### *Clinicians set the tone*

"I don't know how to explain it, she's just got such a comforting presence that you just knew, okay, this is a safe place." Participants described the many ways clinicians set the tone for therapy by creating a safe and empowering space to work through STB. Emotional support fostered through empathic engagement with clients was a defining aspect of a safe environment.

Connection was important for participants, who noticed when clinicians took the time to get to know them and remembered aspects of their lives. Participants also described fears of being judged when sharing their STB and expressed feeling comforted and reassured when clinicians listened to their story and validated and normalized their experiences. "He also was really great about just saying like, right now it's really bad and that's okay. And just knowing that it's okay, that it's not great, just alleviated a lot of pressure..." "It was kind of just, like, being heard. That was, like, such a big thing for me, just being heard by somebody."

This foundation of connection and care allowed clinicians to effectively promote positive change by challenging clients to be vulnerable and self-reflective, guiding clients to change their perspectives and thought patterns, while holding clients accountable for following through on at-home assignments. "They were always open to just listen and then, like, not just tell me what I wanted to hear, but definitely what I also needed to hear. So they kinda gave a mix of both to make me feel, like, just 100% validated, but also, okay, well, I'm going to validate you and also give you the help that you need."

Further, participants found it helpful when clinicians provided coaching and problem-solving support during therapy. This includes collaborative development of coping skills and safety plans, guidance on implementing new thought patterns, and exploration of practical solutions for stressors. Several participants commented that in-session practice of coping skills and difficult

conversations empowered them to enact positive changes, utilize coping skills, and follow through on important conversations with family and friends. "I think that just really helped me take ownership over–It's not just through a therapist that I have these tools and resources. They're mine now."

## Suicide Specific Interventions:
### Experiences in CVN's Suicide Prevention Ecosystem

Measurement-based care and evidence-based practices are essential elements of CVN's suicide prevention ecosystem. Participants initially struggled with these aspects of care, including safety planning, lethal means counseling, completion of weekly standardized measures, and homework assignments–critiquing them as "annoying," "repetitive," and "uncomfortable"–but ultimately saw great value when the purpose of these interventions was explained and when they were deliberately integrated into therapy sessions and treatment planning.

#### *Safety planning can be an impactful therapeutic intervention*

Participants held negative views of safety planning when they felt the plan was superficial, criticizing coping skills as being "surface-level," "repetitive," ineffective during crises, and unable to change difficult situations. Additionally, safety planning required participants to confront and emotionally engage with their STB and underlying drivers, which was a difficult process for some. However, when clinicians thoughtfully and collaboratively implemented safety planning as an intervention and supported participants through the process, participants found their safety plans to be important tools for both navigating crises and maintaining their safety.

The process of intentionally developing a safety plan was therapeutic. For some participants, safety planning helped them to confront the severity of their STB and motivated them to commit to the therapy process. For others, safety planning laid the foundations for implementing new habits to mitigate negative thought patterns. Many participants were initially lost when creating their safety plan and relied on their clinician to help brainstorm coping skills and support resources. Throughout subsequent sessions, participants found it helpful to work with their clinician to reflect on their coping skills and to adjust as needed.

Practicing coping skills during sessions facilitated their use both during crises and in daily life. Practice gave participants "a concrete plan" to follow during a crisis and options to use if a particular skill didn't work. In-session practice also helped participants overcome embarrassment and build confidence in a supported setting. Homework and in-session reflection provided accountability for participants who were reluctant to initiate changes and have difficult discussions. Participants who intentionally integrated newly developed skills into daily life found them to be important tools to "de-stress", "sort out [their] thoughts", or "get out of [a] funk." Support from family and friends was also integral, as often they were listed as contacts on safety plans or were necessary collaborators in implementing safe storage practices. Beyond this

involvement, family and friends provided important support by learning about and facilitating coping skills or by offering a listening ear as participants worked through their emotions.

> "...during the homework and everything, I told [my girlfriend] what I was doing and how it's helping me and she kinda agreed. And every time I go doomscrolling in my head, she would help me with the coping mechanisms...she's been a big help."

> "Now I just randomly call [my cousin], just to talk. And that's something different for me. It's not like I'm in distress....[I] just have these conversations with my cousin and use those to voice how I'm feeling."

Ultimately, the act of collaboratively developing and practicing the safety plan was more important than the resulting document. While most participants knew where they had a physical or digital copy of the plan, they had not reviewed the plan since leaving therapy "mostly because the plan was ingrained or embedded in me."

### *Lethal means counseling is unique for every client*

As a part of safety planning, all participants were asked about lethal means restriction, including ownership of firearms and other potential lethal means. Reactions to this counseling were mixed. Participants with nonspecific plans generally had neutral views while participants with specific plans felt more uncomfortable with the process. "I felt kinda resentful about it. It felt like my privacy was being invaded." "It was really uncomfortable...I was still in that phase of not accepting where I was."

Participants who struggled with the process of lethal means counseling found it helpful when they knew these discussions "came from a place of caring about me," and when clinicians explained the importance of creating a safe environment. "[My clinician] was just very compassionate and just said, you know, I know you don't want to–and that's okay–we want to make sure that you're safe."

Participants believed clinicians were able to collaboratively address safe storage concerns and logistical challenges with the participants to identify solutions. Balancing safety and functionality was a common challenge when potential means included common household objects, such as knives or other sharp objects, cords, or medication. In these instances, participants reported that creating visual barriers or slight inconveniences in access both made an impact–"out of sight, out of mind." When physical barriers were significant impediments to daily life, clinicians helped to identify other solutions. Examples participants shared included removing themselves from locations containing potential means during crises or reminding themselves that they needed to preserve medication to treat physical ailments. "I knew if I messed it up, then I don't have any medications to take for any other experience that I might have...". The presence of children in a home also created challenges in enacting safe storage for some participants, who worried about

their children noticing or being impacted by changes. In these cases, lethal means counseling did not address this challenge, in part due to participants not sharing concerns with their clinician.

For participants with firearms, loss of access was a major concern because they felt safer having their firearm close by. This fear led to discomfort during lethal means counseling or pre-emptive hesitancy to disclose ownership. "I feel safe when I have it near me…. somehow it helps me feel better, secure, secure, more secure if I have it next to me." Ultimately, reassurance and education around safe firearm storage helped make participants more receptive to changes, particularly when the clinician could work through and account for individualized client concerns. "If I think about it, I really didn't need a gun right next to me. It could be in the same room, but it doesn't have to be next to me or loaded. So, she kinda put it in perspective."

***Standardized measures are powerful when integrated into treatment via measurement-based care***

As with other suicide-specific interventions, participants had mixed reactions towards standardized measures. Some participants felt the measures were "fine," not "overly invasive," "pretty short and easy to fill out," and "necessary." "I mean, how is [my clinician] going to know where to start if they're not there?" Others pushed back against the measures, due to discomfort discussing themselves or feeling like the measures were "heartless," "tiring," "annoying," or "wasted" limited session time.

Initial hesitancies around standardized measures resolved or diminished as clients saw the purpose and benefits of completing measures, including gauging current symptoms, opening deeper discussions, and reflecting on progress. "So, I think it has to do with the practitioner and how they implement it. He was really great about saying, you know, I know this can be tedious, but it will show that you are improving if you just give it time."

> "I don't feel like she was pushing the paperwork very hard. If I—if we got to a question that I felt the need to explain, she turned to me, she focused on me, we discussed the answer, and, you know, she made sure that I had finished what I was saying to her before she inputted it into the computer. So, I really felt like she was still listening to me. Now I was still getting a lot out as the paperwork was going."

MBC created opportunities for awareness and self-discovery as participants completed the measures and discussed their responses with their clinician. Looking back over the past 1-2 weeks, participants had the opportunity to reflect on their emotions and ability to deal with stressors. This self-reflection created opportunities for problem solving with guidance and support from their clinician. Often this led to discussions about how to make coping skills more effective for the participant. Most impactful was the ability to chart responses overtime and visualize progress. "I really didn't know that until she [showed] me. And then I was like, okay, these counseling sessions are working. These coping skills are working." Visualizing progress helped participants "celebrate small wins," and recognize "baby steps." These shifts in perspective

were described as "motivating" and "goal-setting" and helped build resilience against difficult days. "[It] was really encouraging, not to let the bad days make it seem like I wasn't making any progress."

> "And for me, celebrating small wins is important. And just kind of marking, all right, you know, a few weeks ago was one of the worst and darkest moments of my life and, I might not necessarily "feel better," but I'm honestly answering this intake form and, she's recognizing or seeing from an outside perspective, like yeah, you are getting better and here's where you're improving…"

## Network Benefits and Challenges

Participants reported significant access challenges when seeking mental health care for STB, with lengthy waitlists at outpatient mental health clinics and military behavioral health. One participant shared that they were still on a waitlist for a different outpatient health clinic that they contacted over two years ago. They have completed two episodes of care at a Cohen Clinic in that timespan. Another participant shared their struggle with waitlists for military behavioral health but felt reassured by receiving a check-in call during their time on a Cohen Clinic waitlist. Despite short wait times, Cohen Clinics offered "immediate availability" compared to alternative providers.

Participants expressed disappointment that Cohen Clinics only offered short-term targeted treatment. For many participants, the initial episode of care helped with stabilization, but many felt they needed continued support. For some, the first episode of care helped them reach a place where they could start working on secondary goals, like rebuilding self-esteem, while others lacked confidence in their ability to maintain new thought patterns, utilize coping skills, and confront new challenges after 12 sessions. Booster sessions and planned returns to care helped clients feel like they still had support when their episode of care ended. Several participants expressed feeling more confident in their ability to navigate future ideations or crises after a second episode of care.

## Implications for Policy, Training, and Practice

***Every Interaction Matters:*** A safe and caring environment is a critical component for effective therapeutic intervention for STB. Every interaction with a client is an opportunity to show care. Professional spaces, whether physical or virtual, waitlist check-ins, friendly and helpful office staff, and compassionate, culturally competent clinicians are all important contributors to the participants' sense of safety and willingness to share their STBs in therapy.

***Back to Basics:*** Therapeutic rapport was the most cited factor in effective care for STB. Building connection by getting to know the client, listening empathically, validating and normalizing experiences, and providing comfort and reassurance made participants feel cared for and safe to share their stories. This connection provided a strong foundation for difficult aspects of therapy.

***Skill Building and Practice Empower Positive Change:*** Participants felt relief when finally sharing their struggles with STB, but lasting change required transforming thought and behavior patterns. With a solid foundation of trust, clinicians challenged clients to be vulnerable and self-reflective and collaboratively built coping skills while cultivating adaptive thought patterns. Planning and practicing skills under clinician guidance, paired with weekly assignments and at-home practice empowered clients to enact these changes in their daily lives. Weekly reviews of challenges and efforts to address them allowed participants and clinicians to collaboratively search for practical solutions and build participant confidence in addressing new challenges.

***Overcoming Initial Hesitancy:*** Suicide-specific interventions were often met with initial hesitancy by participants. Participants often felt screeners were annoying or repetitive, while safety planning was seen as unnecessary or emotionally taxing. Hesitancies were addressed when clinicians took time to explain the purpose of interventions, when participants knew they came from a place of concern, and when interventions targeted participants' STBs.

***Ask About Means:*** All participants were counseled regarding lethal means safety, including firearms and other potential means. They were generally willing to both engage in a conversation and implement safe storage strategies when they believed their clinician was coming from a place of sincere concern. Facilitators included explicit discussions about implementation barriers and planning conversations with involved family members. In many cases, this conversation led to lasting changes in lethal means storage that increased the participants' feeling of safety.

***Integrating Measures is Powerful:*** Standardized measures were frustrating for participants, but when fully integrated into therapy via MBC, they became powerful tools that supported positive outcomes. Participants deeply appreciated MBC when clinicians actively used standardized measures as a tool to facilitate communication and self-reflection, help to focus sessions and support collaborative problem solving. Further, MBC allowed participants to visualize and validate progress overtime that they could not recognize for themselves. This complements experiences of Cohen clinicians who reported consistent use of standardized measures within an MBC framework facilitated suicide risk assessment and intervention (CVN, 2023).

## Recommendations and Conclusions

Participant experiences were varied and reflected the rich diversity of lived experiences within our client population. These unique histories, alongside minoritized status and intersectionality of identities, informed participants' individual experiences with mental health treatment and suicide-specific interventions. Overall, participants had mixed responses to evidence-based, suicide-specific interventions, individualized needs relating to coping skills and modifying thought patterns, and unique concerns and barriers during care. Despite these variations, participants often struggled in the same areas of care and responded positively to similar strategies employed by Cohen clinicians. Importantly, most participants reported entering care motivated specifically to address their STB and made efforts in their daily lives to utilize the skills gained in therapy. Additional research is needed to understand the experiences of and opportunities for clients with negative treatment outcomes, who were not included in this study.

Based on participant accounts, Cohen Veterans Network offered a series of advantages for participants, including comprehensive access for military families, immediate availability compared to local outpatient clinics and on-base behavioral health, and emotionally supportive environments. The welcoming and professional atmosphere of Cohen Clinics created a first impression of safety and connection, allowing participants to feel more comfortable opening up about their experiences with STB. Similarly, connection with their clinician, fostered through listening and validation, alongside efforts to challenge and hold participants accountable, were seen as primary facilitators in care that supported effective interventions. Shared ethno-racial and/or cultural backgrounds and cultural competency were identified as important components of therapeutic rapport that facilitated sharing STB for ethno-racially minoritized and military-affiliated clients. The most frequently reported challenge with CVN's suicide prevention ecosystem was the limited number of sessions offered based on the network's targeted treatment model. Planning for continued care, including booster sessions and secondary episodes of care at the Cohen Clinics, helped to address this challenge.

Specific elements of CVN's suicide prevention ecosystem, including screening, safety planning, and lethal means counseling, were often met with initial frustrations or hesitancy by participants. These challenges were addressed and overcome when participants believed their clinician was acting from a place of care and when they understood the purpose and benefits of the interventions. In particular, participants highlighted three network strengths that contributed to positive treatment outcomes with implications for training and the wider field:

- Appropriate implementation of measurement-based care was valued by participants for its ability to facilitate difficult conversations, highlight and validate progress, and ultimately create opportunities for awareness and self-discovery. Additional research with clinicians and elevated risk clients may further elucidate approaches which optimize measurement-based care effectiveness and engagement.

- Candid and detailed discussion of lethal means and safe storage practices were acceptable to most participants. Often, participants and clinicians were able to identify simple changes to promote safety, which, in some cases, led to lasting changes in behavior. Lethal means counseling during safety planning is a practical step with a robust evidence base for promoting safety for those struggling with suicidal thoughts and behaviors.
- Planning, practicing, and problem solving were critical components of effective care and positive outcomes for participants. Participants in this study emphasized the importance of addressing the stressors and circumstances that contributed to their STB. Guided problem solving with their clinician, combined with in-session planning and rehearsal, gave participants confidence to enact identified strategies in their lives. Additional research on problem-solving therapies is warranted to understand their potential efficacy as suicide-specific interventions.

In conclusion, the findings of this study highlight strengths and opportunities related to CVN's suicide prevention ecosystem, with participants benefiting from standardized protocols, measurement-based care, and practical safety interventions in conjunction with in-session coaching and skills training all in the context of a strong therapeutic alliance. Initial concerns about CVN's time-limited intervention model and hesitancy toward some elements of the ecosystem were reported but were typically mitigated through development of trust and therapeutic rapport based on clear communication between participants and clinicians. While more research is needed to explore the experiences of clients with more varied (neutral or negative) clinician assessed treatment outcomes who were not included in the present effort, the current systematic inquiry provides strong support for CVN's policies and protocols while identifying several areas for further study.

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