

CRISIS PLANNING TOOLS FOR FAMILIES: A Companion Guide for Providers

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NETWORK HEALTH



CONTENTS

INTRODUCTION BY PPAL	1
1: FAMILY-CENTERED SAFETY PLANNING	2
2: OVERVIEW OF CRISIS PLANNING TOOLS	4
COMPONENT I: SAFETY PLAN.....	4
COMPONENT II: ADVANCE COMMUNICATION TO TREATMENT PROVIDER (ADVANCE COMMUNICATION)	4
COMPONENT III: SUPPLEMENTS TO THE ADVANCE COMMUNICATION OR SAFETY PLAN.....	5
3: TIPS TO GUIDE PERSONS/FAMILIES IN THE DEVELOPMENT OF A SAFETY PLAN	7
PROVIDER/TEAM CONSIDERATIONS	7
SETTING THE STAGE FOR SAFETY PLANNING.....	10
COMPLETION OF THE SAFETY PLAN TEMPLATE	12
TESTING "USABILITY"	15
ADVANCE COMMUNICATION TO TREATMENT PROVIDER (ADVANCE COMMUNICATION) TEMPLATE	16
SUPPLEMENTS TO THE ADVANCE COMMUNICATION OR SAFETY PLAN	20
INDIVIDUALIZED ALTERNATIVES	21
ROUTING BOXES	22
4: SAMPLE PLANS.....	23
SAMPLES OF TEMPLATE DOCUMENTS	25
5: RESOURCE INFORMATION.....	32

INTRODUCTION BY PPAL

The Parent/Professional Advocacy League (PPAL) would like to thank all the families who provided feedback for the revision and development of these new Crisis Planning Tools. We would also like to thank the Massachusetts Behavioral Health Partnership (MBHP) for soliciting and incorporating the feedback of families into these tools. PPAL is pleased that the voices and concerns of families have been heard and heeded in making sure that both the Crisis Planning Tools and crisis interventions are family-centered, youth-driven and culturally competent.

Since 1996, when PPAL first published the Crisis Planning Guide for families with children who have mental health needs, we have worked to help families design and decide upon plans that make sense for them and their children. The first handbook provided clear information and organized exercises for families to prepare in advance of mental health crises with their children. Then in 2001, PPAL published the Police Pocket Guide, written by two mothers and informed by the personal experiences, both positive and negative, of thousands of families with law enforcement officers. The premise of this guide is that a sensitive and thoughtful interaction with a youth and their family leads to a more positive outcome than “standard operating procedures.”

Twenty years of working with families have demonstrated that there are no standard operating procedures that fit for all families. Families deserve interventions that are tailored to their unique needs, based on their strengths and considerate of their own culture. More importantly, it is only when families are truly the center of all planning...even during times of crisis...that hope can be inspired and progress can be achieved. These newly revised Crisis Planning Tools are a further example of how the desires and concerns of families have been used as the basis of crisis planning, and their voices have been validated.

1: FAMILY-CENTERED SAFETY PLANNING

The safety planning process and any resulting Safety Plan must be useful to the full array of children, families, and young adults who receive Children's Behavioral Health Initiative (CBHI) services in Massachusetts. This includes parents with a pre-school age child in crisis as well as parents whose young adult child is in crisis. It includes persons/families that are wary of formal treatment services or have had negative experiences. It includes young adults who are seen involuntarily in an emergency room. It includes persons/families experiencing their first crisis episode, parents seeking help for children who don't want assistance, and children seeking help who do not feel supported by their parents. It includes persons/families from a range of cultures and beliefs who bring with them past experiences and personal biases; persons/families who are public about their struggles as well as persons/families who are private about them; and persons/families who have accepted and understand what is happening as well as persons/families who have not and do not.

As many as 40 percent of persons seen by Emergency Service Program (ESP) teams in Massachusetts have not been previously seen by the crisis team and are not receiving other behavioral health services. A first experience in receiving crisis services can be daunting. Engaging persons/families in the process, creating a comfortable environment, and achieving a consensus plan for what should happen next is essential not just for reducing risk in the current crisis episode, but in any future crisis episodes.

Our greatest goal in safety planning is that the process and any resulting products or plans will help to reduce unsafe situations and the likelihood of harm. In order for this goal to be realized, the person/family must actually use the plan in the event of a crisis. A plan may look terrific on paper, but if a family does not use it, what good has it served? If a comprehensive plan is developed for a family who is only ready for and interested in a pragmatic "If this, then this" type of plan, the efforts have been useless. An unauthentic plan that is largely developed for rather than with a person/family can actually increase risk.

As with all treatment services, it is important to consider timing, readiness, value as perceived by the recipient, and personal/familial priorities. An unwanted/un-useful process or off-putting product is not person/family-centered. The process/product may be perceived as an indication that the provider wasn't listening, isn't helpful, and doesn't care. The person/family may not seek the same services willingly in the future. If a person/family does not trust the system or becomes reluctant or unwilling to seek crisis services, risk increases. If a person/family calls for crisis support or intervention, and the team or provider relies on a Safety Plan that lacks authenticity, then the team or provider runs the risk of misunderstanding the person/family and what they are willing/able to do and of misunderstanding the nature of the real risk.

EXAMPLE: If the Safety Plan indicates that 14 year old Johnny will "punch his pillow, shoot baskets or draw in a notebook when he is starting to feel angry and get aggressive," then the team providing crisis support or intervention might assume that Johnny has insight into the

nature of his behavior, has developed useful coping strategies, AND believes those strategies could work.

If in reality Johnny has little insight into the nature of his anger, rarely "feels it coming on," hasn't developed effective strategies, and didn't participate in a meaningful way in crisis planning—then the Safety Plan lacks authenticity, and a key risk factor of "poor insight" is not apparent.

In person/family-centered service provision, creating a Safety Plan involves the provider joining with the person/family as they develop a plan that is truly representative of them. The provider is not the "leader," "expert," or "the one who knows best" about how to manage risk in this family. Rather, the provider's role here is to facilitate, guide, and empower the person/family in the creation of a Safety Plan that reflects not what the provider necessarily wants the person/family to do but rather what the person/family will actually do in the event of a crisis. Here is where you must work jointly and collaboratively with the person/family to reconcile the clinical "best case scenario" with a customized Safety Plan based on the person's/family's natural ecology and culture. As such, you are the collaborators in the creation of a real working tool – not just another paper that the family must sign as part of a crisis episode or assessment process.

The result should be a Safety Plan that is authentic, meaningful, usable, and "person/family-owned." As applicable, the planning process and the Safety Plan should serve to strengthen bridges within the family, the informal support network, and the formal treatment network—and leave a person, parent/guardian, or young adult optimistic that they have a better strategy for "next time."

It is the person's/family's Safety Plan developed through their eyes, for their benefit, and in accordance with their own strengths, resources, and perceptions of what they reasonably think might work now. Crisis self-management skills develop over time, and Safety Plans will evolve accordingly as children, parents, and young adults figure out what works and what doesn't work—uniquely, idiosyncratically, "for me, for now." Most Safety Plans will not work perfectly, especially the first time, and it is important that families are empowered to understand this. There are so many variables in circumstances, and human behavior is complex, so it is reasonable to expect that things will not go as planned. The instinct of family members to use what works remains a valuable ingredient in managing the current crisis, and, in retrospect, their observations of what worked and didn't work are invaluable in improving the Safety Plan for next time.

2: OVERVIEW OF CRISIS PLANNING TOOLS

There are three primary components to the Crisis Planning Tools that are available for use for children, families, and young adults. There is nothing hierarchical about the tools. They can be used separately or in some combination that is useful to the person/family.

COMPONENT I: SAFETY PLAN

Quick Summary: This is an *in-community, in-the-moment* tool used by children, young adults, or parents to reduce or manage worsening symptoms, promote wanted behaviors, prevent or reduce the risk of harm or diffuse dangerous situations. The specifics of the Safety Plan must be meaningful to and actionable by the person/family. As the family chooses, the Safety Plan can be shared with the ESP/MCI team or others who might provide crisis support or intervention in the future. Sharing the Safety Plan promotes the future providers' awareness of and ability to support the strategies being used by the person/family.

Description: The Safety Plan template is two-sided. One side has a simple structure that captures Contacts and Resources, the Goal of the Safety Plan, and Actions. The other side is an open format. The child, parent(s)/guardian(s), or young adult builds the Safety Plan on the side that suits them best.

When to use it: For many persons/families, such as those experiencing a first or infrequent crisis episode or who are addressing behaviors in the home that are unlikely to rise to the level of emergency services, this will often be the one and only crisis planning tool that is used.

For families working with a Community Service Agency (CSA), In Home Therapy (IHT), or other comprehensive service, this one-page form can be used to develop the initial Safety Plan that is completed during or within 24 hours of the first contact. As treatment unfolds and the family develops a more comprehensive Safety Plan, it can replace the initial Safety Plan. Simply use the blank side of the Safety Plan template as the cover sheet for the more comprehensive document. That way, routing information will still be noted at the base of the Safety Plan.

COMPONENT II: ADVANCE COMMUNICATION TO TREATMENT PROVIDER (ADVANCE COMMUNICATION)

Quick Summary: The Advance Communication tool provides a method for persons or parents/guardians to communicate in advance and in writing to potential future providers of crisis support or intervention. It is not a Safety Plan for use in the home or community. It paves the way for future episodes of crisis support or intervention to more closely meet the needs of the person/family. It is a way for a person/family to share information with, and make requests to, a future treatment provider ahead of time. In essence, it communicates the following: "If you see me/my child in crisis, here is how I/we would like to be treated, here are the types of interventions I/we prefer, and here is

what is important to me/our family." This is a tool that promotes the consideration of personal/family voice and choice and the practice of Shared Decision-Making.¹ The Advance Communication is not a legal document; the treatment provider is not bound by the requests made on the form, but its use can simplify communication and allow those requests to be considered.

Description: The Advance Communication is two-sided. One side is intended for young adults (though it may be suitable for some children), and the other side is intended for parents and guardians. Any or all of the sections can be completed as the person completing the form chooses.

When to use it: Many persons/families will not find it necessary to complete an Advance Communication because they don't anticipate using crisis services in the future. Some persons/families have not found it problematic to communicate their needs at the time of the crisis event. In general, the Advance Communication becomes useful when a person/family has experienced crisis episodes in the past and expects that there will be more, or when communication is difficult during a crisis. Persons/families that have been reluctant to use ESP/Mobile Crisis Intervention (MCI) services might be more interested in trying the service if they can share an Advance Communication ahead of time.

The Advance Communication is generally best completed when a parent/guardian feels able to sort out and summarize preferences and previous experiences—most likely this is during a low crisis period. In a crisis, it can be difficult to communicate or think about choices. The Advance Communication gives a child, parent/guardian, or young adult a chance to think about likely crisis scenarios, how they would like that future intervention to unfold, and what they would like those who provide future crisis support or intervention to know.

COMPONENT III: SUPPLEMENTS TO THE ADVANCE COMMUNICATION OR SAFETY PLAN

Quick Summary: These are pre-formatted supplemental sheets that persons/families may find useful in organizing and efficiently communicating information that is commonly sought by treatment providers. Children, parent(s)/guardian(s), and young adult could choose to complete any or all of the sections and add any or all of the sheets to their Safety Plan or Advance Communication.

Description: There are four topic-specific, one-page sheets:

- Personal Demographic Information
- Summary of Prior Treatment
- Summary of Medical Information
- Summary of Current Services, School, and Work

When to use it: The various supplements may become useful to a person/family when there is a need to communicate demographic and current/historic treatment information—particularly when there is a considerable volume to share. Rather than having to remember it all and repeat it each

¹ For an introduction to "Shared Decision-Making" in mental health care, go to <http://www.samhsa.gov/consumersurvivor/shared.asp>.

time, the information can be readily communicated in writing to a provider either in advance or at the time of an intervention.

3: TIPS TO GUIDE PERSONS/FAMILIES IN THE DEVELOPMENT OF A SAFETY PLAN

PROVIDER/TEAM CONSIDERATIONS

If the Safety Plan achieves its promise of being person/family-centered, the content will be a good reflection of where the person/family is right now and where they want and are ready to be heading. The Safety Plan should show:

- where the family is in its “journey”; and
- where the individual is in his/her personal recovery “journey.”

Consistent with:

- Stage of readiness for change/degree of insight into behavior
- Family's self-defined priorities
- Natural ecology and culture
- Degree of comfort and success that has been achieved in managing crisis situations
- Family's interest in use of formal systems
- Family's interest in use of natural supports

Develop a Safety Plan that is sensitive to timing and circumstances for the child/family. It's important to recognize what the family feels is hierarchically important at the time you are assisting in safety planning.

- If the family is focused on behaviors in the school and they are not readily engaging in conversation about behaviors at home, it is clear where the family is poised for action that can lead to real change. Respect that school behavior is the family priority, even if in their shoes you would prioritize behaviors at home, and develop a Safety Plan around that priority. As school-based behaviors improve, the family may have increasing awareness of, less tolerance for, and be ready to take action on home-based behaviors.
- If the family is still managing the acute phase of a crisis (for example, hospitalizing a child), it may be disruptive or off-putting to ask the family to engage in developing a comprehensive Safety Plan. Focus on what is meaningful for the family now. The process may be brief and succinct in this instance. It may just involve identifying contact information and when to call for outside assistance. A more comprehensive Safety Plan may be developed at a later point.

Forcing a Safety Plan on a family when they are not ready or interested is, at a minimum, a waste of time and paper. More importantly, it is a signal that we as providers are off-track in delivering family-centered interventions. It impacts the treatment relationship and the opportunity for real change.

The Safety Plan cannot be what you as the provider would do in the family's shoes, but what the family members can commit to trying or doing. Culture, beliefs, readiness for change,

strengths, barriers, and prior experience will all come into play in the event of a crisis and must be taken into account when creating a usable Safety Plan. For example:

- If a family's culture is such that they have low to no belief that formal systems or services such as counselors, therapists, social workers or similar providers or agencies can help their family in the event of a crisis or otherwise, the likelihood that they will follow the instructions to call their provider's crisis line is low. Having it on the family's Safety Plan is not helpful if this is not something they are going to do.
- If a family's culture includes an aversion to police and law enforcement, adding instructions on the family's Safety Plan to call the police in the event of a crisis will likely not be followed.

The family may not be forthcoming with this information initially, so the provider might use scaling or other methods to determine how likely a family is to follow a given portion of the Safety Plan. For example, you might ask, "How likely are you to call the police in the event that (identified client) threatens to hurt you?" Depending on the answer, other measures may have to be substituted in order to have a Safety Plan that the family is committed to using and that also keeps them safe.

Plans that are filled with things that you as the provider would do may give you a false sense of confidence that the risk of harm is reduced. If the family won't do it in a crisis, it does not reduce risk of harm and it should not be on the Safety Plan.

Depending on the age, maturity level, and amount of insight and vested interest in treatment, the persons whose actions are the focus of the Safety Plan will differ.

- In some cases the child does not agree that he/she has behaviors that are unsafe or that there are things that he/she does that are putting himself/herself and his/her family at risk. In these situations, most or all of the interventions in the Safety Plan will be carried out by the family/caregivers who are willing to take action. The child may not even be aware of the strategies parent(s)/guardian(s) are planning to use.
- In some cases the focus of the Safety Plan is solely on the goals and actions of the child.
- If the child is willing to be an active participant, it is important to include the child and give him/her a customized role in the Safety Plan.

It diminishes the authority of the parent/guardian and the credibility of the Safety Plan to have it filled with actions that a child (or anyone else) is unlikely to take. Attempts to implement this kind of Safety Plan may actually escalate risk in the household rather than reduce risk or unwanted behaviors. That some Safety Plans focus solely on actions of the parent(s) does not in any way suggest that they are to blame. They simply are ready for action while their child is not. As they make strategic changes in their behaviors or responses or take other actions, the child may change in the direction of the desired behaviors as well.

A parent/family may be averse to using a parent/family-based Safety Plan or playing a role in their child/teen/young adult's Safety Plan. Ask the reason. Here are some common reservations and strategies:

For the family who says, "It just won't work":

I realize you have not bought into this idea, but based on what you have told me, it seems you are not happy with the way things are going now—so what have we got to lose in trying this?

Find out what they want and make the connection between their goal for safety (even if it is small and doesn't capture the whole issue, i.e., *to avoid having to leave work to meet the police at my house*) and how their intervention as a parent can make that happen.

For the overwhelmed parent/family:

I see you are investing a lot of time, energy, and stress into the current cycle/system/process that happens during a crisis (for example, going to the emergency room, dealing with police, calling the crisis line, screaming it out with the youth). How about we make a plan where you can invest just a small portion of that energy into some interventions that are more likely to work? Then you can have more time to yourself!

For the parent/family of an older, almost independent teen or a young adult who sees their role as parents/family as reduced to observer vs. intervener:

There are so many factors regarding John's crisis episodes that are out of your control. So, let's focus only on those things that happen before and during a crisis event that you can control as the parent (i.e., your reaction to John's behavior, your decision to have Aunt Laura come over to talk to him when he is starting to get escalated, your leaving the house to walk in the back yard or around the block when he calls you a name to try to engage you in an argument). We can develop a plan to give you to make sure you do just these few things. You can feel good knowing that you did your part, even if John does not do his part of the plan.

Besides considering whether the identified client will be involved in developing the Safety Plan, determining who else in the household will be involved is also important. To increase whole family "buy-in" of the Safety Plan and true family ownership, it can make sense for non-primary adult caregivers who live in the home to have an active role, even if it is just "to gather the other children in the home and take them outside to the yard or the park" when the identified client's behaviors begin to escalate to a certain risk level, or "to take the babies into their mother's bedroom and put on cartoons for them" when the identified client begins yelling and pounding on the walls throughout the house. This is not only a way to make all adult members of the household feel that they have a say in their family's Safety Plan, but it also helps the primary caregiver by removing the 'audience' of other children or other family members so that the primary caregiver can concentrate on implementing the appropriate interventions with the identified client to stop the crisis from escalating. Younger siblings may also want to participate, even if it is just to "quietly go into your bedroom, close the door, and work on your puzzle" when they hear the identified client start yelling. Usually everyone in the household wants the identified client's behaviors to stop, so if they are willing to have an active role in helping to do so, this may renew the confidence and energy of even the most crisis-oriented families who have been dealing with these behaviors for a very long time.

SETTING THE STAGE FOR SAFETY PLANNING

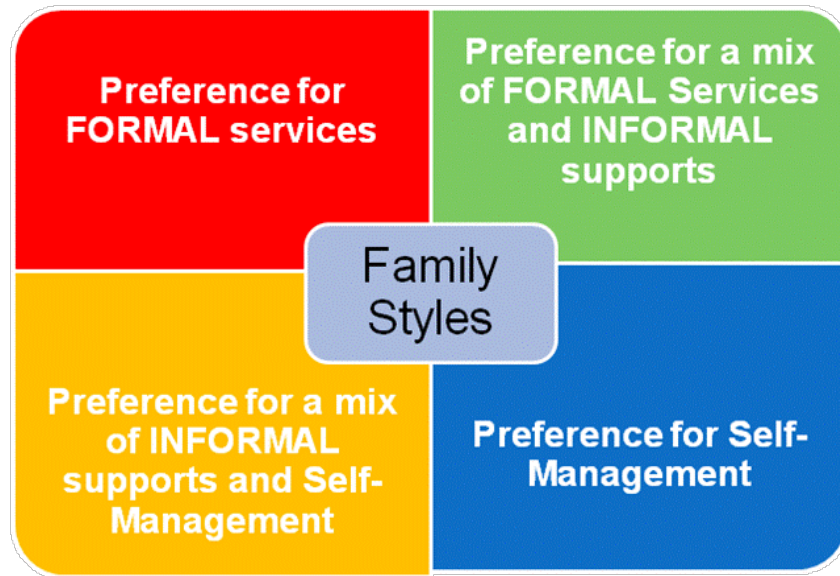
Introduce the Safety Plan. Talk to the family about developing a Safety Plan and explain that it is meant to be a tool for the family to prevent or better manage the type of crises/risk situations they have identified. The Safety Plan consolidates information on who to call and what a person/family intends to do when crisis situations arise. Show them the template that they can use to develop the Safety Plan – one side with preformatted sections, the other side a blank space for the family to develop something unique. If the child/family is not comfortable with a paper/pencil approach, ask if there are other formats that would be useful. Remember, if the family throws it away, files it away, or otherwise will not think of it once you leave, the exercise is useless.

Figure out who wants to play an active role in developing the Safety Plan.

- How involved should the child/young adult be? Roll with resistance and acknowledge that it is his or her choice.
- How involved should the parent(s)/guardian(s) be? Is the desired outcome enhanced or diminished in the eyes of the child, young adult or family by a Safety Plan that lists actions by others?
- Don't drag anyone to the table. A power struggle is not productive. This is a living, evolving Safety Plan, and there will be future opportunities to engage those family members who may be disinterested now.
- If the whole family is resistant, figure out what it means. Realign the planning process so that it is a match to what the family is ready for now. Ask the family what is not working about this process?
- If a family is not ready for much, the Safety Plan should not be much. The choice is theirs to make. Build an authentic relationship that respects where they are now. When they are ready for more, you will be ready to help them.

Get a sense of general preferences when it comes to using resources—does the family lean towards those that are formal, natural, or self-managed?

Often in the field of mental health, providers are oriented towards the use of formal services to solve mental health problems. However, families have unique preferences when it comes to managing a crisis and your understanding of their culture in this regard is important since an authentic Safety Plan will generally reflect those preferences. The following chart shows a sample of four Family Styles for managing a crisis situation:



Lightly exploring lesser-used resources may plant seeds and help a family begin to broaden strategies, but if the family feels pushed into something unwanted the Safety Plan becomes less useful.

Understanding the family's history of planning and managing crises is important in creating a Safety Plan that the family will use. Without gathering this information, the provider runs the risk of asking the family to do the exact same thing that they have been doing for years, which may have not been successful for them in the past. Talking with the person/family about what has worked and what has not worked is vital in eliminating unsuccessful elements and incorporating successful ones. It is helpful if a person/family can figure out why a certain element of their plan did not work in the past. Engaging the family in gathering this information can make the difference between creating a Safety Plan that is followed by the family versus one that is simply filed away with all of the other paperwork provided by helping systems.

In each family, the words like "crisis," "safety," or "risk" mean different things. It is important to use the family's own definition of what they consider to be placing them at risk. You may be surprised when it is not what you assumed it to be. Family identification of the crisis or risk is the first step to helping the family develop a Safety Plan that they can actually own and will want to use.

Sample questions to elicit what the family sees as the crisis or risk:

- *When you think of what has happened in the past or what might happen in the future, what concerns you the most?*
- *When does something become a "crisis" to you?*
- *What is the risk that you are trying to prevent?*
- *What is the most dangerous thing you fear could happen?*
- *What is the most difficult part of getting through a crisis?*

Sample responses:

- *(Child) The risk is when I get really upset I kick and hit and I could hurt someone in my family because when I am that mad I'm not thinking straight.*
- *(Parent) The crisis is that my child won't go to sleep or stay in bed at night.*
- *(Parent) The risk is that I will lose my job if I take another unplanned day off.*
- *(Parent) It is a crisis to me when I become frustrated or helpless—when the situation no longer seems to be within my ability to manage it.*
- *(Young adult) The risk is when I am feeling sad and lonely and then start to drink. Then I start to feel like killing myself.*
- *(Parent and child) The risk is (child) will violate his probation by being aggressive.*
- *(Parent) I feel capable of helping my son when he is in crisis. But, what is most difficult is that I have two other children who are toddlers and they cannot be left unattended while I am helping my son.*

COMPLETION OF THE SAFETY PLAN TEMPLATE

There are two sides to the Safety Plan template, and generally only one side is completed. As mentioned earlier, *for many persons/families, such as those experiencing a first or infrequent crisis episode or who are addressing behaviors in the home that are unlikely to rise to the level of emergency services, this will usually be the one and only crisis planning tool that is used.*

For families who receive CSA, IHT, or other treatment services, this one-page form is used to develop the initial Safety Plan that is completed during or within 24 hours of the first contact. As treatment unfolds and a more comprehensive plan is developed it can be used as a supplement to this core document. Simply use the blank side of the Safety Plan template as the cover sheet for the more comprehensive document. That way, routing information will still be noted at the base of the plan.

The formatted side of the Safety Plan has three sections. A description of each section and sample questions to guide completion follows:

- 1. Contacts and Resources:** A place to list the names and numbers that are most useful to the person/family in a crisis. It is not the place for the provider to list names and numbers the provider thinks are important (although the provider certainly can suggest them and provide resources for consideration). It is the place for names and numbers that the person/family thinks they would actually use.

Sample Questions:

- *Is there anyone you feel you must notify if there is a crisis situation?*
- *Are there any people who you think can help calm the situation (family, friends, teachers, neighbors, clergy)?*

- *Are there any support persons or professionals you might want to contact (current treatment provider, CSA team member, MCI team, helpline, Parent Professional Advocacy League (PPAL), urgent treatment center, hospital emergency department, poison control, 911)?*
- *Is there anyone you might want to call to help with managing other priorities while you are focusing on the crisis (such as child care, pets, closing up the house, transportation, covering a shift, etc.)?*
- *If you could call/talk to anyone to calm you down when you (insert name of crisis/risk), who would it be?*

2. Goals: The goal of the Safety Plan may directly or indirectly align with the crises or risks that the family identifies. For example, the goal may be about preventing behavior via action the child will take (i.e., "My goal is to not hurt anyone.") or about minimizing harm from the behavior through actions that others will take (i.e., "Our goal is to make sure siblings don't get hurt.").

Sample Questions:

- *What do you want the plan to accomplish for you next time?*
- *What would be a measure of success in managing a crisis episode?*
- *If you don't feel you can realistically prevent a crisis, what could you do? How could you take a step towards your long-term goal?*
- *What would you like to accomplish as a parent/guardian in managing the crisis?*
- *What could be done to reduce the chance of harm or injury?*

Sample Goals:

- *(Parent) I want to know what is available, who to call, and what to say.*
- *(Youth) I want to tell someone sooner when I am thinking of killing myself.*
- *(Parent) I want my other children to have a plan of what to do and where to go if "Andrea" gets violent.*
- *(Parent) I want to effectively communicate the needs of my son and my family when I call the MCI team so that they know it is an urgent situation.*
- *(Family) 1. Every family member will perform his/her job when there is a crisis situation; 2. We want to resolve the crisis without having to call the crisis team or 911.*
- *(Young Adult) 1. I want to keep my job; 2. I want to stay out of the hospital.*
- *(Parents) 1. We want to work with each other as parents so that we present a united front; 2. We want to try techniques that we have been working on in treatment sessions.*

- 3. Actions:** Actions should align with goals, and be consistent with investment in the Plan and the stage of readiness for change.

Sample Questions:

- *What actions could child take to achieve the crisis goal?*
- *What actions could parent/guardian take to achieve the crisis goal?*
- *What actions could others take to help achieve the goal?*
- *What has worked the best in the past that you think you could use again?*
- *What are the ways you think you could calm down the situation?*
- *What can you envision yourself actually doing?*

Sample Responses:

- *(Child) When I can tell in my chest that I am getting upset I will say I need to take a break and go to my beanbag chair until I think I am calmer.*
- *(Parents) We will: 1. Pay attention to our own reactions and emotions to our child's behavior; 2. Give (child) space and time to calm down without intervening; 3. Reach agreement about what actions we will take; 4. Wait until the crisis is really over to discuss any consequences.*
- *(Parent) When I call the MCI team I will be clear about what I need: "My son has MassHealth. We have a Safety Plan on file with your team. We have tried to manage the crisis, but he has not calmed down. These are the concerning behaviors:_____. This is the assistance that I would like:_____."*
- *(Family) 1. Remind ourselves we don't want to get the police or crisis team involved; 2. Coach each other that "we can solve it"; 3. Give each other space to calm down before talking about it; 4. Use identified "sleepover" options when tension is starting to build (i.e. agreed upon informal overnight respite options).*
- *(Parents) 1. We will remove existing gun and not keep any guns in our home or grandpa's home; 2. Buy alcohol in smaller quantities when we know the adults are going to use it, so that it is not stored in the home; 3. Enroll kids in afterschool activity of their choice so they are home alone less of the time; 4. Do phone check-in with kids at 4:30 p.m. each school day.*
- *(Teen or Young Adult) 1. Won't drive if I have been using alcohol/drugs; 2. Will program number of who to call for transportation into my phone before going out; 3. Will carry money for a cab; 4. Will program national teen hotline into phone.*

TESTING "USABILITY"

Sample questions to test usability of the Safety Plan:

- *Picture a crisis unfolding. Are all of the right names and numbers at your fingertips?*
- *Do the goals listed match your priorities in a crisis situation?*
 - o *If not, let's modify.*
- *Can you see yourself taking the actions that you have identified?*
 - o *If not, what seems more doable that takes you in the direction of your overall goal?*
- *On a scale of 1-10, how likely is it that you will use this plan?*
- *On a scale of 1-10, how confident are you that the plan will be useful during a crisis?*
- *On a scale of 1-10, how confident are you that you can manage any future crisis with no one getting hurt?*

Rather than using a scale of 1-10, you can substitute High, Medium, Low or No Confidence, or other measurement or language that seems useful to the family.

Is the Safety Plan focused on too much too soon? Behavior change can be difficult, and it is often unrealistic to expect all unwanted behavior to cease. It is more realistic to move in the direction of the long-term goal. Think of it as going from "A to D" instead of "A to Z." So instead of a plan to prevent or stop the behavior, the focus of the Safety Plan may be to:

- reduce harm from the behavior;
- take action after the behavior happens if prevention is not realistic at this time;
- change how others in the home react to the behavior;
- reduce exposure to circumstances that precipitate behavior (i.e., increase structure or supervision or reduce access); or
- build on strengths and engage in activities of interest that change the venue or focus during times of peak difficulty.

Example: If a teenager/young adult won't stop using substances or doesn't see usage as a problem, consider an array of less "head-on" approaches:

- Acknowledge that the decision to stop is his/hers, but with continued use comes his/her responsibility for any fallout: legal, losing job, being kicked off a team, poor grades
- Harm reduction
 - o Strategies to preserve what is meaningful—job, progress toward graduation, sports team
 - o Agreement to not drive if under the influence
 - o Being selective about who he/she associates with
 - o Using sanitary equipment (needles, etc.)
- Reduce free time—fill with things that are purposeful, meaningful to teenager/young adult
- Saving money towards a new, meaningful purchase
- Leave a low-pressure door open for supporting change/seeking treatment down the road

As the teenager/young adult's priorities change, so might the desire, time, or opportunity to use the substances.

ADVANCE COMMUNICATION TO TREATMENT PROVIDER (ADVANCE COMMUNICATION) TEMPLATE

Some families have developed a clear sense of what is useful to them in a crisis situation. They have learned through experience what calms and what escalates. They have preferences for treatment facilities based on location, program style, effectiveness of previous treatment, or other reasons that are meaningful to them. As parents/children/young adults gain insight and clarity on some of these points, they might find it useful to complete an Advance Communication. The Advance Communication is not a Safety Plan. As mentioned earlier, it is *a vehicle for sharing in advance person/family-specific information, to indicate preferences, what has worked or not worked,*

and any other information or request that is germane to the person or parent/guardian. This is a tool that promotes the consideration of personal/family voice and choice and the practice of "shared decision-making." The Advance Communication is not a legal document, and the treatment provider is not bound by the requests made on the form, but its use can simplify communication and allow those requests to be considered.

For those persons/families who use crisis services but have not been willing to develop a Safety Plan, see if they are interested in completing an Advance Communication.

There are instances when a family or individual thinks that "a Safety Plan won't work," when they see the process or document as "stupid/lame/useless," or when they otherwise do not want to engage in safety planning. But the same person/family might see value in writing an Advance Communication so that in the event of another crisis episode, they are "treated more fairly," "get what they need," or "don't have to repeat everything over again." For those persons, extracting information from the Advance Communication and offering it for use in a Safety Plan, in the family's own language, can be useful. For example:

*"I noticed, Jamie, in your **Advance Communication** it says that you calm down fast once you have a family member join you at the crisis center. Should we develop a **Safety Plan** then for you to call (family member) so that you can talk to them on the phone or they can come to see you next time you feel like you are going to escalate to a crisis? (Since Jamie has revealed that his goal right now is to not to do anything that will cause him to have to go to the crisis center or emergency room, he now may have a better sense of how a Safety Plan would be useful.)*

How a person or parent/guardian can use the Advance Communication:

- This is a two-sided template, and most often only one side would be completed. (If it makes sense to the family, they could complete both.)
- One side of the Advance Communication is formatted in first-person and is completed by the child or young adult who is the identified client. The other is formatted to be completed by the parent(s) or guardian(s).
- The person completing the form can choose to fill in information on any or all of the sections based on what they would like a future service provider to know.
- Like the Safety Plan, a person or parent/guardian can update the Advance Communication as it is useful to them to do so.

While a provider can certainly offer assistance in completing the Advance Communication, it is important to keep in mind the purpose of the form and to allow voice and choices to be clearly stated.

Sample Responses by a Young Adult

What I experience when I am in crisis:

- *I am very anxious and afraid for my safety especially if I am left alone.*

- *I shut down, and I find it almost impossible to talk.*

My priorities in a crisis:

- *It is important to me to stay in school. I have missed a lot of classes because of my anxiety disorder.*
- *I want to stay out of the hospital. I have been hospitalized several times before, and it has made me feel worse instead of better.*

What helps me in a crisis:

- *It usually helps when I can talk to my mom, and if she isn't with me her number is X.*
- *Give me time to calm down before you start asking questions.*
- *Let me stay in my own clothes and keep my things with me.*

Treatment I prefer:

- *X medication gives me the fastest relief when I am anxious.*
- *If I have to be hospitalized I want it to be nearby so my family can visit.*
- *X program was really helpful last time, and I want to go there if I am admitted.*
- *I have family who can stay with me for a while until I am better so I don't have to be in the hospital.*

Treatment I prefer NOT to receive:

- *I am been abused in the past and have a fear of being restrained.*
- *I do not want to go to X facility because of (distance, prior experience, schedule, rules).*
- *I don't want X medication because it makes me nauseous.*

If I am admitted to a facility, I need to plan for the following:

- *I have a dog at home. Call my neighbor Katia. She has a key and knows how to care for him. You can tell her where I am being admitted and that I will call as soon as I can.*
- *My rent is due on the 15th of every month, and I need to pay on time or I will lose the apartment.*
- *I need a letter faxed to my boss excusing me from work before my shift starts.*

Additional information or request:

- *If there is a peer specialist available, I would like to talk to him or her.*
- *I am deaf in my left ear and have partial loss in my right ear. I don't want an interpreter, but it helps if you sit on my right side and talk loudly.*
- *Please contact my girlfriend and ask her to come be here with me.*

- *Look at my old files so I don't have to repeat everything.*

Sample Responses by Parent(s)/Guardian(s)

How my/our child looks and acts when in crisis:

- *Lara does not want to be a burden so she often tells the crisis team that she is fine even when she is really upset inside.*
- *Estefan has a hard time calming himself down. Sometimes he cries, and other times he screams and is very angry. He usually feels bad about it later, but in the crisis it seems out of his control to stop it.*
- *Breanna is very clingy and emotional in medical settings especially if she doesn't know the place or the person.*
- *Abdul is usually angry with me if I call the crisis team so it might work better if he can be in a separate space until he is less angry.*

My/our priorities when my/our child is in crisis:

- *Minimize how many people get involved in the situation – we know from experience, the fewer the better.*
- *She is very embarrassed that she has to get help – privacy and discretion are very important to us.*
- *Don't change the medication without talking to me first.*
- *We don't want to put her in a hospital.*

What helps my/our child during crisis support/intervention:

- *Having something to do – listening to music or watching TV while she is waiting.*
- *It is usually difficult for her to open up to men – if a woman is available, it would probably go better.*
- *Talk directly to him instead of to us. He will be 18 later this year and does not want to be treated like a child.*

What helps our family during crisis support/intervention:

- *A lot of times just talking on the phone is very helpful to us—we don't always need or want someone to come out to the home.*
- *We want to be a part of decisions rather than being told what the plan is – we have a lot of experience in knowing what works.*
- *Our other children feel overlooked by the crisis team. If you can take a few minutes to ask them how they are doing or if they have any questions they really appreciate it.*

Treatment I/we prefer for my/our child:

- *We prefer a place where family involvement is allowed and encouraged.*
- *If admitted to a hospital or CBAT, I want to choose one with flexible visiting hours.*
- *We have a lot of family members and friends who will help out at home, and if we can keep him safely in the home, that is our choice.*
- *I only want to get services at X agency/program/hospital.*
- *I want to work with someone who understands trauma.*

Treatment I/we prefer my/our child NOT receive:

- *I don't want her in a program with older kids.*
- *I don't want her to take antipsychotic medications.*
- *I don't want her to get services at X agency/program/hospital.*

If I/we cannot be immediately reached if my/our child is in crisis, please:

- *Call my sister Sylvie at this number, and ask if she can come to be with Luci. Luci is very comfortable with her, and Sylvie can answer a lot of your questions. She spends a lot of time with Luci.*
- *We cannot leave our phone ringers on at work, but you can send me a text message or e-mail at this address: X.*
- *I work in a factory and have breaks at 10, 12 and 2. You can tell the person who answers the phone that it is about Raoul and who I should call. I will get the message on my next break. If it is life threatening, they will get me right away.*

Additional information or request:

- *Juan speaks fluent English, but my English is not very good. I need a Spanish-speaking translator.*
- *If you come to our home, please park on the street in front of the house. I can see you coming from there and can open the door.*
- *If you see Kelly at her school, please talk to Mrs. Juarez in the guidance office. She knows Kelly and me and has been helping Kelly stay in school.*

SUPPLEMENTS TO THE ADVANCE COMMUNICATION OR SAFETY PLAN

The various supplements may become useful to a person/family when they frequently need to communicate demographic and current/historic treatment information. Rather than having to remember it all each time, the information can be communicated in writing to a provider either in advance or at the time of an intervention.

There are four pre-formatted supplement sheets that persons/families may find useful in organizing and efficiently communicating information that is commonly sought by treatment providers.

How the forms are used:

- Children, parent(s)/guardian(s), or young adults can choose to complete any or all of the sections and add any or all of the sheets to the Safety Plan or Advance Communication that is shared with treatment providers.
- Additionally, a child, parent/guardian, or young adult could substitute an alternate document as a supplement.
- If the family/young adult find one or more of the supplements useful, but do not wish to complete a Safety Plan or Advance Communication, that is acceptable—the chosen tools should work for the family and include content that they wish to share with future providers. Over time the person/family might see value in trying the other tools.
- Instead of filing copies of the supplements ahead of time, a person/family may prefer to keep several copies of the supplements on hand to share in the event they are needed.

INDIVIDUALIZED ALTERNATIVES

The Crisis Planning Tools are designed to be flexibly used, but will not meet the needs of everyone. In these instances it is acceptable to develop and use an alternative format or a more comprehensive plan *that works for the person/family*. Examples of an alternate plan:

- The product of more comprehensive safety planning:
 - o Families receiving CSA, IHT or other comprehensive services or treatment may participate in a Functional Behavioral Assessment, or dedicate time and attention to addressing crisis prevention and, as a result, develop a more comprehensive crisis plan.
 - o Some young adults may participate in WRAP training² and, through that process, develop a Wellness Recovery Action Plan, which is a comprehensive, person-centered plan that could stand in the place of the standard plan template.
- Electronic in nature—and kept in cell phone/PDA
- A wallet-sized, laminated card
- In a non-English language
- Pictures rather than words

If a person wishes to share any of these alternative plans with a treatment provider, a copy of the plan can be attached to or described on the blank side of the Safety Plan template with the routing information completed at the bottom of the page.

² Mary Ellen Copeland: Wellness Recovery Action Plan www.mentalhealthrecovery.com

.ROUTING BOXES

At the bottom of each of the templates is a routing box. It is used to communicate information to treatment providers/entities that receive copies of all or part of the Safety Plan and to assure some Safety Plan uniformity so that receiving agencies can appropriately file the Safety Plans.

Developed by: _____ Date Completed ____/____/____ ☐ Initial ☐ Revision Shared With: ☐ _____ ☐ _____ ☐ _____ ☐ _____	This plan is for: _____/_____/_____ Date of Birth First Name Last Name _____ (other information, needs, requests) _____ Printed name of the Parent/Guardian, if applicable ph: _____ _____ Printed name of the Parent/Guardian, if applicable ph: _____
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In addition, in the right-hand side of the footer, the order and number of pages can be documented.

4: SAMPLE PLANS

TYLER: A neighbor has called police several times regarding domestic disturbances when the parents and their 17 year-old son Tyler have been fighting. Tyler and his parents yell, and Tyler breaks things and slams doors. Because Tyler has depression, the officers have either called the MCI team to the house or sent Tyler to the ED. Tyler has tried treatment before and hated it. He is not in school and says he will not get treatment right now. He says he is bored most of the time. The officers indicated that the next time they come to the house they will file charges.

The period of greatest conflict is between 3 and 6 p.m. During that period, things are chaotic and family members are tense, younger siblings get home from school and have homework to do, and the mother arrives home and has to supervise homework and fix dinner. Tyler and his family are in a rut, with a pattern of behaviors and responses that none of them are happy with. Tyler's parents know they cannot force him to get treatment, but they also know he is bored and unhappy. They think they support him in finding things to do that he is good at and enjoys.

Goals: (Tyler and Parents) 1. Focus on the times when things are the worst; 2. Keep police from coming to the house and filing charges.

Actions:

(Family) Remind each other what is at stake—we can figure it out ourselves without getting loud.

(Tyler) Have a plan of something to do outside of the house most days Monday-Friday from 3-6 p.m.:

- YMCA open gym Mondays and Thursdays
- Look for afternoon job
- Library media room open every day
- Can do up to six hours of yard work a week at home for \$10/hr
- Can use car to run family errands when needed (grocery shopping, get gas)

(Parents) Stay out of power struggle, don't make idle threats, back each other--don't add to it by fighting with each other.

(Parents) Tyler can use car on Saturdays when week goes well.

(Parents/Tyler) To get a break, Tyler can spend the night at his friend Jose's house if it is okay with Jose's parents, or at Aunt Sara's two times a week.

(Parents/Tyler) Consider calling Pastor Marshall to help talk it through by phone.

(Parents/Tyler) Consider calling MCI. Can talk by phone, have them come to home or go to MCI office if it feels like the fight is going to get too big to manage.

KIARRA: Nineteen-year-old Kiarra was brought to the ED by police officers. She was intoxicated and saying she wanted to die. Now that she is sober she says she did not mean it, but that people "keep doing [her] wrong." She says she wants to drink less, but doesn't think she is an alcoholic. Kiarra says she lived in numerous foster homes and residential centers until she turned 18. She is

staying with a boyfriend for now but says he gets violent sometimes. She says she does not need treatment, that she was forced to take medications before and that they kept her from thinking clearly.

Kiarra has low trust of the system, and we don't want to turn her off by forcing her into something she isn't ready for. This plan is aimed at engagement, with the hope that she will start to build trust in community resources and that she will connect with supportive people who have had similar experiences. She can call us (MCI team) in the future, and we will let her determine what kind of help she wants.

Goal: Have someone to talk to but not someone who will force me to do anything

Actions:

If I need to get out of the house:

- I can call my uncle in New Hampshire. He will come get me if he can.
- Call domestic violence support line
- Emergency shelter options

Can try out any of these options to see if I find them helpful:

- PAL Young Adult Support Group Wednesdays from 7-9 p.m., can walk-in
- National teen hotline if I'm feeling suicidal or just to talk
- Transformation Center Young Adult Advisory Council meetings to talk to others with similar experiences
- Can call MCI line and see if there is someone to talk to. I don't have to be seen, but can be if I want to. I can go to office or they can meet me at home.

JACKSON: Jackson is seven years old, and he lives with his dad and five year old sister. Jackson has times when he does really well and is a lot of fun to be around, but also times when he gets really angry and has major outbursts that can include hitting his dad and sister, throwing things, punching walls, knocking over tables, etc. His dad says by the time he figures out that it is going to be a big outburst, Jackson is "too far along" and he hasn't been able to calm him down, and he has had to call the police on two occasions. During the crisis intervention Jackson was hard to engage. He was being silly, coming in and out of the room, and could not pay attention to developing the Safety Plan. His dad and the crisis team agreed that the plan would focus on actions that he (Dad) will take and that he will explain his plans to Jackson when he is interested and paying attention.

Goal: (Dad) Notice when Jackson's physical behavior is getting worse and use outside help sooner.

Actions:

If he gives mean looks, slams doors, stomps loudly—

- Give calm reminders
- Remind him he "knows how to keep it together"
- Help him find an acceptable activity

If he threatens to hit or hurt or if he is starting to throw things around—

- Give a short and clear warning

If the warning doesn't work—use a brief timeout

- Tell him to wait in his room while I (Dad)
 - o Calm down, or
 - o Call a support person, or
 - o Call team member for coaching
- Ask sister to play in a different space

If he tries to hurt/hurts himself or someone else or damages/destroys property—

- Try an extended timeout
- Call for in-home support
- Call for MCI
- Arrange a caregiver for sister

SAMPLES OF TEMPLATE DOCUMENTS

Sample uses of the Safety Plan and Advance Communication templates are on the pages that follow, but by no means do the samples reflect all of the ways individuals and families might choose to use the forms.

Contacts and Resources

Pastor Marshall/friend of family # <u>617-111-1111</u> _Susan/babysitter_ # <u>617-111-1111</u> _MCI team_ # <u>617-111-1111</u> Name/role _____ phone _____	Aunt Sara _____ # <u>617-111-1111</u> Jose/Friend _____ # <u>617-111-1111</u> _____ # _____ Name/role _____ phone _____
---	--

Notes: Aunt Sara works Tuesdays and Thursdays—cannot do overnights on those days

Goal of Plan

1. We all agree to focus on improving things during the times of the day/week when things are the worst
2. We want to keep police from coming to the house and charges from being filed by working together

Actions

Whole Family: We will remind each other what is at stake—we know we can figure it out ourselves without getting loud.

Tyler: I will have a plan of something to do outside of the house most days Monday-Friday from 3-6 pm.

Some options:

- *YMCA open gym Mondays and Thursdays
- *Look for afternoon job
- *Library media room open every day
- *Can do up to 6 hours of yard work a week at home for \$10/hr
- *Can use car to run family errands when needed (grocery shopping, get gas)

Parents: Stay out of power struggle, don't make idle threats, back each other--don't add to it by fighting with each other.

Tyler can use car on Saturdays when week goes well.

To get a break, Tyler can spend the night at (friend) Jose's if okay with his parents or Aunt Sara's twice a week.

Parents/Tyler: Consider calling Pastor Marshall to help talk it through by phone if we are having a hard time working it through on our own.

Parents/Tyler: Consider calling MCI. Can talk by phone, have them come to home or going to MCI office if it feels like the fight is going to get too big to manage ourselves

Developed by:

Tyler, Joan S, Lars S.

Date Completed 06/06 / 11 ☒ Initial ☐ Revision

Filed With:

☒ _North MCI Team_

☐ _____

☐ _____

☐ _____

This plan is for:

01/01/1994 Tyler _____ Sample _____

Date of Birth First Name Last Name

Lars B. is legally blind

(other information, needs, requests)

Joan S _____ ph: _____ ph: _____

Parent/Guardian

Lars S _____ ph: _____ ph: _____

Parent/Guardian

Miguel was not interested in completing a written safety plan—he says he would not keep it around where other people might see it. He has not told very many people that he has had suicidal thoughts.

He did choose, however, to add a new contact to his cell phone called "Information." He listed names and numbers of three people he could call if he is "feeling stressed" and wants to talk to somebody.

He also listed the number for the national suicide hotline and the MCI team.

Developed by: <u>Summarized by J. Rodriguez, MCI team</u>	This plan is for: <u>01 / 01 / 1991</u> <u>Miguel</u> <u>Sample</u>
Date Completed <u>06 / 06 / 11</u> ☒ Initial ☐	Date of Birth <u>01 / 01 / 1991</u> First Name <u>Miguel</u> Last Name <u>Sample</u>
Revision	<u>Miguel does not have contact with his parents. He is an adult and does not have a guardian</u>
Filed With:	<u>(other information, needs, requests)</u>
☒ <u>MCI Team</u>	_____ ph: _____ ph: _____
☐	Parent/Guardian
☐	_____ ph: _____ ph: _____
☐	Parent/Guardian

<u>Contacts and Resources</u>			
_Best Friend/Support Person _ # <u>617-111-1111</u> _	Team daytime number _____ # <u>617-111-1111</u> _____		
_Lola/babysitter _____ # <u>617-111-1111</u> _	Team 24/7 on-call pager _____ # <u>617-111-1111</u> _____		
_MCI team _____ # <u>617-111-1111</u> _____	_____ # _____		
Name/role phone	Name/role phone		
<u>Notes:</u>			

Goal of Plan
I (Dad) want to Notice when Jackson's physical behavior is getting worse, try new techniques, and use outside help sooner.

<u>IF THIS HAPPENS</u>	<u>Actions</u>
If he gives mean looks, slams doors, stomps loudly—	<u>TRY THIS:</u> Give calm reminders. Remind him he "knows how to keep it together". Help him find an acceptable activity.
If he threatens to hit or hurt or throws things around—	Give a short and clear warning.
If the warning doesn't work—use a brief timeout	Tell him to wait in his room while I (Dad) *Calm down or Call a support person *Call team member for coaching Ask (sister) to play in a different space
If he hurt himself or someone else or damages property—	Try an extended timeout - Call for in-home support by team - Call for MCI - Arrange a caregiver for (sister)

.....

Attached to this document is a functional behavioral assessment and plan that was developed by the ICC Care Planning Team.

In addition, an Advance Communication to Treatment Provider is attached. It was completed by Estaban's mother, Mrs. Luciana S.

Developed by:
FBA completed by ICC Care Planning Team

Date Completed 06/06/11 ☒ Initial ☐

Revision

Filed With:

☒ MCI Team

☐

☐

☐

This plan is for:

01/01/1991 Estaban Sample

Date of Birth First Name Last Name

Estaban's father, Luis requires a Spanish Language interpreter

(other information, needs, requests)

Luciana S ph: ph:

Parent/Guardian

Luis S ph: ph:

Parent/Guardian

Advance Communication to Treatment Provider

What I experience when I am in crisis

The problem is usually that I have been angry or feeling sorry for myself and I start drinking. Then I start thinking about killing myself. When people try to help me, I shut down at first—it isn't personal. I just need time to get my words together.

My priorities in a crisis

STAYING OUT OF THE HOSPITAL! I can pull it back together pretty quickly and I know the point when I need to call crisis. Also, I just started a new job that I really like and I cannot miss any shifts for the first three months or I will be fired.

What helps me in a crisis

Give me some space and then I will be ready to talk. Don't just come in asking all of your questions all at once. I want to keep my cell phone with me so I can call a friend or my aunt at some point. I am not going to go into details about the abuse—look at the old files if you want to know, but don't ask me. It is in the past and I am done talking about it.

Treatment I prefer (specific programs, medications, types of intervention, alternatives to hospitalization, involvement of friends and family)

I am done going to treatment. Maybe someday, but not now. I am trying it on my own and am doing ok so far. My focus is my career and my friends and enjoying the GOOD instead of talking about the BAD. I can use crisis if I slip.

Treatment I prefer NOT to receive

NO MEDICATIONS.

If I am admitted to a facility, I need to plan for the following (pet, child, housing, car, job, school, etc)
I SHOULDN'T be admitted anywhere, but IF I EVER AM, call my aunt Jasmine at ###. She has a key and will pick up my dog and watch my place.

Additional information, needs or requests

Do not call my mother—she is not in my life anymore and I do not want her to have any information.

Developed by: Jasmine Sample

Date Completed 07/07/11 ☒ Initial ☐ Revision

Filed With:

- ☒ MCI Team
☐
☐
☐

This Advance Communication is for (person who will be receiving the crisis service):

01/01/1992 Jasmine Sample

Date of Birth First Name Last Name

I have diabetes and will have to check my levels every 4 hours
(other information, needs, requests, accommodations)

N/A ph: ph:

Parent/Guardian

ph: ph:

Parent/Guardian

Advance Communication to Treatment Provider

How my/our child looks and acts when in crisis

Lara does not want to be a burden so she often tells the crisis team that she is fine even when she is really upset inside and is having thoughts of hurting herself.

My/our priorities when my/our child is in crisis

She is very embarrassed that she has to get help—privacy and discretion are very important to us.

What helps my/our child during crisis support/intervention

1. It is usually difficult for her to open up to men—if a woman is available, it would probably go better.
2. She may want one of us to stay with her while she is being interviewed. Please respect her wishes.
3. She carries a sketchpad and pen and uses it when she is upset. Please let her keep it with her.

What helps my/our family during crisis support/intervention

1. We want to be a part of decisions rather than being told what the plan is—we have a lot of experience in knowing what works.
2. Our other children feel overlooked by the crisis team. They are scared for their sister. If you can take a few minutes to ask them how they are doing or if they have questions they really appreciate it.

Treatment I/we prefer for my/our child

1. We have a lot of family members and friends who will help out at home and if we can keep her safely in the home, that is our choice.
2. We only want referrals to providers that are experts in trauma and will tell us about their trauma training and experience.

Treatment I/we prefer my/our child NOT receive

Anything that is overnight—we do not think she could bear it and she has been very upset when crisis staff have talked to her about it before. Unless it is a life or death situation, we will keep her at home.

If I/we cannot be immediately reached if child is in crisis, please:

If the crisis is at school, talk to Mrs. Washington, the adjustment counselor. Also, any time you cannot reach us call Aunt Martha at ### to see if she can come to be with Lara

Additional information, needs or requests

If you come to our home, please pull in to the back of the driveway and use the side door

Developed by: John and Jill Sample

Date Completed 01/01/2011 ☒ Initial ☐

Revision

Filed With:

☒ MCI Team

☒ _____

☐ _____

☐ _____

This Advance Communication is for (person who will be receiving the crisis service):

01/01/1996 Lara Sample

Date of Birth

First Name

Last Name

John uses a wheelchair and needs an accessible space to park and meet
(other information, needs, requests, accommodations)

John Sample ph: _____ ph: _____

Parent/Guardian

Jill Sample ph: _____ ph: _____

Parent/Guardian

5: RESOURCE INFORMATION

Mental Health Recovery and WRAP, Mary Ellen Copeland

www.mentalhealthrecovery.com

This website contains an abundance of information about mental health wellness, crisis self-management and recovery. It includes information and resources for persons of all ages, including personal workbooks, e-learning tools, research, and details about creating a personal "Wellness Recovery Action (WRAP) Plan."

Shared Decision-Making in Mental Health

<http://www.samhsa.gov/consumersurvivor/shared.asp>

The SAMHSA website has a number of resources for learning about the application of Shared Decision-Making in mental health care, including tools for providers, webinars, and links to publications.

Stages of Change

James Prochaska, John Norcross and Carlo DiClemente. *Changing for Good*, 1994. Additional information at: www.addictioninfo.org

Foster W. Cline and Jim Fay

Parenting with Love and Logic, 2006

Parenting Teens with Love and Logic, 2006

Love and logic Magic for Early Childhood, 2000

Dr. Ross Green

The Explosive Child, 2009

David A. Jobes

Managing Suicidal Risk: A Collaborative Approach, 2006

William Miller and Stephen Rollnick

Motivational Interviewing: Preparing People for Change, 2002

Scott P. Sells, Ph.D.

Parenting Your Out of Control Teenager: Seven steps to reestablish authority and reclaim love. 2001