The HCP Approach

Holistic Crisis Planning for Children, Youth and Families:
A Companion Guide for Providers

November 2014
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Introduction by Peel Service Collaborative

The Peel Service Collaborative
The Peel Service Collaborative is one of 18 Service Collaboratives across the province of Ontario. Funded by the Ministry of Health and Long-Term Care and supported by five other ministries, the goal of the Peel Service Collaborative is to improve access to and coordination of mental health and addictions services and supports for children and youth in Peel. The Collaborative is comprised of over 60 human and social services agencies representing a diverse range of sectors in Peel (e.g. community crisis, children’s mental health and addictions, education, child protection, youth justice, hospital, settlement, community centres) and includes representatives from the ministry partners as well as service users and family members.

The Intervention
In Peel, the unique profile of diversity in the community has shaped the collaborative’s intervention which has been designed to bridge the gap between formal and informal mental health and addiction support systems in order to better link all children and youth to appropriate community supports and to reduce overuse of the Emergency Department.

There are two key components of the Peel intervention, Building Bridges for Inclusive Care. They are:

1. Holistic Crisis Planning (HCP): A holistic, strength-based and person/family-centred approach to crisis planning for children and youth with mental health and addiction issues and their families. The HCP tools/approach was originally developed by Kappy Madenwald of Madenwald Consulting, LLC Columbus, Ohio for the Massachusetts Executive Office of Health and Human Services and have since been updated and adapted for the local Canadian context.

2. Mental Health First Aid (MHFA): This internationally recognized evidence-based program helps participants recognize mental health issues and provides guidance on referring to community services. The program also helps to combat the stigma that prevents many families from accessing help.

“We must reframe our professional thinking about culture, and we must move from thinking of diversity as a problem to solve to seeing culture as one of our greatest assets for healing and mental wellness. I challenge you to tap into the richness of culture as a resource and to meet people where they are most closely engaged in meeting their needs. I also challenge you to help our children find the strengths, positive emotions, and mental wellness that are part of every culture.” – Terry Cross (MacKean et al, 2012)
Together these two components will:

- Reduce mental health and addiction related stigma
- Increase awareness of existing community mental health and addictions services
- Improve the experience and effectiveness of services provided to children, youth and their families experiencing a mental health and/or addiction crisis
- Support the development of meaningful connections and opportunities for knowledge exchange between service providers and faith/community leaders

The Peel Service Collaborative would like to extend its appreciation and thanks to the forward-thinking staff at the Massachusetts Executive Office of Health and Human Services for their insight to implement an approach to crisis planning that is strength-based and person/family driven (rather than provider driven) and their generosity in sharing the approach and the tools with Peel. In addition, we would like to acknowledge the incredible expertise and support of Kappy Madenwald of Madenwald Consulting, LLC Columbus, Ohio who developed the original crisis planning tools for the Massachusetts Behavioral Health Partnership and who has been instrumental to the modification of these tools for Peel.
Person and Family-Centred Care
The use of a common approach to Holistic Crisis Planning which is strength-based and person and family-centred will support the goal of bridging the gap between formal and informal mental health and addiction support systems. A growing body of evidence supports person and family-centred care in mental health and addictions treatment. The evidence reveals documented benefits at the individual, family and system level, including improved cost-effectiveness of services, earlier access to services, increased child and family satisfaction, amongst many others (MacKean, et al, 2012). A successful shift to a person/family-driven approach to crisis planning would mean that:

- Youth and families are thinking differently about their role in harm reduction and crisis resolution
- Providers are thinking differently about their role in harm reduction and crisis resolution
- The expertise and preferences of the youth and families is driving plan content
- The provider creates the climate that allows these expertise to flourish

The need for this shift has been consistently documented:

- “The dominant system is focused on individual treatment approaches with stringent expectations of privacy. In many cultures, a family level approach is desired or expected; individual, private treatment can be confusing and alienating to families.” (Newberry, 2014)

- “The challenges are for systems to actually share decision making with families, for families to have the confidence to share in making decisions with professionals, and for everyone to feel respected and safe when contributing their views, expertise, and experiences in the decision-making process, both for individual families and for programs and systems as a whole.” (Osher et al, 2011)

- “Through our work with children and youth, we believe that they are more likely to invest and benefit from supports and services when they are included and feel in control of their lives. Young people not only have the right to make decisions about their own health and services, but their participation also furthers their own development and benefits their communities.” (The Office of the Provincial Advocate for Children and Youth, 2013)

Using a client and family-centred approach to crisis planning is also recognized as an effective way to reduce harm and/or mitigate risk (Dept. of Veteran affairs, 2008, SAMHSA 2009, NICE 2011). When youth and families are invited to partner with service providers to create safety plans, this results in plans that are authentic, meaningful, usable and “person/family owned”.

Part One: Introduction to Person and Family-Centered Safety Planning

Who is Safety Planning For?

All children, youth and families experiencing a mental health and/or addiction related issue(s) should be offered the choice of creating a safety plan including:

- All parents, including those with pre-school age children, young adult children, and children who refuse treatment
- Parents who accept mental health services for their child, youth or young adult and those who do not
- Youth who accept mental health and addictions services and those who do not
- Satisfied and unsatisfied users of traditional, non-traditional, formal, and informal community based services and other supports for mental health and addictions issues
- Youth and their families who come in to services voluntarily and involuntarily
- Individuals who understand and accept what is happening to them and those who do not

Once the offer is accepted, all plans are developed in partnership with the child/youth and/or their families and are designed to be useful to the children, youth and families creating them. Service providers can support children, youth and families in developing useful plans by ensuring they:

- Engage children, youth and their families to arrive at a consensus plan
- Create a plan that the children, youth and family will actually use
- Consider timing, readiness, priorities and value as perceived by the youth or family
- Facilitate, guide and empower the youth and family to create a working tool
- Empower youth and families to revisit their plans, adding new successful strategies

Research shows that many people access the mental health and addiction systems through the Emergency Department (ED). This trend tends to be higher for some groups, as noted by the Canadian Mental Health Association: “available evidence indicates that some marginalized groups experience more frequent use of the ED for mental health and addictions-related reasons” (CMHA, 2008). Studies also indicate that racialized populations are more likely to use the Emergency Department as a first point of entry to the mental health system bypassing available crisis-oriented services in the community.

56.8% of Peel residents are visible minorities
The reasons for this are complex and varying, but some possibilities are:

- Wide variances in cultural understandings of mental illness and addictions
- Community-, family- and self-stigma around mental illness
- Fear or wariness of western medical approaches
- Lack of services in familiar and trusted settings
- Lack of awareness of the services available in the community
- Concerns over cultural compatibility

Providers are encouraged to take the time to understand the barriers that families face when they receive care through crisis. Regardless of whether crisis services are received in the ED or the community, a first experience in receiving crisis services can be daunting.

To reduce risk in the current crisis episode, and in any future episodes, it’s essential to:

- Engage persons/families in the process
- Create a comfortable environment
- Achieve a consensus plan for what should happen next

**Person and Family-driven Planning**

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 to accomplish this, 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, efforts have been useless. An inauthentic plan that is largely developed for rather than with a person/family can actually increase risk. To ensure that safety planning is person/family-driven, it’s important to remember the following:

- As with all treatment services, it is important to consider timing, readiness, value as perceived by the recipient, and personal/familial priorities in developing a safety plan.
- 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 willingly seek the same services 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 Chong 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 Chong has insight into the nature of his behaviour, has developed useful coping strategies, and believes those strategies could work.

If in reality Chong 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.

Empowering Youth and Families

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 meet the person/family where they are at and work jointly and collaboratively with them 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 working tool—not just another paper that the family must sign as part of a crisis episode or assessment process.

The provider's role is to facilitate, guide and empower the person/family in the creation of a Safety Plan that reflects what the person/family will actually do in the event of a crisis.

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."
Using what works: For Me, For 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 and circumstances, and human behaviour 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.
Guiding Principles

Holistic Crisis Planning (HCP) is less about the introduction of a new tool(s) and more about implementing a set of principles in how children, youth and their families are meaningfully engaged in the process of crisis planning. This approach draws strongly on the ten principles of the Wraparound Process as outlined by the National Wraparound Initiative. These principles are infused within the HCP approach. They are:

1. **Family Voice and Choice**: Caregivers’ and children and youth’s perspectives are intentionally elicited and prioritized during all phases of the Wraparound process. Planning is grounded in caregivers’ perspectives, and the team strives to provide options and choices such that the plan reflects the caregivers’ values and preferences.

2. **Team Based**: The wraparound team consists of individuals agreed upon by the family and committed to the family through informal, formal, and community support and service relationships.

3. **Use of Natural Supports**: The team actively seeks out and encourages the full participation of team members drawn from family members’ networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

4. **Collaboration**: Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members’ perspectives, mandates, and resources. The plan guides and coordinates each team member’s work towards meeting the team’s goals.

5. **Community-Based**: The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible; and that safely promote child and family integration into home and community life.

6. **Culturally Competent**: The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the child/ youth and family, and their community.

7. **Individualized**: To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

8. **Strengths-Based**: The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

9. **Unconditional**: A wraparound team does not give up on, blame, or reject children, youth, and their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the goals in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer necessary.

10. **Outcome-Based**: The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.
**Stages of Change**

In addition to the ten Guiding Principles that are infused within the HCP Approach, the stages of change or the trans theoretical model underpins this approach. A brief overview of the stages of change model is provided below. For more information, please see the resource list at the end of this guide.

In the trans-theoretical model, change is viewed as a "process involving progress through a series of stages" (Prochaska et al., 2008). These stages are described below:

1. **Pre-contemplation (Not Ready)** - "People are not intending to take action in the foreseeable future, and can be unaware that their behaviour is problematic"

2. **Contemplation (Getting Ready)** - "People are beginning to recognize that their behaviour is problematic, and start to look at the pros and cons of their continued actions"

3. **Preparation (Ready)** - "People are intending to take action in the immediate future, and may begin taking small steps toward behaviour change"

4. **Action** - "People have made specific overt modifications in modifying their problem behaviour or in acquiring new healthy behaviours"

5. **Maintenance** - "People have been able to sustain action for a while and are working to prevent relapse"
Part Two: Overview of Holistic Crisis Planning Tools

The HCP Tools consist of three primary components for use by children, families, and young adults.

1. Safety Plan
2. Advance Communication to Treatment Provider
3. Plan Supplements

There is nothing hierarchical about these tools. They can be used separately or in some combination that is useful to the person/family.

1. Safety Plan
   • This is an **in-community, in-the-moment** tool used by children, young adults, or parents to reduce or manage worsening symptoms, promote wanted behaviours, prevent or reduce the risk of harm or diffuse dangerous situations.

2. Advance Communication
   • 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.

3. Supplement
   • 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. Youth and/or parent(s)/guardian(s), choose to complete any or all of the sections, and add any or all of the sheets to their Safety Plan or Advance Communication.
1. Safety Plan

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 behaviours, 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 person/family chooses, the Safety Plan can be filed with those who might provide crisis support or intervention in the future.
- Sharing the Safety Plan promotes future providers’ awareness of and ability to support the strategies being used by the person/family.

Description:

The Safety Plan template has three formatted options:

1. The first option has a simple structure that captures contacts and resources, the goal of the Safety Plan, and actions to reach the identified goal(s).
2. The second option is an open format.
3. The third option contains a portable credit-card sized plan that can travel with the person.

The person/family builds the Safety Plan on the template that suits them best. Also, in addition to or in replacement of any of the paper versions, the plan can be created directly on a personal mobile device such as a smart phone.

When to use it:

For many persons/families, such as those experiencing a first or infrequent crisis episode or who are addressing behaviours 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.
2. Advance Communication to Treatment Provider  
(Advance Communication)

**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.
- 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.

a) One side is intended for young adults (though it may be suitable for some children)  
   b) The other side is intended for parents and guardians

Any or all of the sections can be completed; it is up to the person filling out the form to decide which sections to complete.

**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. In addition, some persons/families have not encountered difficulties in communicating their needs at the time of a crisis event.
When to use it (continued):

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 community crisis services might be more interested in trying the service if they can file 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 the 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.
3. Supplements to the Advance Communication or Safety Plan

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 can 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:

1. Personal Demographic Information
2. Summary of Prior Treatment
3. Summary of Medical Information
4. 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 time, the information can be readily communicated in writing to a provider either in advance or at the time of an intervention.
Part Three: Engaging Children, Youth and Families in Safety Planning

In this section we will cover how to set the stage for safety planning. It’s important to set the stage because this is the first opportunity to introduce the concept of safety planning and to engage children, youth and families in the process. Safety Planning should feel like an empowering process for children, youth and families.

There are five key steps involved in setting the stage. These steps are not necessarily sequential and should be completed in the order that makes most sense to the family. The steps are

1. Introduce the concept of safety planning
2. Explore who wants to play an active role in developing the plan
3. Get a sense of general preferences when it comes to using resources
   a. Does the family lean towards those that are formal, natural, or self-managed?
4. Understand the family’s history of planning and managing crises
5. Clarify what the words "crisis," "safety," or "risk" mean to the youth or family

Introduce the Concept of Safety Planning

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, one side a blank space for the family to develop something unique and the third side a portable, pocket-sized version.

If the child/family is not comfortable with a paper/pencil approach, ask if there are other formats that would be useful, (such as entering the information into a smart phone). Remember, if the family throws it away, files it away, or otherwise will not think of it once you leave, the exercise is useless.
## Overcoming Reservations

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. It’s important to understand the reasons why parents/families may have reservations, in order to help address these concerns. Examples of potential reservations and strategies to overcome them are listed below.

### Strategies and Tips to Address Potential Reservations

<table>
<thead>
<tr>
<th>Child/youth/family’s Reservations</th>
<th>Strategies to Address these Reservations</th>
<th>Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>It just won’t work</td>
<td>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?</td>
<td>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 home) and how their intervention as a parent can make that happen.</td>
</tr>
<tr>
<td>I/we have too much going on right now to sit and talk about a plan...</td>
<td>I see you are investing a lot of time, energy, and stress into the current cycle that happens during a crisis (for example, going to the emergency room, dealing with police). 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!</td>
<td>For the family who is feeling overwhelmed, acknowledge their experience and connect how the Safety Plan can help reduce stress rather than create more.</td>
</tr>
<tr>
<td>Our child is almost an adult now and doesn’t care about what we say or think. All we can do is watch the crisis unfold.</td>
<td>There are so many factors regarding Jayesh’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 (i.e., your reaction to Jayesh’s behaviour). We can develop a plan around these actions, and you can feel good knowing that you did your part, even if Jayesh does not do his part of the plan.</td>
<td>For the family that feels they have no influence over their child’s behaviours, focus on what is within their control.</td>
</tr>
</tbody>
</table>
Explore Who Wants to Play an Active Role in Developing the Plan

To increase whole family "buy-in" of the Safety Plan and true family ownership and to recognize the importance of extended family for many diverse communities, it can make sense for non-primary adult caregivers who live in the home to have an active role in the Safety Plan. This role could even be something simple like "gathering the other children in the home and taking them outside to the yard or the park" when the identified person's behaviours 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 person begins yelling and pounding on the walls throughout the home.

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 person 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 person start yelling. Usually everyone in the household wants the identified person's behaviours 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 behaviours for a very long time.

The following are questions you can consider when determining who might play an active role in developing the plan:

- How involved should the child/young adult be? Roll with resistance and acknowledge that it is his or her choice.
- In some cases the focus of the Safety Plan is solely on the goals and actions of the child/youth.
- If the child/youth is willing to be an active participant, it is important to give him/her a customized role in the Safety Plan.
- How involved should the parent(s)/guardian(s) and/or extended family 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.
Family Styles for Managing a Crisis

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.

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.

**Example:**
The provider might say:
“Most of us have developed ways of managing challenging situations. Our choices are based on things like how we were raised, personal beliefs, and past experiences. They are also often based on the information we have about what is available, whether we think it would work, and if we think there is a downside to the option.

There is usually more than one way to manage a crisis. When you are in the midst of a crisis situation it is great to be able to choose from the broadest array of “possibilities.” To think through the various options I would like to show you some examples of individual/family “styles” of managing crises. (Describe the four example styles above).

It may be that each of you has different habits and preferred ways of handling situations—that is true in many families. Which of these “styles” best describes how you like to manage challenging or crisis situations?

When you develop a Safety Plan it can be helpful to use strategies that are at least partly/mostly in your “comfort zone” but it is also important that the plan reduces any risk to a safe enough level—maybe by including options that are not part of your usual habit. Which of the styles have you tried in the past?”
Sample Questions to Understand Crisis Management Style Preference

In addition to the questions posed in the previous example, the following questions can be used to assess a person/family’s preference for formal, informal, or self-management styles.

**Formal**

- Have you called your (doctor, psychiatrist, clinician, case manager) in between appointments or after hours because of a crisis situation? If it were up to you, would you call them in the future?
- What do you know about local crisis services? Are there crisis services have you used before? If it were up to you, would you use local crisis services in the future?
- Have you called 911 before because of a mental health crisis? If it were up to you, would you call 911 in the future? Why/why not?
- If the choice was yours, under what circumstances, if any, would you definitely use formal services?
- Is there anything that could help in deciding whether to use any of these services in the future?

**Informal**

- What/who have been your best informal supports (friends, extended family, persons from place of worship, peers, teachers, coaches, blogs, groups, drop-in centers)?
- What offers for support have you received/are you aware of that you haven’t yet tried?
- If the choice was yours, under what circumstances, if any, would you definitely use informal services?
- Is there anything that could help in deciding whether to use any of these services in the future?

**Self**

- What have been your best strategies for resolving crises on your own (within your family)?
- What have been the advantages of managing on your own (within your family)?
- What have been the disadvantages/dangers, if any?
Understand the Person/Family's History of Planning and Managing Crises

Without gathering this information, the provider runs the risk of asking the person/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 person/family in gathering this information can make the difference between creating a Safety Plan that is followed by the person/family versus one that is simply filed away with all of the other paperwork provided by helping systems.

Clarify What the Words "Crisis," "Safety," or "Risk" Mean to the Youth or Family

It is important to use the person/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.

A list of sample questions that can be used to elicit what the family sees as the crisis or risk is provided below. Sample responses are provided on the following page.
Sample responses to questions posed by person/family

These sample responses show how children, youth and families can define crises in a multitude of ways. For this reason, it’s important to understand what crisis means to the child, youth or family you are working with.

Parent

The crisis is that my child won't go to sleep or stay in bed at night.

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.

The risk is that I will lose my job if I take another unplanned day off.

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’m helping my son.

Child/young adult

The risk is when I get really upset I kick and hit and could hurt someone in my family because when I’m that mad I’m not thinking straight.

The risk is when I am feeling sad and lonely and then I start to drink. Then I start to feel like killing myself.

Parent & child

The risk is (child) will violate his probation by being aggressive.
Two Key Factors to Developing an Authentic Safety Plan:

If a Safety Plan is going to actually reduce the risk of harm for a child, youth or family it needs to be authentic to that child, youth or family and represent actions they would actually do in a crisis situation. **Focusing on Family Priorities and Ensuring the Safety Plan is Family-Driven are key to the creation of an authentic plan.**

Focusing on Family Priorities

It's important to recognize what the person/family feels is hierarchically important at the time you are assisting in safety planning. It’s important to meet the person/family where they’re at, and to prioritize planning according to their values. Some examples are described below:

- If the family is focused on behaviours in the school and they are not readily engaging in conversation about behaviours at home, it is clear where the family is poised for action that can lead to real change.
  - Respect that school behaviour is the family priority, even if in their shoes you would prioritize behaviours at home, and develop a Safety Plan around that priority. As school-based behaviours improve, the family may have increasing awareness of, less tolerance for, and be ready to take action on home-based behaviours.

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.

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

The completed Safety Plan should be consistent with:

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

**Age, maturity level, amount of insight and vested interest in treatment will influence Safety Plans.**
Ensuring Safety Planning is Person/Family-Driven

Forcing a Safety Plan on a person/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.

- 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.

- If a person/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 them/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 person/family's Safety Plan is not helpful if this is not something they are going to do.

- If a person/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 person/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.

In some cases the child/youth does not agree that he/she has behaviours that are unsafe or that there are things that he/she does that are putting himself/herself and family at risk. In these situations, most or all of the interventions in the Safety Plan will be carried out by the family/caregivers that are willing to take action.

- The child may not even be aware of the strategies parent(s)/guardian(s) are planning to use. Attempts to implement this kind of Safety Plan may actually escalate risk in the household rather than reduce risk or unwanted behaviours.

- 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 behaviours or responses or take other actions, the child may change in the direction of the desired behaviours as well.
Part Four: Completing the Templates

Completing the Safety Plan Template

There are three options to the Safety Plan template, and generally only one of them is completed. As mentioned earlier, for many persons/families, such as those experiencing a first or infrequent crisis episode or who are addressing behaviours 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 mental health and/or addiction services, this one-page form is used to develop the initial Safety Plan that is completed during or within the first or second 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 first option of the Safety Plan has three sections. A description of each section and sample questions to guide completion follows.

Safety Plan Option One: Formatted Version

Contacts

When I need help, I can call: This is the place to list the names and numbers that are most useful to the person/family in crisis. It is not the place for the provider to list names and numbers the provider thinks are important (although providers 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:

- Are there any people who you think can help calm the situation (family, friends)?
- Is there anyone you feel you must notify if there is a crisis situation?
- If you could call/talk to anyone to calm you down when you (insert name of crisis/risk), who would it be?
- Are there any other support persons or professionals you might want to contact? Are these the same people that you feel would help calm the immediate situation or are there others you have not yet mentioned?
- Is there anyone you might want to call to help with managing other priorities while you are focusing on the crisis (e.g. child care, pets, transportation, covering a shift, etc.)?
Goal Setting

“Goal(s) of this Plan”: This is the place to note down the goal(s) of the Safety Plan. These goals may directly or indirectly align with the crisis or risks that the person or family identifies.

The goal may be about preventing behaviour via action the child will take (i.e., "My goal is to not hurt anyone.") or about minimizing harm from the behaviour through actions that others will take (i.e., "Our goal is to make sure siblings don't get hurt.").

Sample questions to help guide goal setting are provided below, followed by some sample responses. In addition, the chart on the following page provides more in-depth ways to think about goal setting, and to guide your discussion with children, youth and families.

Sample Questions:

1. What do you want the plan to accomplish for you next time?
2. Describe what would happen if a crisis was managed successfully?
3. 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?
4. What would you like to accomplish as a parent/guardian in managing the crisis?
5. What could be done to reduce the chance of harm or injury?

Sample Goals:

<table>
<thead>
<tr>
<th>Parent</th>
<th>Young adult</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I want to effectively communicate the needs of my son and my family when I call the crisis team so that they know it is an urgent situation.</td>
<td>• I want to tell someone sooner when I am thinking of killing myself.</td>
<td>• Every family member will perform his/her job when there is a crisis situation</td>
</tr>
<tr>
<td>• I want my other children to have a plan of what to do and where to go if &quot;Andrea&quot; gets violent.</td>
<td>• I want to keep my job</td>
<td>• We want to resolve the crisis without having to call the crisis team or 911</td>
</tr>
<tr>
<td>• We want to work with each other as parents so that we present a united front;</td>
<td>• I want to stay out of the hospital.</td>
<td></td>
</tr>
<tr>
<td>• We want to try techniques that we have been working on in treatment sessions.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Establishing Safety Plan Goal(s)

The provider might say: “One way to reduce the impact of a crisis situation is to do some planning ahead of time. This means imagining the crisis event itself, but also thinking about anything that contributes to how complicated a crisis can be for you AND the parts that you think you can improve or control. This can help you take some of the “crisis” out of the crisis. Each of you might have different ideas on this and that is okay—you will also have different ideas on how to make the crisis go more smoothly next time.”

<table>
<thead>
<tr>
<th>Some areas to think about when identifying the goal(s) of your Safety planning</th>
<th>How important is this to you right now?</th>
<th>How Controllable does this seem right now?</th>
<th>Where do you want to start and what is the goal? (You don’t have to do it all at once)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention</strong> Things we (child, parent, other) can do to try to keep the crisis from occurring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Resolution</strong> Things we (child, parent, other) can do once the crisis starts to try and resolve the crisis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Safety/supervision</strong> This is about safety for the person in crisis, but also for everyone else that is around.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Communication</strong> Knowing who to ask, what to ask for and how to ask for it, so we get what we need</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Logistics</strong> Knowing where to go, what to take with us and how we are going to get there</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Time efficiency</strong> Finding ways to simplify the process and reduce waiting time and redundancy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Multi-tasking</strong> Figuring out and managing the rest of our responsibilities (work, school, siblings, pets, etc.) while at the same time working on the crisis.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Information</strong> This might include giving or getting information ahead of time or knowing how to give/get information once a crisis happens. Or, it might be about knowing what will happen, what choices there will be, how will decisions be made, who might talk to us, or understanding our rights.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Action Items

“**What I and/or others can do**: Once the person/family have identified some goal(s) they can then be invited to discuss ideas for reaching or getting closer to these goal(s). The actions/strategies should be ones that are likely to be used and that will reduce the risk of harm to a level that is acceptable to the person/family.

**Example:**

The provider might say:

- You have identified a goal or two to focus on in the Safety Plan. Would you like to brainstorm some ideas for reaching or getting closer to the goal?
- No one experiences a crisis or resolves a crisis in exactly the same way. Safety planning evolves over time as you gain more information and build skills in managing the particular types of crises that you/your family are likely to experience. It is important to identify strategies that you are pretty sure you will use and that will reduce the risk of harm to a level that is acceptable to you.

Here are some questions that might help:

- What is the most natural way you can think of to (prevent the problem/make the situation easier/feel better/feel more expert in managing the situation)?
- Can you think of ideas that involve things you already do best or enjoy the most?
- What are the simplest things you could do that everyone would be okay with?
- What are some ideas that interest you that might calm the crisis or improve how it is Managed?
- If you could imagine a new resource, habit or strategy that would make a difference, what would it be? How close could you get to adding it?
- What are the things you can see yourself actually doing next time there is a crisis situation?
- If the safety plan targets the crisis behaviour it is helpful to remember that preventing behaviour is not always possible. If it can’t be prevented:
  - What could make it safer?
  - What is the most useful thing you have done (could do) after the behaviour happens?
  - Are there changes that others in the home could make that would make things better? For example, how they react to the behaviour?
  - What is most likely to help (child) regain his/her control? What is most likely to make the out of control last longer?
  - If you think of the long-term goal as going from "a to d" instead of "a to z" are their changes you need to make?
Sample Questions:

1. What actions could the parent/guardian take to achieve the crisis goal?
2. What actions could the child/youth take to achieve the crisis goal?
3. What actions could others take to help achieve the goal?
4. What has worked best in the past that you think you could use again?
5. What can you envision yourself actually doing?
6. What are the ways you think you could calm down the situation?

Sample Responses:

Parent

When I call the crisis team I will be clear about what I need: “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 behaviours: ____________. This is the assistance that I would like: ________________.”

1. Buy alcohol in smaller quantities when we know the adults are going to use it, so that it is not stored in the home; 2. Enroll kids in afterschool activity of their choice so they are home alone less of the time; 3. Do phone check-in with kids at 4:30 p.m. each school day.

Child/Parents

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 behaviour; 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.

Teen/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 Kids Help Phone number into phone.

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).
Safety Plan Option Two: Unformatted Version

This version of the Safety Plan can be an option for children, youth and/or families who are not interested in completing the formatted versions. As it is a blank space, it is flexible to meet the needs/preferences of the child, youth and/or family. For example, pictures can be included in this plan if this would be most helpful to ensure the plan is understood and used. All of the above prompting questions can still be employed when completing this unformatted version.

Safety Plan Option Three: Pocket Version

The third option of the Safety Plan template is a “pocket version”. This version can be folded and carried on the person. The benefits of this is that:

- It’s easier for children/young adults to carry this plan with them and access it when they need it.

- It can also be used as a communication tool during a crisis should the child/young adult have difficulty communicating information verbally.

Like the first side of the Safety Plan, the pocket version includes information about contacts and resources, the goal of the plan and actions.

In the pocket version however actions are separated into “Actions I can take” and “Actions others can take to help me”. There is also space for the person to include identifying information if they feel that there may be a time during a crisis that they would have difficulty relating this information to a helper. It is important to communicate that only the sections that are helpful to them should be completed.

A child or young adult can use the “Actions others can take to help me” space to let others know how to support them in a crisis. If the child/young adult is struggling to communicate their needs verbally during a crisis, this section can help others know what would be useful.

Actions others can take to help me

- Speak in a quiet voice and dim the lights.
- Call my mom on her cell phone at __________
- Give me space. Don’t get too close to me and ask before touching me.
Testing “Usability”

Regardless of which version of the Safety Plan a family decides to use, it is helpful to ask a few questions to ensure that the youth or family will use the plan. Some examples include:

• Picture a crisis unfolding. Are all of the right names and numbers at your fingertips?
• Does this plan include what you want it to include? If not, let's modify.
• On a scale of 1-10, how confident are you that you can manage any future crisis with no one getting hurt?*
• How useful do you think this plan will be for you?
• Can you see yourself taking the actions that you have identified? If not, what seems more doable that takes you in the direction of your overall goal?

*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 Plan Reasonable and Realistic?

Behaviour change can be difficult, and it is often unrealistic to expect all unwanted behaviour 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 behaviour, the focus of the Safety Plan may be to:

• Reduce harm from the behaviour.
• Take action after the behaviour happens if prevention is not realistic at this time.
• Change how others in the home react to the behaviour.
• Reduce exposure to circumstances that precipitate the behaviour (i.e., increase structure or supervision or reduce access).
• 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.)
Example (continued):

- 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. This can be re-visited with the client as treatment progresses. Motivational Interviewing can be useful when working with clients who are ambivalent to change and can support increases, over time, in their motivation to make positive changes in their life.

**Fidelity Checklist: Checking in on your approach to Safety Planning**

**To Begin Planning:**
- Explore who in the family wants to play an active role in developing the plan.
- Ask the youth/family if they already have a plan that is working for them.
- Determine the youth’s/family’s priority.
- Support youth/family in sharing what has worked well for them in the past.
- Support the youth/family in incorporating ideas and supports that are relevant to them and include ideas shared by them.
- Ensure you are not insisting on incorporating supports that the youth or family are not ready to use or don’t believe will work.
- Ask the youth/family if they are interested in sharing their plan. If yes, obtain consent and track the sharing of the plan.

**Upon Completion of the Plan:**
- Upon completion of the plan, ask the youth/family:
  - How useful do you think this plan will be for you?
  - Does this plan include what you want it to include?
- Invite the youth/family to complete the optional and anonymous evaluation form.
- Instruct the youth/family to submit their completed evaluation in the drop box, envelope or other designated place.
- After completing a plan, reflect back on your approach in the session and what the experience may have been like for the youth/family.
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, the Advance Communication 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 relevant 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, extracting information from the Advance Communication and offering it for use in a Safety Plan, in the family's own language, can be useful.

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

Example:

Provider might say:

“I noticed, Lin, in your Advance Communication it says that you calm down fast once you have a family member join you at the emergency department. 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 Lin has revealed that her goal right now is to not to do anything that will cause her to have to go to the emergency department, she 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 will be completed. (If it makes sense to the family, they can 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 side 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 the purpose of the form in mind and to allow voice and choices to be clearly stated.

Sample Responses by a Young Adult:

<table>
<thead>
<tr>
<th>What I experience when I am in crisis</th>
<th>My priorities in a crisis</th>
<th>What helps me in a crisis</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I am very anxious and afraid for my safety especially if I am left alone.</td>
<td>• It is important to me to stay in school. I have missed a lot of classes because of my anxiety disorder.</td>
<td>• It usually helps when I can talk to my mom, and if she isn’t with me her number is X.</td>
</tr>
<tr>
<td>• I shut down, and I find it almost impossible to talk.</td>
<td>• 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.</td>
<td>• Give me time to calm down before you start asking questions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Let me stay in my own clothes and keep my things with me.</td>
</tr>
</tbody>
</table>
### Sample Responses by a Young Adult (continued):

<table>
<thead>
<tr>
<th>Treatment I prefer</th>
<th>Treatment I prefer NOT to receive</th>
<th>If I'm admitted to a facility, I need to plan for the following</th>
</tr>
</thead>
<tbody>
<tr>
<td>• X medication gives me the fastest relief when I am anxious.</td>
<td>• I have been abused in the past and have a fear of being restrained.</td>
<td>• I have a dog at home. Call my neighbour 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.</td>
</tr>
<tr>
<td>• If I have to be hospitalized I want it to be nearby so my family can visit.</td>
<td>• I do not want to go to facility X because of (distance, prior experience, schedule, rules, etc.)</td>
<td>• My rent is due on the 15th of every month, and I need to pay on time or I will lose the apartment.</td>
</tr>
<tr>
<td>• X program was really helpful last time, and I want to go there if I am admitted.</td>
<td>• I don't want X medication because it makes me nauseous.</td>
<td>• I need a letter faxed to my boss excusing me from work before my shift starts.</td>
</tr>
<tr>
<td>• I have family who can stay with me for awhile until I am better so I don't have to be in the hospital.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Additional Information or Requests

• 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.
• 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.
**Sample Responses by Parent(s)/Guardian(s):**

<table>
<thead>
<tr>
<th>How my/our child looks and acts when in crisis</th>
<th>My/our priorities when my/our child is in crisis</th>
<th>What helps my/our child during crisis support/intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Kya 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.</td>
<td>• Minimize how many people get involved in the situation – we know from experience, the fewer the better.</td>
<td>• It is usually difficult for her to open up to men – if a woman is available, it would probably go better.</td>
</tr>
<tr>
<td>• Breanna is very clingy and emotional in medical settings especially if she doesn't know the place or the person.</td>
<td>• She is very embarrassed that she has to get help – privacy and discretion are very important to us.</td>
<td>• Having something to do – listening to music or watching TV while she is waiting.</td>
</tr>
<tr>
<td>• 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.</td>
<td>• Don't change the medication without talking to me first.</td>
<td>• 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.</td>
</tr>
<tr>
<td>• 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.</td>
<td>• We don't want to put her in a hospital.</td>
<td></td>
</tr>
</tbody>
</table>
Sample Responses by Parent(s)/Guardian(s) (continued):

<table>
<thead>
<tr>
<th>What helps our family during crisis support/intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>• A lot of times just talking on the phone is very helpful to us—we don’t always need or want someone to come to our home.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment I/we prefer for my/our child</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We prefer a place where family involvement is allowed and encouraged.</td>
</tr>
<tr>
<td>• We prefer a place that is responsive to our cultural/religious needs.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• I want to work with someone who understands trauma.</td>
</tr>
<tr>
<td>• I only want to get services at X agency/program/hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment I/we prefer my/our child NOT receive</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I don’t want her in a program with older kids.</td>
</tr>
<tr>
<td>• I don’t want her to take antipsychotic medications.</td>
</tr>
<tr>
<td>• I don’t want her to get services at X agency/program/hospital.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If I/we cannot be immediately reached if my/our child is in crisis, please:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 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 Charlotte 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.</td>
</tr>
<tr>
<td>• We cannot leave our phone ringers on at work, but you can send me a text message or e-mail at this address: X.</td>
</tr>
<tr>
<td>• Call my sister Naveena at this number, and ask if she can come to be with Kavita. Kavita is very comfortable with her, and Naveena can answer a lot of your questions. She spends a lot of time with Kavita.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information or Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Gurpreet speaks fluent English, but my English is not very good. I need a Punjabi-speaking interpreter.</td>
</tr>
<tr>
<td>• If you see Kelly at her school, please talk to Mrs. Jarwar in the guidance office. She knows Kelly and me and has been helping Kelly stay in school.</td>
</tr>
<tr>
<td>• If you come to our home, please park on the street in front of the apartment building. I can see you from there and can open the door.</td>
</tr>
<tr>
<td>• We would like to be able to smudge if we want.</td>
</tr>
</tbody>
</table>
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 filed with treatment providers.
- Additionally, a child, parent/guardian, or young adult can 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 they may 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 include:

- The product of more comprehensive safety planning:
  - Families receiving behavioural services may participate in a Functional Behavioural Assessment, or dedicate time and attention to addressing crisis prevention and, as a result, develop a more comprehensive crisis plan.
  - Some young adults may participate in WRAP training\(^1\) 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.

\(^1\) For more information on WRAP go to: [www.mentalhealthrecovery.com](http://www.mentalhealthrecovery.com)
Individualized alternatives (continued):

- Electronic in nature—and kept in cell phone (such as on a secured App)
- In a non-English language
- Pictures rather than words

If a person wishes to file 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.

**Routing Boxes**

At the bottom of each of the templates is a routing box. The purpose of the routing box is to prompt discussion with the child/youth/family member on the potential benefits and risks of sharing the Plan and identifying how it will be shared (e.g. will the youth share their Plan themselves with their school or do they prefer for the service provider to share it for them).

Note that all information in a plan would be considered Personal Health Information (PHI) as defined by the Personal Health Information Protection Act (2004) and providers would follow their organizations established protocol for sharing PHI.

```
I want this plan to be shared with: ____________________________________________ *

*Note that if you want the provider to share this plan consent must be provided.
```
Part Five: Sample Plans

Ajeet:
A neighbour has called police several times regarding domestic disturbances when 17 year-old Ajeet and his parents have been fighting. Ajeet and his parents yell, and Ajeet breaks things and slams doors. Because Ajeet has depression, the officers have either called the mobile crisis team to the home or sent Ajeet to the ED. Ajeet 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 home they will file charges.

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

Goals:
Ajeet and Parents
1. Focus on the times when things are the worst;
2. Keep police from coming to the home and filing charges.

Actions:
Family: Remind each other what’s at stake: we can figure it out ourselves without getting loud.
Ajeet: Plan something to do outside the home 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: Ajeet can use the car on Saturdays when the week goes well.
Parents/Ajeet: To get a break, Ajeet can spend the night at his friend Joe’s home if it is okay with Joe’s parents, or at Aunt Hardeep’s two times a week.
Parents/Ajeet: Consider calling the Imam to help talk it through by phone.
Parents/Ajeet: Consider calling the mobile crisis line. Can talk by phone, have them come to home or go to a drop in counselling session if it feels like the fight is going to get too big to manage.
Marie:
Nineteen-year-old Marie 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. Marie 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.

Marie 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 (mobile crisis team) in the future, and we will let her determine what kind of help she wants. Marie declines to create a paper version of a safety plan and instead enters 3 action items into her notes section of her mobile phone. She also agreed to take the contact information for 3 local services that could help her avoid being brought back to the ED should she be in crisis.

Goal (discussed verbally):
Marie would like to have someone to talk to but not someone who will force her to do anything

Actions (listed in notes section of her cell phone with accompanying phone numbers):
If I need to get out of the house:

- Call my uncle in Toronto. Call domestic violence support line
- Emergency shelter options

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

- Tangerine Walk-In Counselling
- Kids Helpline if I'm feeling suicidal or just to talk
- Can call the mobile crisis line
Charles:
Charles is seven years old, and he lives with his dad and five year old sister. Charles 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, Charles 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 Charles 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 Charles when he is interested and paying attention.

Goal:
Dad: Notice when Charles’ physical behaviour 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)
  - Calm down, or
  - Call a support person, or
  - 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 children’s crisis response
- 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.

Example one
When I need help, I can call:

<table>
<thead>
<tr>
<th>Name/role</th>
<th>Phone:</th>
<th>Name/role</th>
<th>Phone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imam Ahmad</td>
<td># 905-111-1111</td>
<td>Mom</td>
<td># 905-111-1111</td>
</tr>
<tr>
<td>Carol from IR</td>
<td># 905-111-1111</td>
<td>Kids Help Phone</td>
<td>#1-800-668-6868</td>
</tr>
<tr>
<td>Aunt Seema</td>
<td># 416-111-1111</td>
<td>Crisis Response</td>
<td># 416-111-1111</td>
</tr>
</tbody>
</table>

Notes:
Imam Ahmad is only available on his cell phone after 5 pm. Carol can be reached during the day. Leave her a message and she always gets back to me.

Goal of this plan is...
1. We will all agree to try to focus on improving 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 being filed by working together.

I will use this plan when...
1. Things start to feel out of control.
2. To prevent an argument from starting.

Actions
Whole Family: We will remind ourselves of what is at stake – we know we can figure it out ourselves without getting loud.

Aatif: I will have a plan to do something outside of the house most days Monday-Friday between 3 – 6 pm. Some options:
- YMCA open gym Tuesday and Thursday
- Look for afternoon job
- Library computer room open every day
- Can do up to 6 hours of yard work at home every week for $10/hr.
- Can use car to run family errands (i.e. groceries)

Parents: Stay out of power struggles, don’t make idle threats. Back each other up – don’t make things worse by fighting with each other. Aatif can use the car on Saturdays when the week goes well. To get a break, Aatif can spend the night at his friend’s house once a week (as long as parents agree) or at his aunt’s house twice a week.

Parents/Aatif: Consider calling Imam Ahmad to help talk through problems on the phone.

Parents/Aatif: Consider calling the Crisis Response Service to get some help if it feels like we can’t manage the fight on our own. Can also call Carol from IS – and leave a message.

I want this plan to be shared with: Imam Ahmad and the Crisis Response Team*
*Note that if you want the provider to share this plan consent must be provided.
Example Two

Contacts and Resources

<table>
<thead>
<tr>
<th>Best Friend/Support Person</th>
<th>#617-111-1111</th>
<th>Team daytime number</th>
<th>#617-111-1111</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lola/babysitter</td>
<td>#617-111-1111</td>
<td>Team 24/7 on-call pager</td>
<td>#617-111-1111</td>
</tr>
<tr>
<td>MCI team</td>
<td>#617-111-1111</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name/role                  | phone                     | Name/role                  | phone                     |

Notes:

Goal of Plan

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

Actions

**IF THIS HAPPENS**
- If he gives mean looks, slams doors, stomps loudly—
- If he threatens to hit or hurt or throws things around—
- If the warning doesn't work—use a brief timeout
- If he hurt himself or someone else or damages property—

**TRY THIS:**
- Give calm reminders.
- Remind him he "knows how to keep it together".
- Help him find an acceptable activity.
- Give a short and clear warning.
- 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
- Try an extended timeout
  - Call for in-home support by team
  - Call for MCI
  - Arrange a caregiver for (sister)

I want this plan to be shared with: PCCN
*Note that if you want the provider to share this plan consent must be provided.*
Example Three

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.

I want this plan to be shared with: ____________________________________________

*Note that if you want the provider to share this plan consent must be provided.
Example Four

THE GOAL OF THIS PLAN IS:
To not end up in emergency again!

I NEED TO USE THIS PLAN WHEN:
I feel like cutting.

ACTIONS I CAN TAKE:
- Play music
- Don't drink if I am upset
- Text Aunty Teena
- Call Kids Help Phone

ACTIONS OTHERS CAN TAKE TO HELP ME:
- Give me space!
- Don't talk to me like a child

WHO I AM:
NAME
ADDRESS
TELEPHONE
DATE OF BIRTH DD/MM/YYYY

OTHER IMPORTANT INFORMATION ABOUT ME:

SOME CONTACTS AND RESOURCES THAT ARE HELPFUL TO ME INCLUDE:

Aunty Teena
555-4865

Kids Help Phone
1 800 668 6858

1 800 668 6858
Example Five

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.
Part Six: Glossary, Resources and References

Glossary

**Consensus plan:** A plan aimed at increasing safety and reducing risk that is developed through a process where the input of the youth, family and supports are all carefully considered and reflected. It is a plan that synthesizes the wisdom of all the participants into the best decision possible at the time.

**Culture:** The system of shared beliefs, values, customs, behaviours, and artifacts that the members of society use to cope with their world and with one another, and that are transmitted from generation to generation through learning.

**Harm reduction:** (adapted from: https://www.porticonetwork.ca/treatments/approaches-to-care/harm-reduction)
Harm reduction refers to policies, programs and practices that aim to reduce harm (e.g. drug related harm) without requiring the person to stop the behavior/substance use. Harm reduction strategies aim to reduce harms not just for the individual at risk, but also for families, friends and communities. This approach aims to balance an individual’s right to self-determination within the broader public health.

Harm reduction helps care providers to adopt a less judgmental stance when working with individuals engaged in potentially harmful behaviors/substance use. It is built on various guiding principles including:

- Focus on harms: The focus of harm reduction policy and programs is on reducing harmful consequences without necessarily requiring any reduction in particular behaviours or substance use.
- Prioritizing goals: Harm reduction prioritizes each person's goals to emphasize immediate, realistic reductions in harm rather than hoped-for, longer-term outcomes.
- Flexibility and maximization of intervention options: Initiatives are flexible and collaborative to account for the uniqueness of each person.
- Autonomy: The person's decision to use is acknowledged as a personal choice for which the person takes responsibility.

**Motivational interviewing:** A method of communication that is specifically designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.
(Motivational Interviewing: Helping People Change. William R Miller, PhD, Stephen Rollnick, PhD. Guilford Press, Sep 2012.).
Natural ecology: A person’s natural ecology is comprised of supports/influences by which they are surrounded in their day-to-day lives. Examples are: family, neighbours, spiritual community, sports teams, cultural community. In reference to crisis planning it is a good practice to explore a person’s natural supports in addition to more formal supports. It is also important to understand an individual/family’s preference for natural vs. more formal supports when developing a crisis plan.

Peel Service Collaborative: The Peel Service Collaborative is one of 18 Service Collaboratives across the province of Ontario. Funded by the Ministry of Health and Long-Term Care and supported by five other ministries, the goal of the Peel Service Collaborative is to improve access to and coordination of mental health and addictions services and supports for children and youth in Peel.

Person and family-centered care: (adapted from: http://www.ipfcc.org/faq.html) Person and family-centered care is an approach to the planning, delivery, and evaluation of health related services, including mental health and addictions care that is grounded in mutually beneficial partnerships among service providers, clients/patients and families. It redefines the relationships in service provision. Person- and family-centered practitioners recognize the vital role that families play in ensuring the health and well-being of infants, children, adolescents, and family members of all ages. They promote the holistic health and well-being of individuals and families and restore dignity and control to them. Person- and family-centered care is an approach to service provision that shapes policies, programs, facility design, and staff day-to-day interactions. It leads to better health outcomes and wiser allocation of resources, and greater client/patient and family satisfaction.

Wraparound: (from: http://www.nwi.pdx.edu/wraparoundbasics.shtml) Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. The values of wraparound, as expressed in its core principles, are fully consistent with the system of care framework. Wraparound’s philosophy of care begins from the principle of “voice and choice,” which stipulates that the perspectives of the family—including the child or youth—must be given primary importance during all phases and activities of wraparound. The values associated with wraparound further require that the planning process itself, as well as the services and supports provided, should be individualized, family driven, culturally competent, and community based. Additionally, the wraparound process should increase the “natural support” available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family’s network of social and community relationships. Finally, the wraparound process should be “strengths based,” including activities that purposefully help the child and family to recognize, utilize, and build talents, assets, and positive capacities.
Resources

**HARM REDUCTION**


**MOTIVATIONAL INTERVIEWING**


**PARENTING**


**RECOVERY MODEL**

Copeland, M. S. Mental Health Recovery and WRAP. www.mentalhealthrecovery.com

**TRAUMA-INFORMED PRACTICE**

References


Newberry, J. Mapping the Mental Health System in Peel Region: Challenges and Opportunities (2014).Newberry of Taylor Newberry Consulting.


Health and Human Services. [http://store.samhsa.gov/shin/content/SMA09-4371/SMA09-4371.pdf](http://store.samhsa.gov/shin/content/SMA09-4371/SMA09-4371.pdf)


Appendix A: Tips for Service Providers from a Family Member

Tips for Service Providers on how to be a ‘Gem of a Listener’ for Families in Various Kinds of Crises. Written by Susan Moss

- Trust the parents’ perspective.
- Remember the parent knows the child/youth more than you do so listen and learn.
- Marriages WILL be negatively affected but don’t let the marriage problems be what you focus on if the client is asking for something else at the moment. (I had a worker take 8 months to do an assessment and recommend a focus on marriage when all along I communicated I did not want ‘to go there’, was getting counseling with my spouse in a different setting, and I was here for Cognitive Behavioural Therapy since my son’s mood disorder was stable with medications).
- Expect complicated layers of problems and deal with your own feelings of being overwhelmed during an intake so you do not respond with ‘caretaking behaviours’ when the short time the client has with you is used up with your worry instead of his/her expressed goal for that session.
- Keep an open mind when reading someone else’s written notes so you do not go into a session with a bias. I’ve had counselors peg me as the parent without firmness when it was my husband who was and this was repeated with each new counselor as we received short-term sessions while waiting for a long-term worker.
- Listen to current CLIENT FEEDBACK about the present services (I communicated many times that the method being used for therapy didn’t fit with my child at the time, because he was ‘shut down’. But it wasn’t heard and didn’t work).
- When there’s mental illness remember this order of priorities my son’s psychiatrist told me: 1. Alive (stable on meds) 2. Happy at home 3. School. This has helped me to let go of everything else and stay focused.
- Use your field of discipline when it fits with what the client is asking for, otherwise look from a broader perspective and help the client find other disciplines they are communicating they need at that moment. There are so many layers and everything can’t be taken care of at once. Go with what the family member is identifying at that time.
- When a client describes their child/youth, find out what the words mean to the client (e.g., ‘shut down’).

- Don’t let your emotions direct service provided. Know yourself, recognize if/when it’s happening and find a way to deal with yourself so you don’t bring harm to client.

- Recognize your limits. If this case is beyond your skills, help client get a more experienced worker!!!!!!!

- Be aware of conflicting ‘help’ if a client is receiving more than one service provider at the same time (e.g., two agencies were working on one of my son’s phobias and gave conflicting methods.)

- Be aware of all services so you can help client find the one they need at the time they are accessing (especially for the first time in the system).

- Listen to find out most distressing symptom of child (e.g., rages for me) and recognize when medication might be the ONLY thing that can help the symptom (i.e., when no parenting skills can...).

- Listen for feelings of failure, loss of confidence, hopelessness and find ways to help parent see what they ARE doing that’s positive, or focus on their efforts/trying - not success.

- Realize dealing with service providers uses up a lot of emotional energy, and time and how limited these resources are for clients (and it is double when there is more than one child needing help).

- Believe that children can get depressed so that you won’t deny this reality if a client says this. It is extremely discouraging & frustrating to hear a professional say ‘children don’t get depressed’ when they actually do.

- If you are a friend or family member, or from a community centre or faith-based support, you are also vitally important because when you listen effectively, the load then lightens and when you don’t the load becomes heavier to bear for the one you are helping. And that load is already too heavy!
Appendix B: Provider Tip Sheet

1. **Before starting a plan you can ask yourself:**
   - What do I believe about this youth and his/her family? (Do my beliefs serve them well? Can I strengthen my beliefs?)
   - How am I interpreting the circumstances? (Am I clear on my motive? Are shifts in interpretation necessary?)
   - If I were standing in the shoes of this youth (or parent): What would be the essence of this situation? What would be most important to me? What would be the consequences of acting/not acting? Do the benefits outweigh the cost? How have past experiences influenced my attitudes? Do I believe I know how to do this?

2. **To begin planning with a youth/family you can ask:**
   - If you are interested, I would like to talk to you about safety or crisis planning and to figure out if it is something that would be useful for you/your family.
   - Do you have a Safety Plan that is working for you?

3. **To determine the youth/family’s definition of crisis, the current level of crisis and motivation for planning you can ask:**
   - Does it feel like you are in a crisis right now? If yes, how would you describe the crisis?
   - What is the riskiest/scariest part of it for you?
   - What is the hardest part of it for you?

4. **To understand their preference for formal vs. informal supports you can ask:**
   - There is usually more than one way to manage a crisis. I would like to know more about how you tend to handle a crisis situation – for example some people prefer seeking professional help (crisis worker, hospital, police, etc.) or turning to informal supports (such as teachers, members from a faith organization, neighbours, family, etc.)? Others tend to want to manage things on their own or perhaps prefer a combination of these different styles. How would you describe your/your family’s preference for dealing with situations that feel unsafe? Often different members of the family have different answers to this – that’s ok.
5. To understand what has worked well for them in the past you can ask:
   - What is the biggest crisis that you have experienced in the past?
   - What was the hardest part about the crisis?
   - Looking back now, how happy/proud/satisfied are you with how you handled it?
   - Looking back, what was the best thing you did during the last crisis? (decision you made/action you took)?
   - Looking back, what was the best thing someone else did during the last crisis?

6. To understand how useable the plan will be you can ask:
   - How useful do you think this plan will be for you?
   - Does this plan include what you want it to include?
   - Overall, do you feel good about how your plan was developed?
Appendix C: Motivational Interviewing

Motivational Interviewing (MI) focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. This method differs from more ‘coercive’ or externally driven methods for motivating change as it does not impose change that may be inconsistent with the person’s own values, beliefs or wishes but rather supports change in a manner congruent with the person’s own values and concerns.

Motivational interviewing has been defined in a number of ways. The most recent definition of motivational interviewing (2009) is: “a collaborative, person-centered form of guiding to elicit and strengthen motivation for change.”

In the context of the HCP approach, the spirit and principles of MI can support aligning with children, youth and families around their readiness and interest in creating a plan, exploring the range of helpful options for them, or understanding their lack of motivation for creating a plan.

The Spirit of MI has 4 basic parts and four basic processes:

When working with children, youth and families and using the HCP approach to explore the usefulness of or strategies for safety planning, MI helps support a process that meets people where they are at and puts them in the driver seat. Through the use of OARS: open-ended questions, acceptance, reflection and summarizing, practitioners can support a safety planning process that is empowering, effective, authentic and ultimately, resulting in some form of a conversation or plan that will reduce real risks for children, youth, and their families.