Safety Planning Intervention: SAFE VET Demonstration Project

Suicide Assessment and
Follow-up Engagement:
Veteran Emergency Treatment

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Overview of Presentation

- Overview of Safe Vet project which includes safety planning and follow-up
- Rationale for ED as an ideal site to intervene with suicidal patients
- Expansion of the use of the safety planning intervention
- Description of safety planning intervention (SPI), adaptations and other applications

Blue Ribbon Report

Encouraged the VA to reach out to community emergency departments to improve care for veterans at risk for suicide behavior, and recommended the development of “evidence-based interventions that can be used with veterans in both VA and community EDs...”

Blue Ribbon Work Group on Suicide Prevention in the Veteran Population (2008)

SAFE VET

- The Safe Vet demonstration project was created in response to this report
- The VA Central Office provided funding for the SAFE VET clinical demonstration project
- Project Executive Committee: Kerry Knox (Project Director), Gregory K. Brown, Glenn Currier, Barbara Stanley

SAFE VET Vision

Develop a delivery system that will enhance the care of suicidal veterans in both community and VA Emergency Departments (EDs)

SAFE VET Goals

Designed to enhance care by:

(1) Improving the identification of suicidal veterans in VA and Community EDs

(2) Linking suicidal veterans to appropriate VA services

(3) Providing a brief ED-based intervention to reduce suicide risk (safety planning intervention) and enhance retention in outpatient treatment

(4) Ensuring that veterans receive appropriate follow-up care

Current SAFE VET Demonstration Sites

- Buffalo VAMC
- Denver VAMC
- Manhattan VAMC
- Philadelphia VAMC
- Portland VAMC

Project Timeline

- SAFE VET approved in February 09 as Clinical Demonstration Project
- 2 year time horizon
- Possibility of expansion as roll-out continues
- As a clinical demonstration project including program evaluation, but does not include a formal research component

“A Brief Intervention to Reduce Suicide Risk in Military Service Members and Veterans”

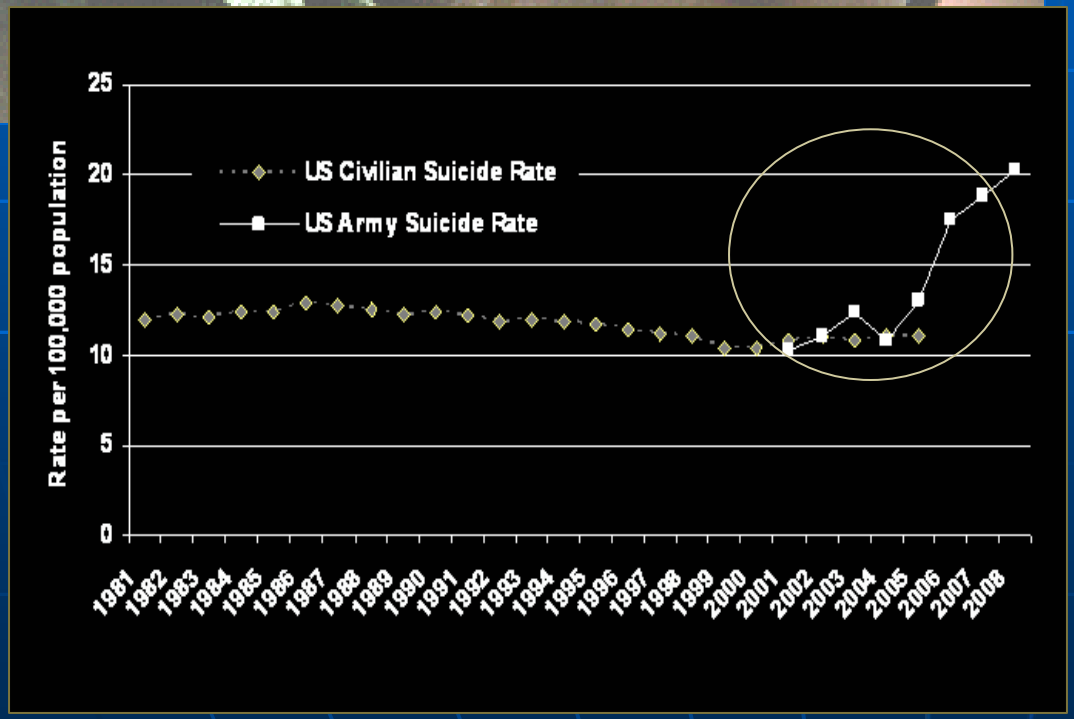
- Received funding from DoD: Military Operational Medicine Research Program (MOMRP)
  - Added Evaluation of Research Outcomes to SAFE VET
  - Expanded the Use of the Safety Planning Intervention
  - Included ED Control Sites
- Principal Investigators: Lisa A. Brenner, Gregory K. Brown, Glenn Currier, Kerry Knox, Marjan Holloway (contact PI) & Barbara Stanley

"A Brief Intervention to Reduce Suicide Risk in Military Service Members and Veterans"

- Project spans the active Army and the VA by developing and adapting a single intervention for suicidal individuals that can be used while on active duty and then as a veteran
- Two projects:
  1. Adapts and evaluates Safety Planning Intervention for inpatients at WRAMC
  2. Provides research support to directly assess outcomes in SAFE VET

WHAT'S THE PROBLEM?

Suicide Rates from Army ASER Reports



Army official: Suicide Rise in January, 2009 'terrifying'

WASHINGTON (CNN) -- One week after the U.S. Army announced record suicide rates among its soldiers last year, the service is worried about a spike in possible suicides in the new year. The Army said 24 soldiers are believed to have committed suicide in January alone -- six times as many as killed themselves in January 2008, according to statistics released Thursday. If those prove true, more soldiers will have killed themselves than died in combat last month. "This is terrifying," one official said. "We do not know what is going on."

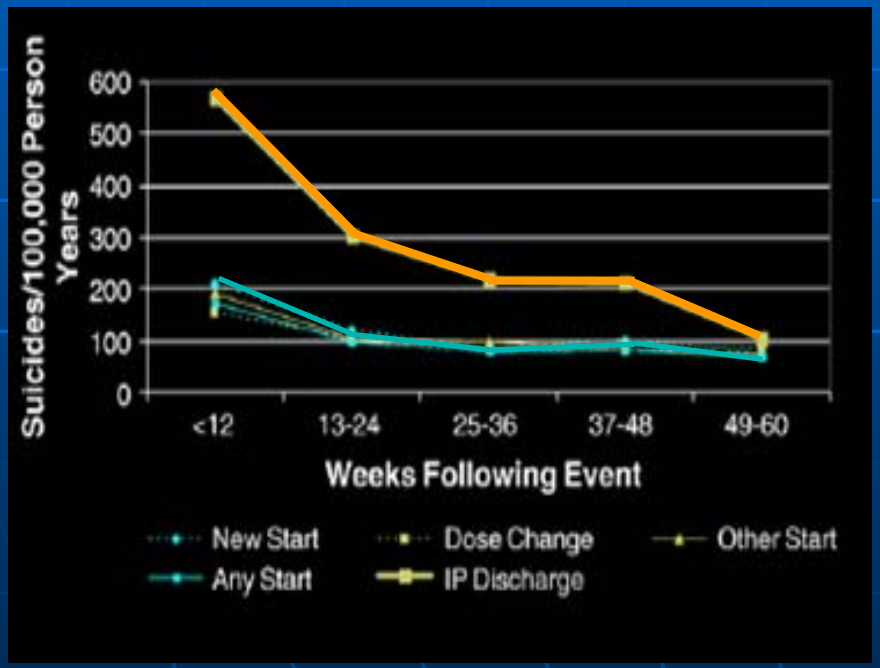
http://www.cnn.com/2009/US/02/05/army.suicides /accessed 4.27.09

Slide Courtesy of Cynthia Claassen, Ph.D.

WHERE ARE THE PROBLEMS?

Higher-risk Periods for Suicide among VA Patients

- **Calculated suicide rates for 12-week periods following readily-identifiable treatment events: psychiatric hospitalizations, new antidepressant starts (> 6 months without fills), "other" antidepressant starts, and dose changes.**
- **In the first 12-week periods, suicide rates were:**



- 568/100,000 p-y following psychiatric inpatient care;
- 210/100,000 p-y following new anti-depressant starts;
- 193/100,000 p-y following other starts; and
- 154/100,000 p-y following dose change
- Overall, VA-treated patients have a relative risk of suicide of 1.66, compared to US matched age/gender groups

21-20% of all suicides in a recent CDC study were veterans

Valenstein M, Kim HM, Ganoczy D, et al.: Higher-risk periods for suicide among VA patients receiving depression treatment: Prioritizing suicide prevention efforts. Journal of Affective Disorders 112 (2009) 50–58. McCarthy JF, Valenstein M, Kim HM, et al.: Suicide mortality among patients receiving care in the Veterans Health Administration Health System. Am J of Epi, (2009) 169, 1033-1038

Case: Recent ED Presentation

- 25 YO WM OIF Veteran
- Neg Ψ or CJ Hx
- TBI via IED x 2, motorcycle accident X 1
- Unemployed, lives with parents
- Stated “I could kill you” to GF while intoxicated at bar; feeling suicidal
- BIBP BAC 0.14
- Slept it off overnight in ED

Recent ED Presentation

- In AM recants all statements, GF & family back him up
- Admits to increasing “thoughts of times in Iraq.”
- “Keeping a lid on it occupies most of my time.”
- Initially refuses VA referral – “They’ll make me talk about everything.”
- Discharged with referral to VA ROPC

From the Non-VA Perspective:

- New returnees are showing up in non-VA EDs in increasing numbers, voluntarily or involuntarily
- EDs don't screen veteran status well and are not well-informed about veterans' needs & experiences
- Local MH services to which EDs refer are ill-equipped to deal with specific needs of veterans
- MH burden often compounded by polytrauma and substance abuse-Diagnostic Trifecta
- VA remains a "Black Box," path in is unclear

Emergency Departments as Locus of Care

- Each year, more than 32,000 people die by suicide in the US
  www.cdc.gov/ncipc/dvp/Suicide/SuicideDataSheet.pdf

- Every day, there are ~ 2000 suicide attempt related injuries and up to 10,000 suicide related visits to US Emergency Departments (EDs) (Institute of Medicine 2002, McCraig and Nawar 2006)

- 15% decrease in number of EDs over prior decade (1,100 EDs closed in 1990's)
  http://www.acep.org

Suicidal Individuals in Emergency Department: A Growing Concern

- More patients in fewer EDs
- Less patients get admitted; Two-thirds discharged
- Risk of repeat attempt is very high
- Most people are lost to follow-up
- Risky situation, but scope of problem hard to assess
- Systematic under-reporting at provider, institutional, state and national levels

Suicide Risk in Medical Emergency Care

- Suicidal ideation common in ED patients who present for medical disorders
- Study of 1590 ED patients showed 11.6% with SI, 2% (n=31) with definite plans
- 4 of those 31 attempted suicide within 45 days of ED presentation

Claassen & Larkin, 2005

ED GRIDLOCK

Although escalating patient acuity places a large strain on ED resources, the most important cause of ED overcrowding is insufficient inpatient capacity for ED patients who require hospital admission.

Psych beds are more scarce than general medical/surgical beds.

Richardson LD, Asplin BR, Lowe RA. Emergency department crowding as a health policy issue: past development, future directions. *Ann Emerg Med.* 2002;**40**:388–393. doi: 10.1067/mem.2002.128012. [PubMed]

American Hospital Association. Hospital Statistics. 1999. http://www.hospitalconnect.com/healthforum/hfstats/downloads.html

ED Experience Can Run Counter to Mandate of Primum Non Nocere

- More than half of 465 consumers and almost a third of 300 family members felt directly punished or stigmatized by staff.
- Fewer than 40% of consumers felt that staff listened to them, described the nature of treatments to them, or took their injury seriously.
- Consumers and family members also reported negative experiences involving a perception of unprofessional staff behavior, feeling the suicide attempt was not taken seriously, and long wait times.

Cerel J, Currier GW, Conwell Y. J Psychiatr Pract. 2006 Nov;12(6):341-7 Consumer and family experiences in the emergency department following a suicide attempt.

EDs as Locus of Care: Why Does Good ED Care Matter?

ED patients who survive suicide attempts are reluctant to engage in follow-up treatment:

- Up to half refuse outpatient treatment at outset (Rudd et al, 1996)
- Up to 60% of attempters do not attend up to 1 week of treatment after ED discharge (Jauregui et al, 1999; Piacentini et al, 1995)

Are Treatment Engagement Efforts Important for Suicide Prevention?

- As of 11/30/09---16,275 suicidal Veterans called the National Suicide Prevention Call Center (hotline)
  - 54% (n=8858) of callers refused a treatment referral
  - Of the 46% (7414) of callers accepting a referral, 21% (1578) did not follow through.
  - Therefore, approximately 36% of hotline callers engage in follow-up VHA treatment as a result of their call.
  - Similar follow-up rate as civilian hotline calls. (Gould, 2007)

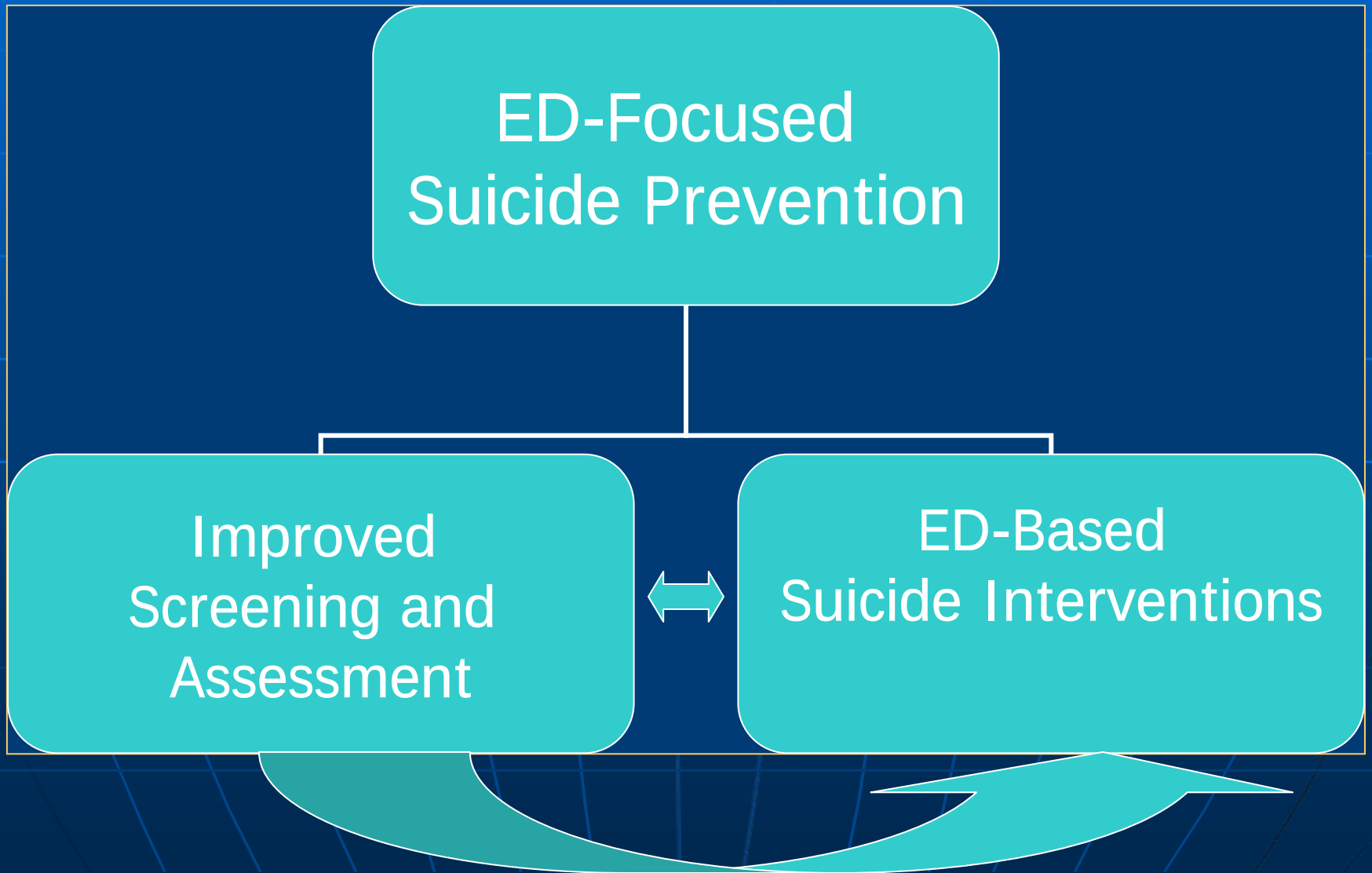
Rationale for SAFE VET

- Emergency Department (ED) is a primary site responding to suicidal individuals
- At least 1/20 patients in EDs are classified as having a psychiatric reason for the visit
- Approximately half of these visits are for suicide-related concerns
- Unique strategies for treating suicidal veterans in the ED are largely unexplored
- Therefore, responding effectively to any suicidal patients in the ED is crucial for suicide prevention, perhaps especially veterans

Rationale for SAFE VET

- Highest risk period for further suicidal behavior: 3 months following an attempt
- Most patients get discharged from ED, even those at relatively high risk.
- Up to 50% of attempters and 90% of “ideators” refuse outpatient treatment or are no-shows
- Up to 60% of suicide attempters attend $\leq$ 1 week of treatment post ED discharge
- Of those attempters who attend treatment:
  - 38% drop out of outpatient treatment after 3 months
  - 73% drop out by 1 year

Moving Forward with ED-Based Efforts to Prevent Suicide



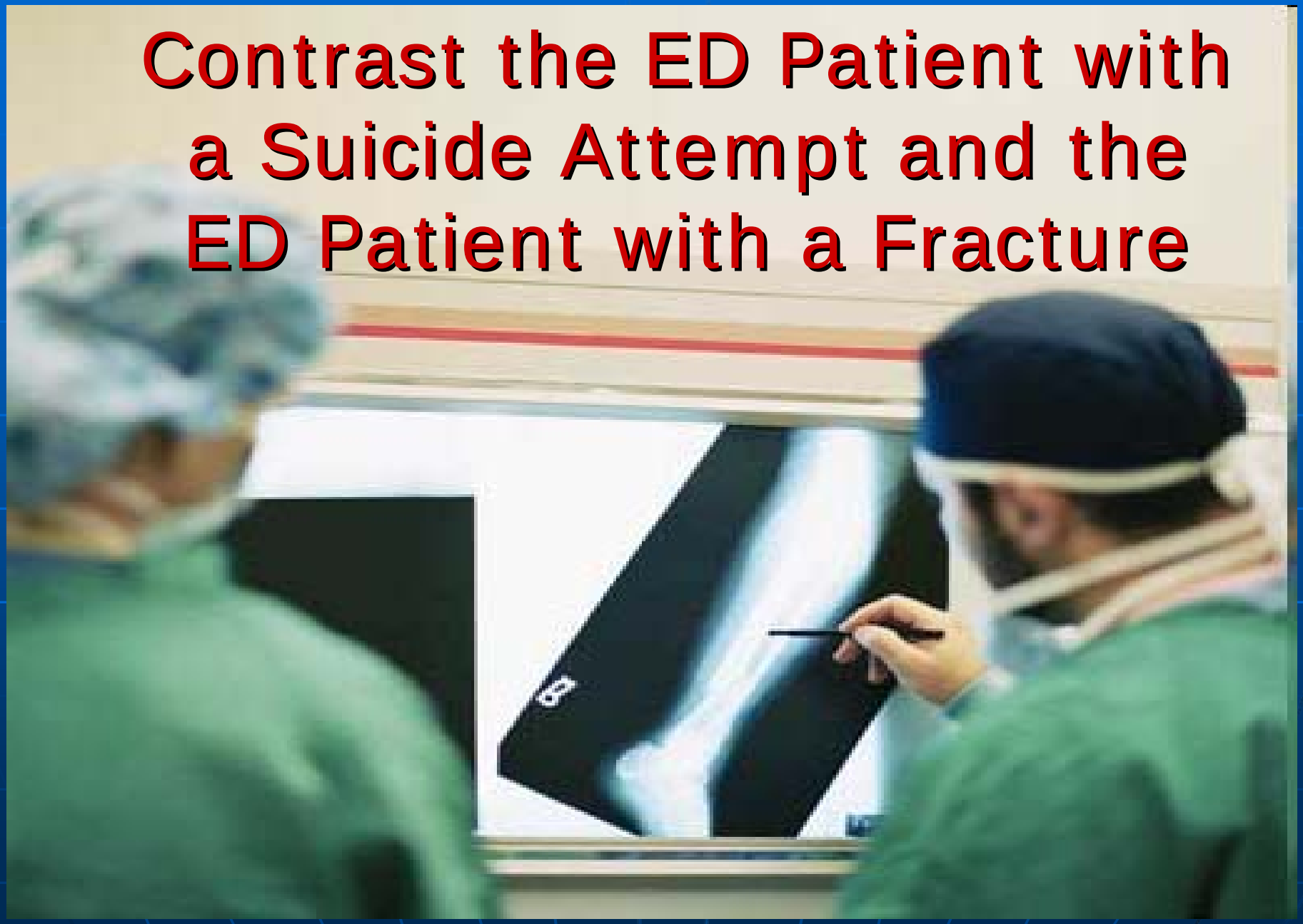
U.S. Suicide Statistics 2000-2006

Deaths and Rates per 100,000 Population			
Year	**Number of Suicide Deaths**	**Population**	**Rate**
2000	29,350	281,421,906	10.4
2001	30,622	285,112,030	10.7
2002	31,655	287,888,021	11.0
2003	31,484	290,447,644	10.8
2004	32,439	293,191,511	11.1
2005	32,637	295,895,897	11.0
2006	33,300	298,754,819	11.2
Total	**221,487**	**2,034,470,224**	**10.9**

Typical Approach to Suicidal Patients in the ED

- Assess imminent danger—conduct a risk assessment
- Triage---hospitalization vs. discharge to community
- If discharged, refer for treatment
- Is this approach acceptable with other problems presented in the ED?

Contrast the ED Patient with a Suicide Attempt and the ED Patient with a Fracture



ED Patient with Apparent fracture

- Diagnose----exam and x ray
- Treat---apply a cast
- Refer for follow-up

Do we have the equivalent of a cast available?

Given the limited success of referrals, alternative strategies that include immediate intervention ought to be considered

Crisis contact may be the ONLY contact the suicidal individual has with the mental health system

May be able to increase the ED's "therapeutic" capacity

SAFE VET Demonstration Project incorporates aspects of two recent VA-wide initiatives

Stanley & Brown (2008) developed a brief behavioral intervention, Safety Planning Intervention, that incorporates elements of four evidence-based suicide risk reduction strategies:

1. Means restriction,
2. Teaching brief problem solving and coping skills (including distraction)
3. Enhancing social support and identifying emergency contacts
4. Motivational enhancement.

SAFE VET Demonstration Project incorporates aspects of two recent VA-wide initiatives

Building on the success of the VA Suicide Prevention Coordinator Initiative, SAFE VET seeks to enhance the VA infrastructure by providing more support and guidance for identifying high risk veterans in community EDs, VA EDS and Urgent Care Units

SAFE VET Innovative Aspects

Emergency department based position called an Acute Services Coordinator [ACS] was created. Trained to administer a version of the safety plan intervention tailored to the unique needs and experiences of veterans in the ED.

The ACS facilitates entry into the VA by suicidal veterans treated outside the VA at community EDs, and provides training to non VA ED staff in Safety Planning implementation for veterans who can't or won't seek VA services.

SAFE VET Approach

Use the ED visit as an opportunity to intervene:

1. To mitigate suicide risk to help patients identify their personal obstacles
2. To enhance motivation to attend treatment regularly and to problem solve to remove obstacles

Provide follow-up contact to:

1. Enhance safety
2. Encourage ongoing treatment attendance

Steps 1 and 2: SAFE VET Intervention

1. Suicide Status Categorical Rating
   - Rating of current suicide status assigned to each individual
   - Concise and consistent manner of communicating current suicide status
2. Safety Planning
   - Several key components designed to help individuals cope with suicidal feelings and urges in order to avert a suicidal crisis
   - Hierarchically-arranged list of coping strategies identified for use during a suicidal crisis or when suicidal urges emerge over anticipated period between ED discharge and intake at VA

Step 3: Motivational Enhancement & Problem Solving

a) Psychoeducation to address the importance of treatment and to correct any misconceptions regarding treatment
b) Problem-solving to address any anticipated barriers to engaging in treatment
c) Encouragement to attend outpatient therapy
d) Motivational enhancement strategies to help:
    i. Increase motivation to utilize the safety plan as developed
    ii. Attend ongoing treatment and next level of care

Step 4: Follow-Up Protocol

- Weekly contact for the first two weeks and biweekly contact for the next ten weeks
- Contact by phone, mail or email
- Content consists of:
  - Friendly support
  - Brief risk assessment
  - Safety plan review
  - Problem solving with respect to obstacles to treatment engagement


Safety Planning Intervention (SPI)
To reduce suicide risk and enhance coping
To increase treatment motivation and enhance linkage

Safety Planning Intervention (SPI)

- What is it?
- What it is not?
- Why do it?
- Who does it?
- When should it be done?
- How to do it?

What is SPI?

- Prioritized written list of coping strategies and resources for use during a suicidal crisis.
- Helps provide a sense of control.
- Uses a brief, easy-to-read format that uses the patients' own words.
- Enhances commitment to treatment.

Safety Plan: What it is not? "No-Suicide Contract"

- No-suicide contracts ask patients to promise to stay alive without telling them how to stay alive.
- No-suicide contracts may provide a false sense of assurance to the clinician.

Safety Plan: Why do it?

- Development and implementation of a safety plan IS treatment.
- Should be the first intervention with a suicidal patient.
- Helps to immediately enhance patients' sense of control over suicidal urges and thoughts and conveys a feeling that they can "survive" suicidal feelings.
- Similar to fire drill or rehearsal.

Who Develops the Plan?

- Collaboratively developed by the clinician and the patient.

- Patients who have…
  - made a suicide attempt.
  - suicide ideation.
  - psychiatric disorders that increase suicide risk.
  - otherwise been determined to be at risk for suicide.

When Is It Appropriate?

- A safety plan may be done at any point during the assessment or treatment process.
- Usually follows a suicide risk assessment.
- Safety Plan may not be appropriate when patients are at imminent suicide risk or have profound cognitive impairment.
- The clinician should adapt the approach to the patient's needs -- such as involving family members in using the safety plan.

How Do You Do It?

- The clinician and patient should sit side-by-side, use a problem solving approach, and focus on developing the safety plan.
- The safety plan should be completed using a paper form with the patient.

“Telling the Story”

- Have patients describe the events and situations and their reactions to these events in as much detail as possible.
- Beginning of the story:
  - Major decision point associated with increased suicide risk
  - Strong emotional reaction to a specific event
    - External event such as a significant loss
    - Internal event such as an automatic thought
  - Follows backwards in time

“Telling the Story”

1. Understand the function of suicidal behavior or thinking from the patient’s perspective; that the behavior “makes sense” to the patient in the context of his or her history, vulnerability, and circumstances.
2. Empathize with the patient’s strong feelings and desire to be reduce distress.
3. Refrain from trying to solve the patient’s problems before understanding the motivations for suicide.
4. Don’t rush the interview!

It is Critical to Communicate...

- that ending the patient's emotional pain is the most important goal and is possible with treatment.
- that preserving the patient's life is essential.
- support and encouragement that therapy will be helpful.

Overview of Safety Planning: 6 Steps

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help to resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means

Step 1: Recognizing Warning Signs

- Safety plan is only useful if the patient can recognize the warning signs.
- The clinician should obtain an accurate account of the events that transpired before, during, and after the most recent suicidal crisis.
- Ask “How will you know when the safety plan should be used?”

Step 1: Recognizing Warning Signs

- Ask, “What do you experience when you start to think about suicide or feel extremely distressed?”
- Write down the warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the patients’ own words.

Step 1: Recognizing Warning Signs

57%	Low mood/crying
36%	Irritability/anger
43%	Social Isolation
29%	Increased sleep
29%	Anhedonia/loss of interest in activities
29%	Feeling overwhelmed
14%	Feeling numb
14%	Loss of energy
14%	Changes in appetite
7%	Physical pain
7%	Anxiety
7%	Poor concentration

Step 2: Using Internal Coping Strategies

- List activities that patients can do without contacting another person
- Activities function as a way to help patients take their minds off their problems and promote meaning in the patient's life
- Coping strategies prevent suicide ideation from escalating

Step 2: Using Internal Coping Strategies

- It is useful to have patients try to cope on their own with their suicidal feelings, even if it is just for a brief time

- Ask “What can you do, on your own, if you become suicidal again, to help yourself not to act on your thoughts or urges?”

Step 2: Using Internal Coping Strategies

- Ask “How likely do you think you would be able to do this step during a time of crisis?”
- Ask “What might stand in the way of you thinking of these activities or doing them if you think of them?”
- Use a collaborative, problem solving approach to address potential roadblocks

Step 2: Internal Coping Strategies

58%	Watching TV
43%	Reading
29%	Music
21%	Browsing the Internet
21%	Video games
21%	Exercising/Walking
14%	Cleaning
14%	Playing with Pets
7%	Cooking

Step 3: Socializing with Family Members or Others

- Coach patients to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- Family, friends, or acquaintances who may offer support and distraction from the crisis.

Step 3: Socializing with Family Members or Others

- Ask “Who helps you take your mind off your problems at least for a little while?”
- Ask “Who do you enjoy socializing with?”
- Ask patients to list several people, in case they cannot reach the first person on the list.

Step 3: Social Settings that Provide Distraction

23%	Bookstore/library/coffee shop
23%	Gym
23%	Shopping
23%	Park
23%	Church
15%	Friend’s Home

Step 4: Seeking Support: Contacting Family Members or Friends for Help

- Coach patients to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- Ask “How likely would you be willing to contact these individuals?”
- Identify potential obstacles and problem solve ways to overcome them.
- Ask if the safety plan can be shared with family members.

Step 5: Contacting Professionals and Agencies

- Coach patients to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- Ask “Which clinicians should be on your safety plan?”
- Identify potential obstacles and develop ways to overcome them.

Step 5: Contacting Professionals and Agencies

- List names, numbers and/or locations of:
  - Clinicians
  - Local ED or urgent care services
  - VA Suicide Prevention Coordinator
  - Suicide Prevention Hotline 800-273-TALK (8255), press “1” if veteran
- May need to contact other providers especially if listed on the safety plan

Step 6: Reducing the Potential for Use of Lethal Means

- Ask patients what means they would consider using during a suicidal crisis.
- Regardless, the clinician should always ask whether the patient has access to a firearm.

Step 6: Reducing the Potential for Use of Lethal Means

- For methods with low lethality, clinicians may ask patients to remove or restrict their access to these methods themselves.
  - For example, if patients are considering overdosing, discuss throwing out any unnecessary medication.

Step 6: Reducing the Potential for Use of Lethal Means

- For methods with high lethality, collaboratively identify ways for a responsible person to secure or limit access.
  - For example, if patients are considering shooting themselves, suggest that they ask a trusted family member to store the gun in a secure place.
  - Try to limit access in ways that increases the amount of time and effort required to use the preferred method.

Step 6: Means Restriction

50%	Give pills to a friend or family member
20%	Seek company
10%	Place knife in a location that is difficult to access
10%	Discard razor blades
10%	Store pills at workplace
10%	Avoid areas with bridges and trains when warning signs are present

SAFETY PLAN

Step 1: Warning signs:

1. Becoming numb
2. Not being able to think rationally/ Not being able to concentrate
3. Excessive Crying
4. A lot of Anxiety

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

1. Watch TV-funny shows and movies
2. Reading Magazines (US, Hollywood, Fashion)
3. Play with my dog

Step 3: People and social settings that provide distraction:

1. Name: Joe Smith Phone: 888-888-8888
2. Name: Sally Brown Phone: 777-777-7777
3. Place: Dunkin Donuts 4. Place: Walk around the city/Central Park

Step 4: People whom I can ask for help:

1. Name: Nancy King Phone: 666-666-6666
2. Name: Bob Wang Phone: 555-555-5555
3. Name:_____ Phone:_____

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

1. Clinician Name: Dr. Shell Phone: 444-444-4444
   Clinician Pager or Emergency Contact: 333-333-3333
2. Clinician Name: Dr. Moran Phone: 222-222-2222
   Clinician Pager or Emergency Contact: 111-111-1111
3. Local Urgent Care Services: Columbia Presbyterian Hospital
   Urgent Care Services Address: 622 W. 168th Street
   Urgent Care Services Phone: 212-305-8075
4. Suicide Prevention Hotline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:

1. Give sleeping pills to husband to store

Safety Plan Treatment Manual to Reduce Suicide Risk (Stanley & Brown, 2008).

Implementation: What is the Likelihood of Use?

1. Ask: “Where will you keep your safety plan?”

2. Ask: “How likely is it that you will use the Safety Plan when you notice the warning signs that we have discussed?”

Implementation: What is the Likelihood of Use?

3. Ask: “What might get in the way or serve as a barrier to your using the safety plan?”
   - Help the patient find ways to overcome these barriers.
   - May be adapted for brief crisis cards, cell phones or other portable electronic devices – must be readily accessible and easy-to-use.
   - Identify cues to use the safety plan.

Implementation: Review the Safety Plan Periodically

- Periodically review, discuss, and possibly revise the safety plan after each time is it used.
- The plan is not a static document.
- It should be revised as patient's circumstances and needs change over time.

Possible Applications

- EDs, especially if patients are not hospitalized.
- Prior to discharge from inpatient facilities.
- Ongoing outpatient treatment with individuals who struggle with suicidal crises.
- Crisis call centers.

Adaptations

- Self administered
- SPI Workbook
- SPI Groups
- Buddy-to-buddy support when access to mental health professionals is limited
- Online, interactive version

Patient Reactions

- “I think it is very helpful, especially with people going through depression, with showing you and telling you how to use different coping skills when you are feeling depressed.”
- “Gave me the opportunity to more clearly define signs, when my mood is beginning to deteriorate and when to start taking steps to prevent further worsening of my mood.”
- “I like the safety plan. I could hang it on my room wall because I could look at it and it helps me remember how to deal with things.”
- “It hadn’t occurred to me before that I could do something about my suicidal feelings.”

Resources

- Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version
- VA Safety Plan Form
- VA Safety Plan: Brief Instructions

  vaww.mentalhealth.va.gov

- VA Safety Plan: Pocket Card
- VA Safety Plan CPRS Template

VA Safety Plan- QUICK GUIDE For Clinicians

WHAT IS A SAFETY PLAN?

A Safety Plan is a prioritized written list of coping strategies and sources of support veterans can use who have been deemed to be at high risk for suicide. Veterans can use these strategies before or during a suicidal crisis. The plan is **brief,** is in the **veteran's own words**, and is **easy** to read.

WHO SHOULD HAVE A SAFETY PLAN?

Any veteran who has a suicidal crisis should have a comprehensive suicide risk assessment. Clinicians should then collaborate with the veteran on developing a safety plan.

HOW SHOULD A SAFETY PLAN BE DONE?

Safety Planning is a clinical process. Listening to, empathizing with, and engaging the veteran in the process can promote the development of the Safety Plan and the likelihood of its use.

IMPLEMENTING THE SAFETY PLAN

There are 6 Steps involved in the development of a Safety Plan.

Clinicians are strongly advised to read the manual, "*VA Safety Plan Treatment Manual to Reduce Suicide Risk*," and review associated video training materials at the following link:

http://vaww.mentalhealth.va.gov/files/suicide prevention/VA_Safety_planning_manual_8-19-08revisons.doc