The Empowerment Plan:
Enhancing the Safety Plan with a CBS Approach to Repertoire Expansion

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Aspirations for this Presentation

- Address the relevance of ACT-D for suicide prevention
- Discuss the clinical utility of safety planning for steps 1 and 2.
- Comment on the relevance of repertoire expansion in the context of crisis management through example case

ACT and Suicide Prevention: Repertoire Expansion

- Oriented towards expanding patient repertoires by promoting open, aware and engaged living.
- Core processes increase psychological flexibility

Open	Aware	Engaged
Acceptance/willingness	Present moment	Values clarification
Defusion	Perspective taking/SAC	Committed action

- Work with patients supporting behaviors consistent with patients' values.
- Empowerment planning sets the occasion for values work.

ACT and Suicide Prevention: Repertoire Expansion

- ACT is transdiagnostic and can be used short-term
- A meta-analysis of meta-analyses*
  - Twenty meta-analyses included
  - 100 controlled effect sizes
  - n = 12,477 participants
  - ACT is efficacious for all conditions examined, including anxiety, depression, substance use, pain, and transdiagnostic groups
- Over 700 RCTS for different conditions

(*Gloster, et al., 2020)

ACT and Suicide Prevention: Repertoire Expansion

ACT trials in the context of suicidality:

- Acceptability and feasibility trial examining ACT for acute suicidal crisis in hospitalized veterans*
  - Treatment was well-tolerated despite condensed and intense application
  - Retention rates remained high (<75% of the participants completed)
  - Veterans: continue to participate in the intervention
- Open trial of ACT in outpatients suffering from Suicide Behavior Disorder (SBD)**
  - Significant reductions in suicidal ideation (Columbia-Suicide Severity Rating Scale; *C*-SSRS).
  - Treatment was acceptable
  - Depression and anxiety decreased, while functioning improved
  - Maintained at 3-month follow-up
- Veterans undergoing ACT for depression***
  - Decreases in suicidal ideation as acceptance increased across time
  - Proportion of patients without suicidal ideation increased from 44.5% at baseline to 65% at follow-up
  - Decreased odds of SI

*(Barnes, Borges, Smith, & Bahraini, 2019; **Ducasse et al., 2014; ***Walser et al., 2015).

Clinical Utility of Safety Planning

Barbara Stanley's Pragmatism: Why Make a Safety Plan?

Stanley & Brown, 2012

- Suicidal crises are difficult to predict
- Suicidal crises are often sudden
- Adaptable to address other impulsive behaviors
  - Relapse prevention
  - Violence prevention
- It can be highly useful to have the most important information all in one place

Need for Immediacy

- Low treatment engagement is an added cause for significant concern,
  - The first 90 days following a suicide attempt are the riskiest time for a subsequent attempt
- Limited research on ACT indicates suicidality can be reduced in time limited fashion (e.g., a single inpatient
- stay).
- Brief ACT interventions are emerging. For instance:
  - RCT with depressed adults
  - Compared three single-session group interventions examining how much is enough to treat depression (diagnosis associated with SI)
  - Findings indicated that all intervals (90 minutes, 3 hours, 6 hours) reduced depressive symptoms

(Kroska, Roche, & O'Hara, 2020)

What is a safety plan?

WHAT ARE THE STEPS AFTER THE PLAN IS DEVELOPED?

1. **ASSESS** the likelihood that the **overall safety plan** will be used and problem solve with the Veteran to identify barriers or obstacles to using the plan.
2. **DISCUSS** where the Veteran will keep the safety plan and how it will be found during a crisis.
3. **EVALUATE** whether the format is appropriate for the Veteran's capacity and circumstances.
4. **REVIEW** the plan periodically when the Veteran's circumstances or needs change.

REMEMBER: THE SAFETY PLAN IS A TOOL TO ENGAGE THE VETERAN AND IS ONLY ONE PART OF A COMPREHENSIVE SUICIDE CARE 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://www.mentalhealth.va.gov/providers/suicideprevention/index.asp

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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 that Veterans who have been deemed to be at high risk for suicide can use before or during a crisis. The plan is **brief, easy to read,** and in the **Veteran's own words.**

U.S. Department of Veterans Affairs

Veterans Crisis Line

1-800-273-8255 PRESS 1

U.S. Department of Veterans Affairs

Veterans Crisis Line

1-800-273-8255 PRESS 1

Confidential chat at VeteransCrisisLine.net or text to 838255

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An approach beyond a list…

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 YOU MAKE A SAFETY PLAN?

Listen to, empathize with, and engage the Veteran in the process. Safety planning is a clinical process, and involving the Veteran can promote the development of the safety plan and increase the likelihood of its use.

DEVELOPING THE SAFETY PLAN

There are six steps involved in the development of a safety plan.

IMPLEMENTING THE SAFETY PLAN

Step 1: Warning Signs

- ☐ Ask ***"How will you know when the safety plan should be used?"***
- ☐ Ask ***"What do you experience when you start to think about suicide or feel extremely distressed?"***
- ☐ List warning signs (thoughts, images, thinking processes, mood, and/or behaviors) using the **Veteran's own words.**

Step 2: Internal Coping Strategies

- ☐ Ask ***"What can you do on your own, if you become suicidal again, to help prevent yourself from acting on your thoughts or urges?"***
- ☐ Assess likelihood of use: Ask ***"What do you think is the likelihood that you would be able to do this step during a time of crisis?"***
- ☐ If doubt about use is expressed, 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 and identify alternative coping strategies.

Step 3: Social Contacts Who May Distract from the Crisis

- ☐ Instruct the Veteran to use Step 3 if Step 2 does not resolve the crisis or lower risk.
- ☐ Remember, in this step, the goal is distraction from suicidal thoughts and feelings.
- ☐ Ask ***"Who or what social settings help you take your mind off your problems at least for a little while?"*** or ***"Who helps you feel better when you socialize with them?"***
- ☐ Ask for safe places where the Veteran can go, such as a coffee shop, to be around people.
- ☐ Ask the Veteran to list several people and social settings, in case the first option is unavailable.
- ☐ Assess the likelihood that the Veteran will engage in this step; identify potential obstacles and problem solve as appropriate.

Step 4: Family Members or Friends Who May Offer Help

- ☐ Instruct the Veteran to use Step 4 if Step 3 does not resolve the crisis or lower risk.
- ☐ Ask ***"Among your family or friends, who do you think you could contact for help during a crisis?"*** or ***"Who is supportive of you and who do you feel that you can talk with when you're under stress?"***
- ☐ Ask the Veteran to list several people, in case one contact is unreachable. Prioritize the list. In this step, unlike the previous step, patients reveal they are in crisis to others.
- ☐ Assess the likelihood that the Veteran will engage in this step; identify potential obstacles and problem solve.
- ☐ Role play and rehearsal can be very useful in this step.

Step 5: Professionals and Agencies to Contact for Help

- ☐ Instruct the Veteran to use Step 5 if Step 4 does not resolve the crisis or lower risk.
- ☐ Ask ***"Who are the mental health professionals that we should identify to be on your safety plan?"*** and ***"Are there other health care providers who should be added?"***
- ☐ List names, numbers, and/or locations of clinicians, local urgent care services, a VA Suicide Prevention Coordinator, and VA's Veterans Crisis Line (1-800-273-8255 and Press 1, confidential chat at VeteransCrisisLine.net, or text to 838255).
- ☐ Assess the likelihood that the Veteran will engage in this step; identify potential obstacles and problem solve.

Step 6: Making the Environment Safe

- ☐ Ask the Veteran which means he or she would consider using during a suicide crisis.
- ☐ Ask ***"Do you own a firearm, such as a gun or rifle?"*** and ***"What other means do you have access to and may use to attempt to kill yourself?"***
- ☐ Collaboratively identify ways to secure or limit access to lethal means: Ask ***"How can we go about developing a plan to limit your access to these means?"***
- ☐ For methods with **low lethality**, clinicians may ask Veterans to remove or restrict their access to these methods themselves.
- ☐ Restricting the Veteran's access to a **highly lethal method**, such as firearms, should be done by a designated responsible person—usually a family member, close friend, or the police.

Evaluating the Effectiveness of Safety Plans for Military Veterans: Do Safety Plans Tailored to Veteran Characteristics Decrease Suicide Risk?

(Green et al., 2018)

- Data from Suicide Prevention Applications Network (SPAN)
  - 68 veterans followed
  - Charts review - 2016
  - Scored Safety Plans for completeness and quality
- Outcomes
  - 10% decrease in Suicide Behavior Reports for each **high-quality** item listed on the 6 steps of the SP.
  - Importance of specific and even idiosyncratic items for **step 3**.
  - 11% of SPAN veterans lacked a safety plan

Essential Elements of a Safety Plan

1. **Warning signs**
2. **Internal coping strategies**
3. Reinforcing social contexts
4. Emergency contacts
5. Mental health providers and crisis line contacts
6. Means restriction and environmental changes to limit access to lethal means

How can we make steps 1 & 2 more specific and detailed?

What gets in the way of quality safety planning?

What gets in the way of quality safety planning for the patient?

- Patient is struggling and doesn't want to go too deeply
- Why?
- Talking about warning signs could elicit memories, evaluations, feelings and sensations.
- How willing would you be to talk about the worst day of your life to someone you hardly know?
- As clinicians how do we earn the opportunity to hear and bear witness?

What gets in the way of quality safety planning for the clinician?

Clinician wants to validate and support patient

- Is worried about patient's safety
- Needs to document steps to assure safety is addressed
- Concerned about how those steps might be evaluated
- Juggling whether to prioritize short-term vs. long-term contingencies

Looks like a set up for a very superficial clinical encounter

How can we do meaningful present moment work in this context?

Informed consent – I would like to ask you about the details leading up to your crisis.

Why would it be important to you now to have a deep awareness of your experience leading up to your crisis? Why would that be helpful in the future?

Why would it be worth it to you to be uncomfortable with me?

Preparing for step 1

Step 1:
CBS approach to Recognizing Warning Signs

IF I WERE YOU JUST AS YOU WERE BEGINNING TO GET UPSET, WHAT \WOULD I BE NOTICING?

5 LIKELY OUTCOMES

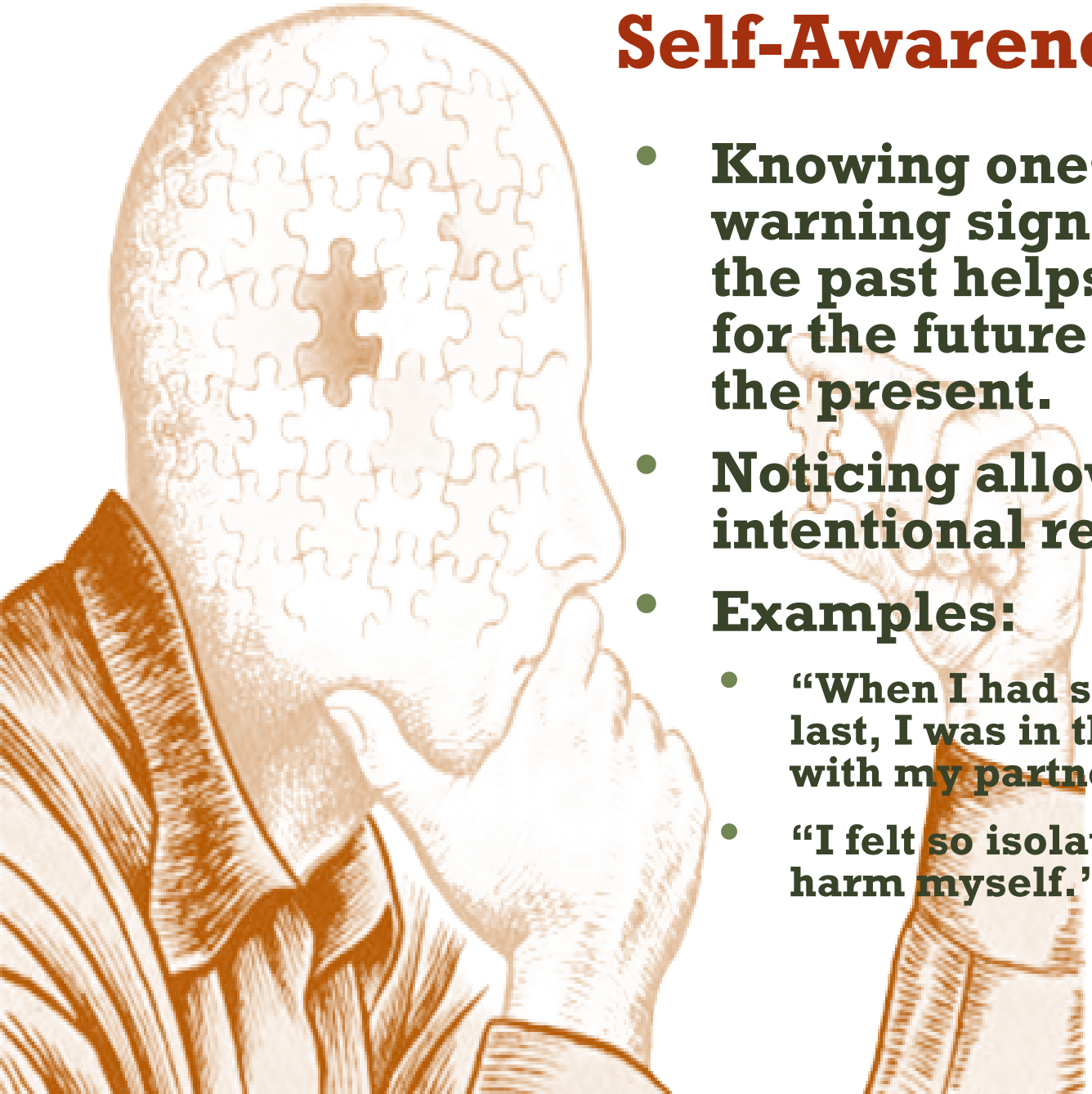
THOUGHTS AND EVALUATIONS

EMOTIONS

SENSATIONS

MEMORIES

NONE OF THE ABOVE – JUST BEFORE THAT WHAT WAS HAPPENING?



Self-Awareness

- **Knowing oneself and the warning signs of distress in the past helps us prepare for the future and *notice* in the present.**
- **Noticing allows an intentional response.**
- **Examples:**
  - **"When I had suicidal thoughts last, I was in the middle of a fight with my partner."**
  - **"I felt so isolated that I wanted to harm myself."**

For sensations/feelings: Up to now, has this awareness of your own struggles been one that needed to go away?

For thoughts: ***What do you say to yourself when you catch yourself wanting a feeling to go away?***

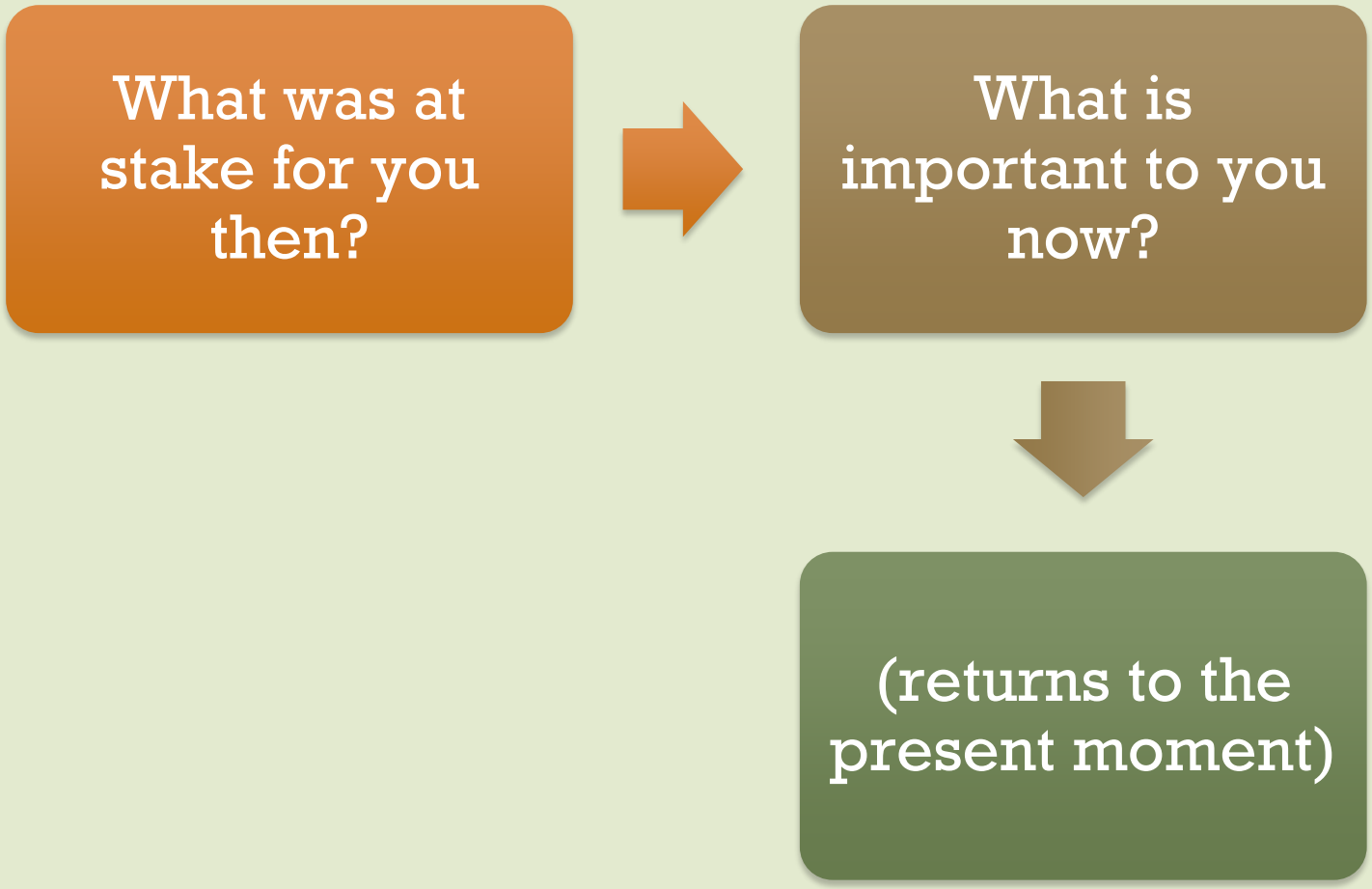
What feelings or sensations that go along with it?

Getting to Thoughts and Emotions

Emotions can tell us what we value

(Porosoff & Weinstein, 2020)

Getting From Values Then to Values Now



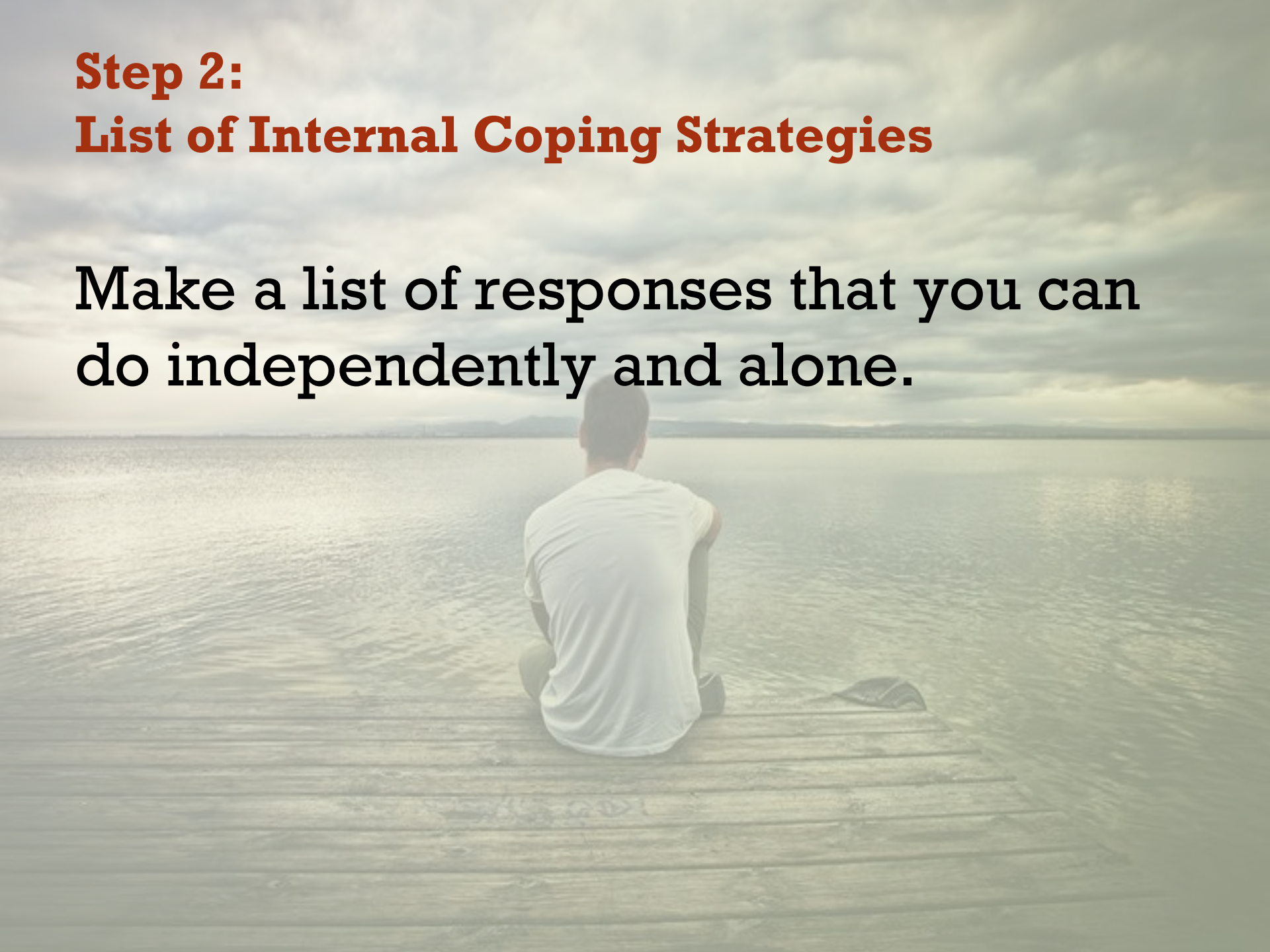
Present Moment Awareness

- Being in the here-and-now can be painful, and it is the only time and place where we can respond to our environment.
- We can choose to respond intentionally.
- Our goal: Increase values-driven responding, even in moments of distress.

Workability and Creative Hopelessness

- When was another time you had this feeling?
- How long have you been carrying this around?
- What has been the cost of not changing?

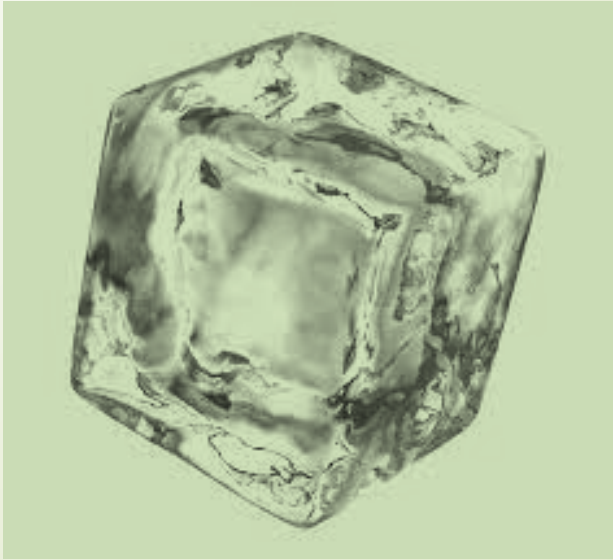
What about coping skills?



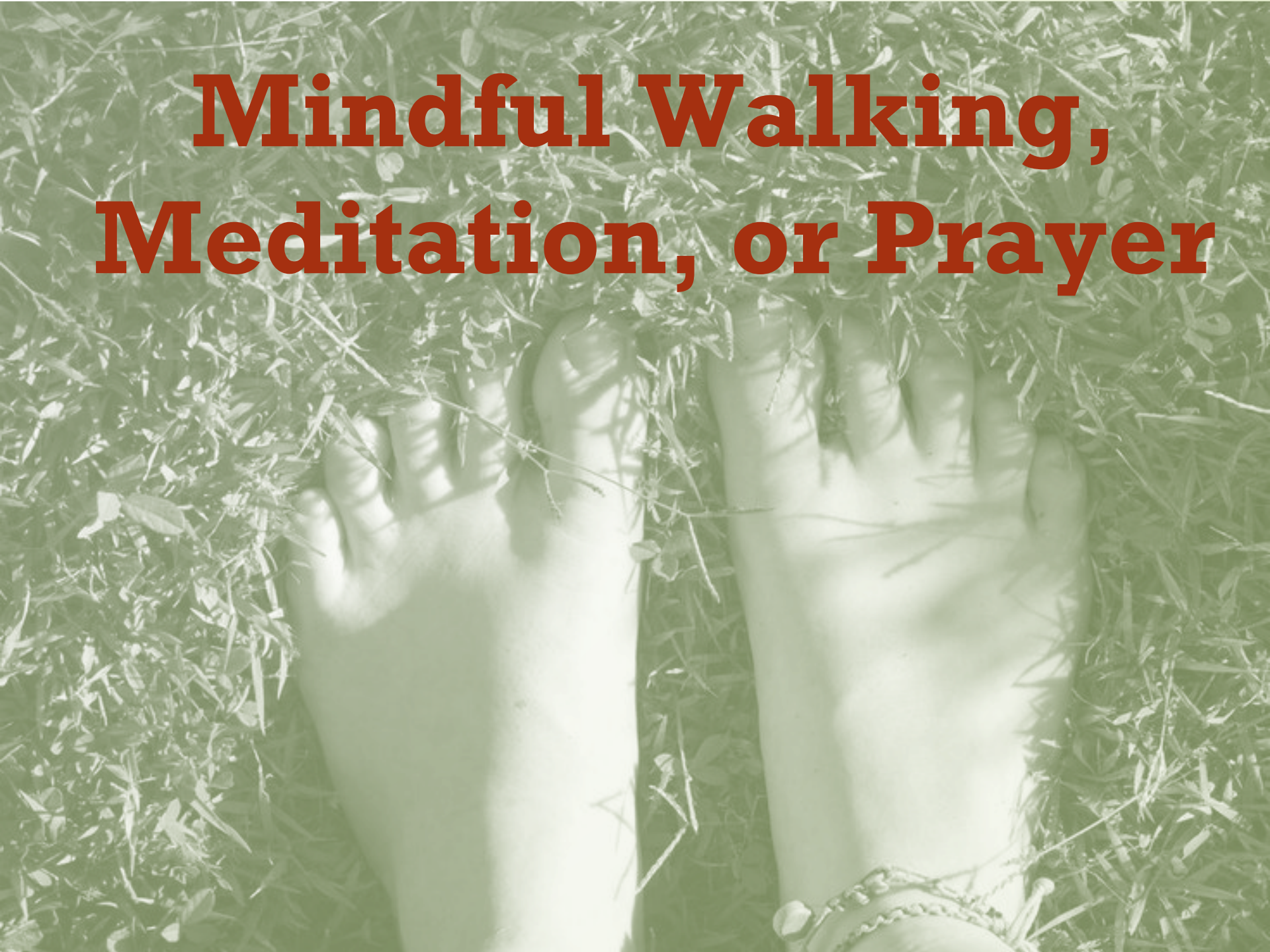
Step 2:
List of Internal Coping Strategies

Make a list of responses that you can do independently and alone.

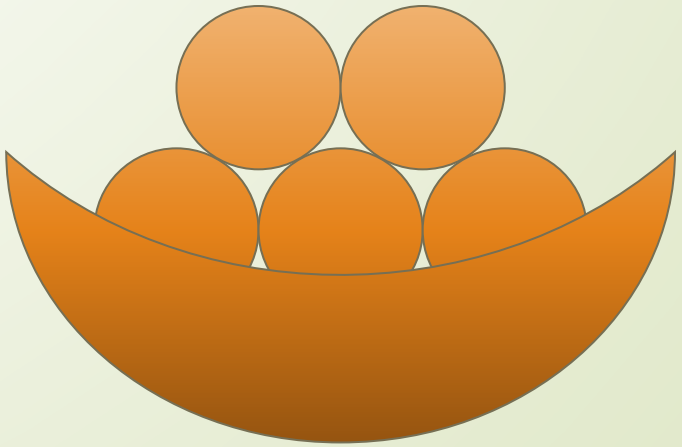
Holding an Ice Cube



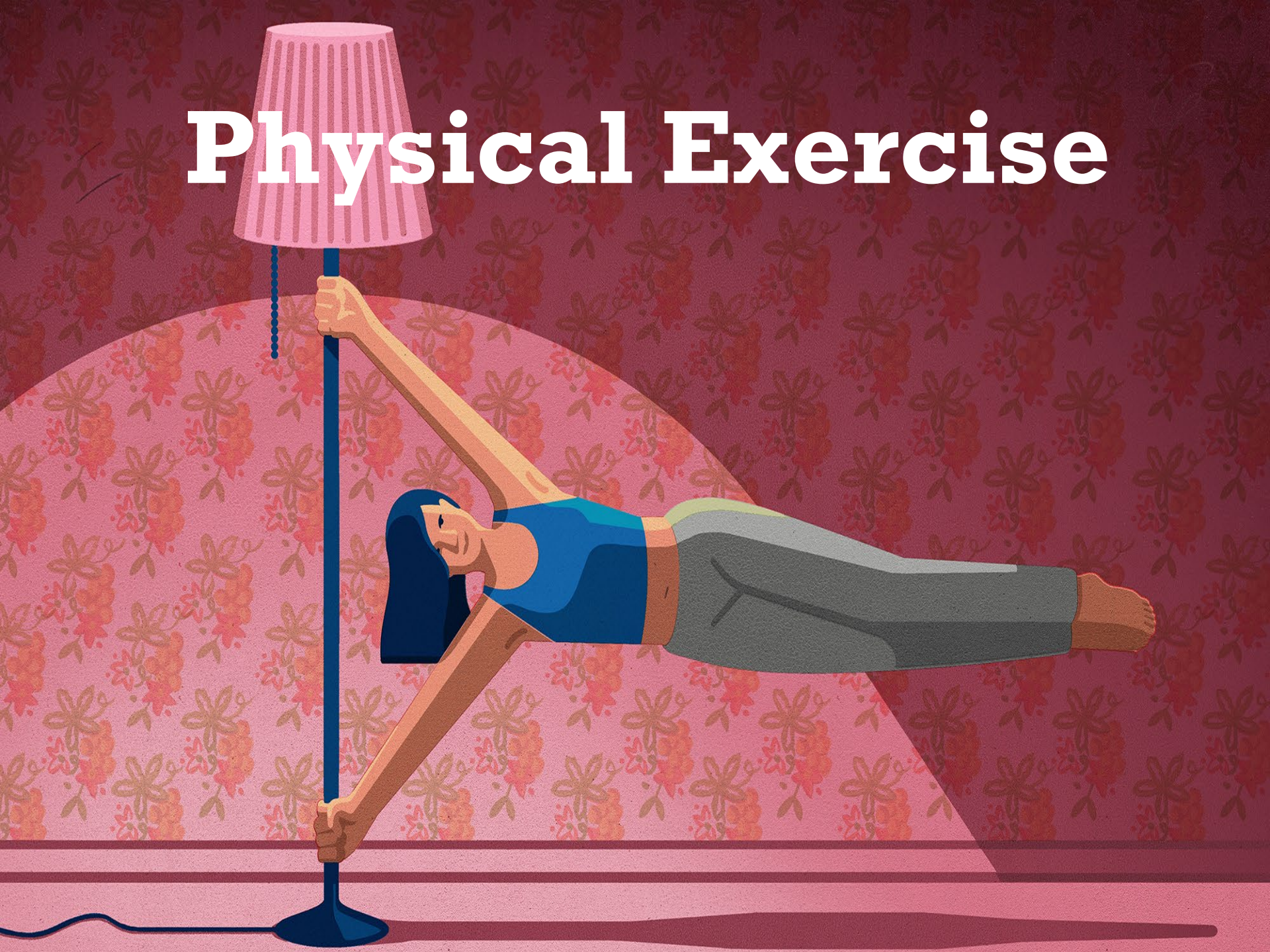
Mindful Walking, Meditation, or Prayer



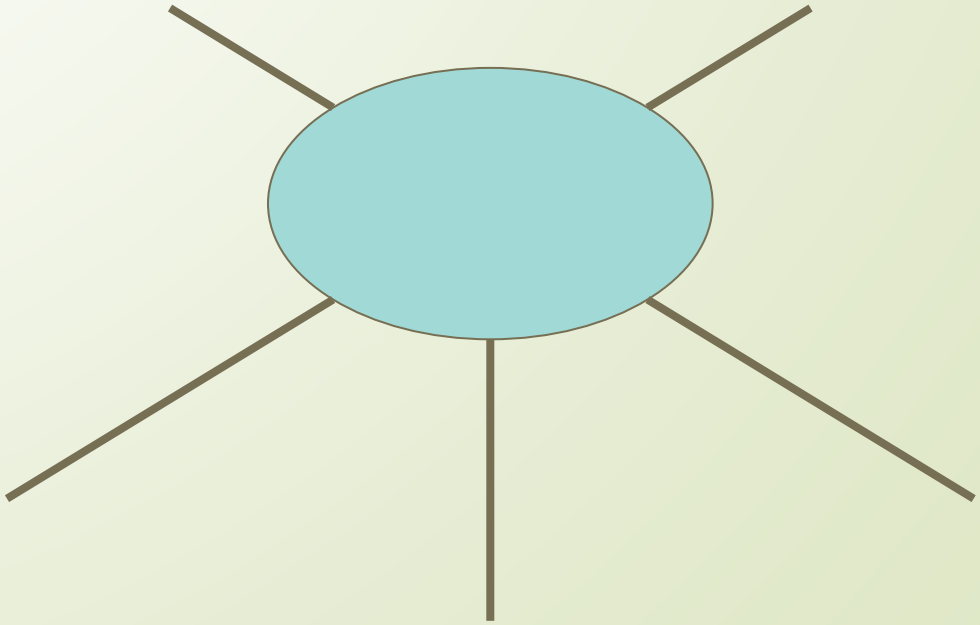
Sensory Stimulation



Physical Exercise



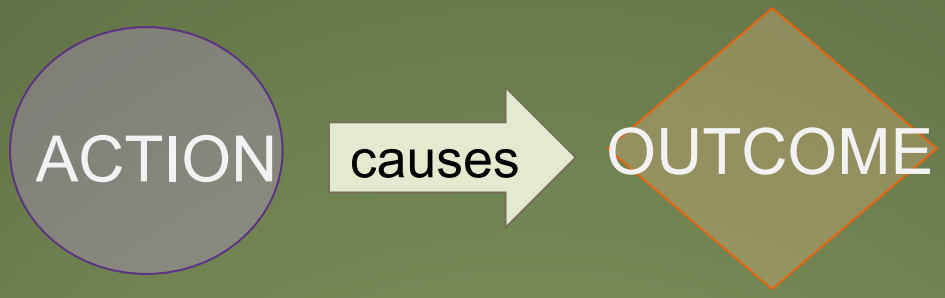
Making Lists in Categories



Variation on Step 2: Self-Awareness and Perspective Taking

Step 2: Potential limitations of Internal Coping Strategies (Villatte, Villatte & Hayes, 2016)

If I practice [insert coping skill], I'll feel better.



- When we frame actions as causes of desirable outcomes, we don't feel satisfied unless and until we achieve the outcome
- Coping implies a frame of causality
- Coping implies a frame of distinction with your current experience

Step 2a:
Liberation from Causal Thinking

Questions for the patient:

- *If this feeling didn't have to go away in order for you to do something really important to you, what would that be?*
- *If you can't do everything that's important to you right now, is there some smaller step that would move you in the right direction?*

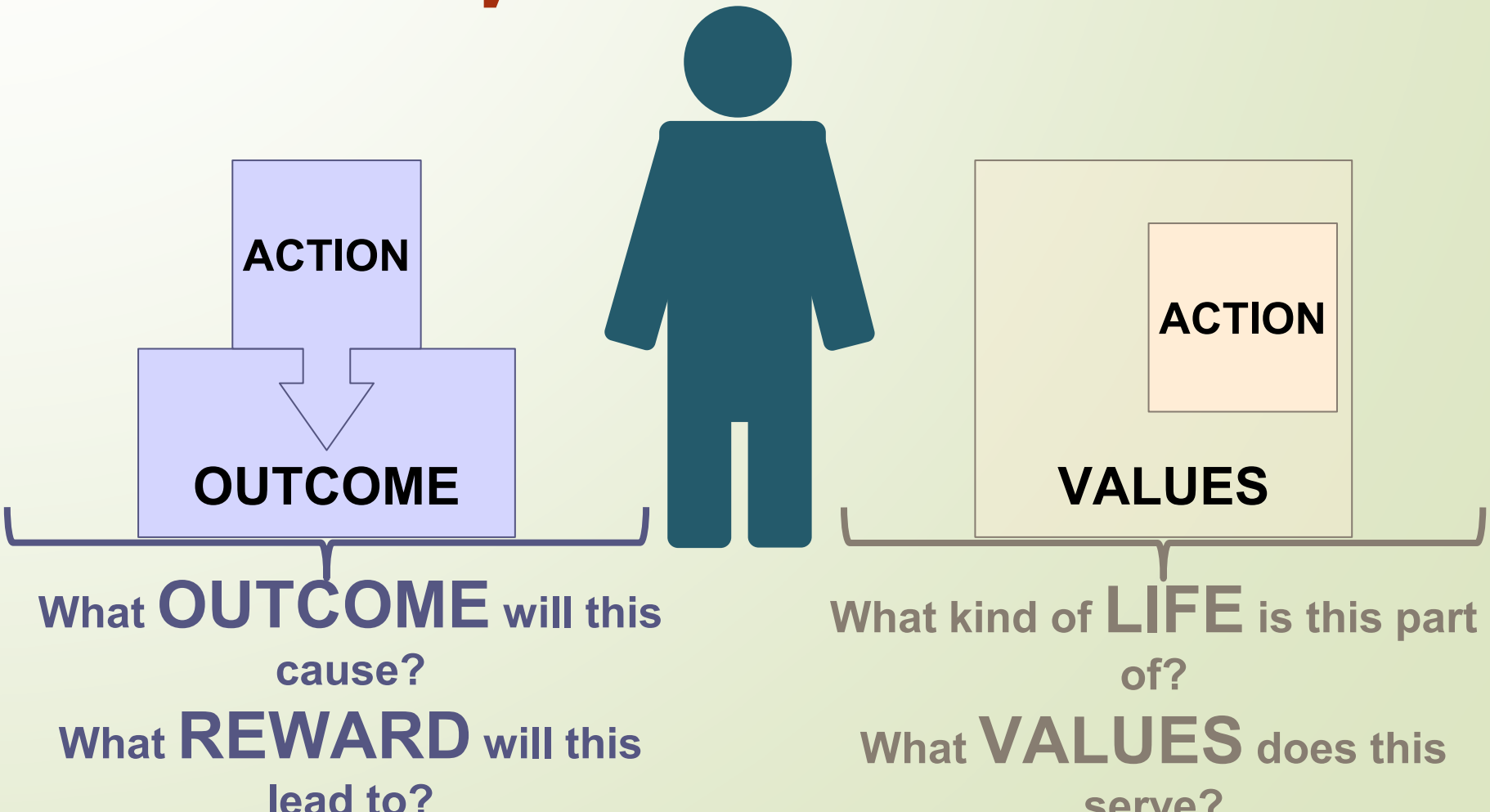
Question for the clinician:

- *If you didn't have to satisfy your worry for your patient's safety, what would you be asking about*?

Step2b:
Conditional vs. Hierarchical Framing

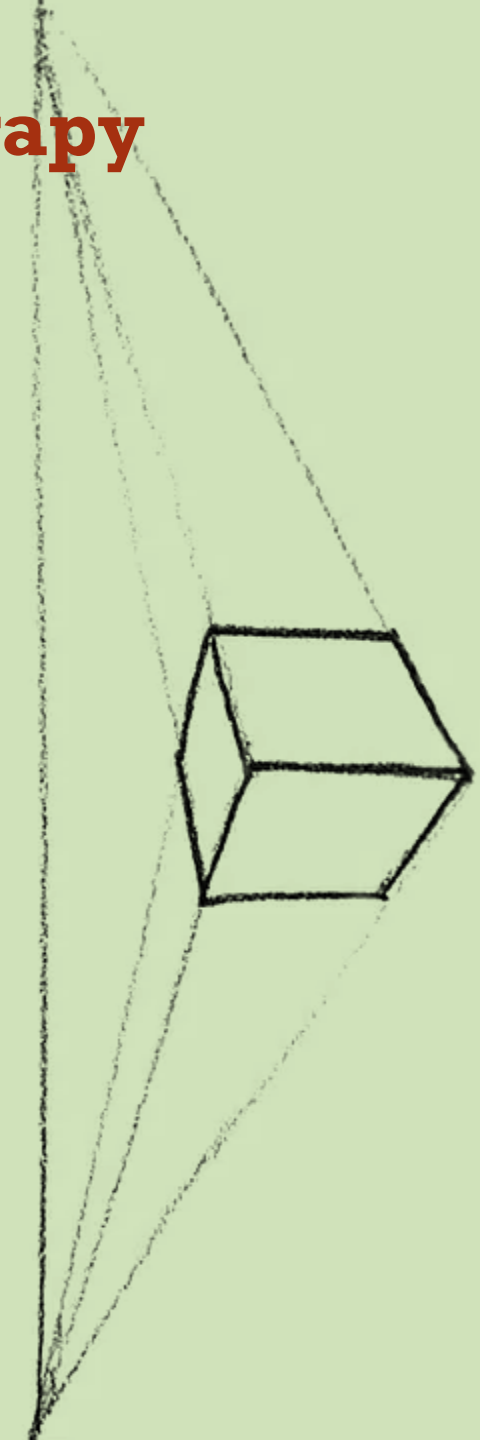
Villatte, Villatte, & Hayes, 2015

Why should I do this?



Hierarchical Framing – In Therapy

- How might your actions impact your sense of contributing to the community?
- If you could maintain sobriety without going to recovery or therapy, what would be some reasons to go anyway?
- When you're not able to exercise, what other forms of self-care can you do?



Step 2c: Analogical Framing

Some set piece questions when all else fails:

- Activities you're really good at
- Things that make you curious
- Topics you know a lot about
- Anything you can make

Step 2d: Internal Coping Strategies +CBS

You can always return to generic:

- Holding an ice cube can be a mindfulness exercise rather than a form of distraction
- Mindful walking, meditation, prayer can be an exploration of values
- Categories can be forms of committed action

Deidentified Example

Client A

- A combination of several clients to avoid disclosing any PHI
- Veteran who served in the Middle East
- Severe PTSD, including impulsive and reckless behaviors, frequent suicidal ideation, re-experiencing, and extreme avoidance

Suicide Risk Assessment

- Active suicidal ideation
- Method
- Fleeting intent, no intent at present
- No current plan
- Previous aborted attempts
- Family history of attempted suicide

Empowerment Plan

- Step 1 – Warning Signs
  - Injustice (particularly at work)
  - His children being at risk
  - Guilt, shame, or regret
  - Limitations on his free choice
- Values
  - Family, being a caring and generous father, free choice, work, respect, integrity, kindness to family

Expanding Warning Signs

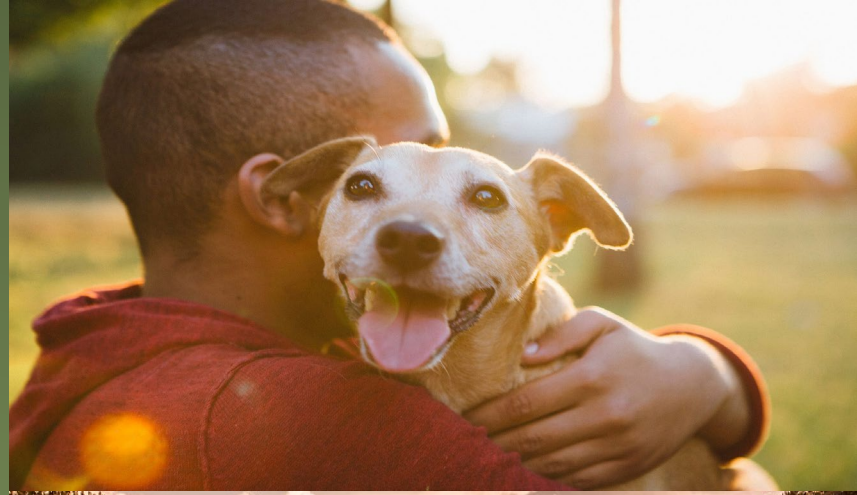
- Internal experiences associated with warning signs that are external contexts
  - Thoughts – "This isn't fair" or "It doesn't have to be this way"
  - Emotions – anger, shame, fear, panic
  - Physical sensations – dry throat, heart racing, stomach tumbling, sweaty, clenched fists
  - Memories – feeling out of control, losing friends

Step 2 – Internal Coping Strategies

- Distraction, reckless driving, isolating, taking a break, using alcohol or drugs, sleeping, thinking instead of acting, imposing rules on himself or others
- Evaluating workability
  - Short-term – provide relief
  - Long-term – increased painful experiences
  - Cost – "I'm nothing like who I want to be"

Step 2 – Internal Coping Strategies

- Spending time with the family dog
- Exercising
- Taking a deep breath before speaking
- Physical work – mowing lawn, working in the garden, shoveling snow
- If needing alone time, fishing, walking, or sitting outside



Summary

- ACT-D for suicide prevention
- Key additions from CBS to SBs
  - Expanding Repertoires
  - Values-based living
  - Expansion doesn't have to wait

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Supporting Providers Who Serve Veterans

Free consultation and resources for any provider in the community or VA who serves Veterans at risk for suicide.

Request a consult: srmconsult@va.gov

#NeverWorryAlone

- **Risk assessment**
- **Lethal means safety counseling**
- **Conceptualization of suicide risk**
- **Best practices for documentation**
- **Strategies for how to engage Veterans at high risk**
- **Provider support after a suicide loss (Postvention)**

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