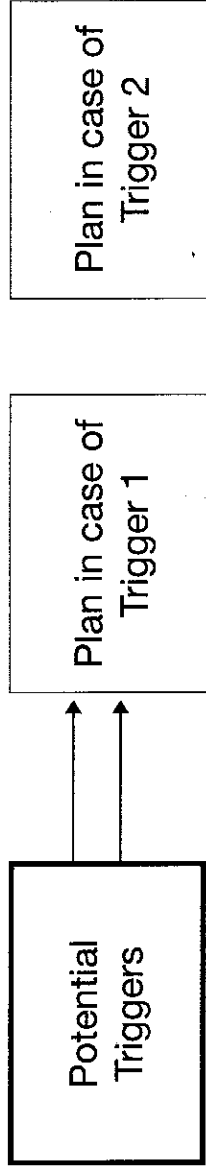


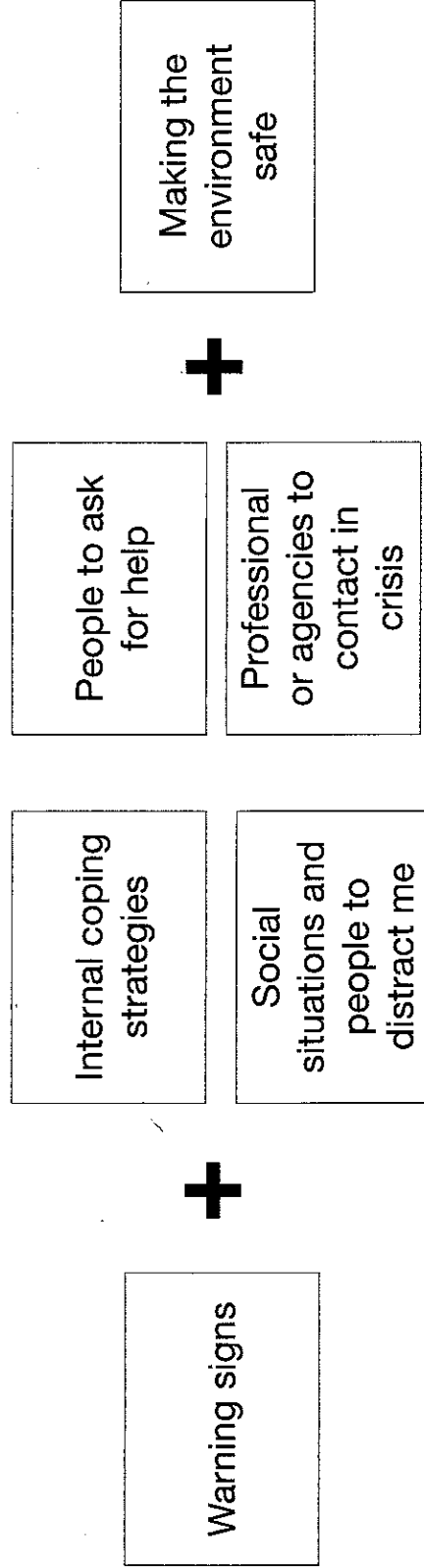
# Specific contingency plans

(Pisani et al, 2012)



# Safety planning

(Brown & Stanley, 2012)



## Contingency and Safety Planning – Sample Form

List the names and signatures of those involved:	Name	Relationship	Date/Signature
<b>Potential Triggers/Specific Contingency Plans</b>			
What are some specific events or changes that could quickly overwhelm you? (at least the top two)		What is the specific plan you or someone else will follow in case these things happen?	
1.	3.	1.	3.
2.	4.	2.	4.
<b>Personal Warning Signs</b>			
Understanding your feelings and being aware of early warning signs will make it easier for you to take care of yourself and not become overwhelmed to the point of wanting to harm yourself.			
What are some early warning signs? (examples: withdrawal, substance use, impulsivity, anger)			
<b>"On my own" Coping Strategies</b>		<b>"With others" Strategies for Distraction and Support</b>	
Here are things I can do on my own to cope with distress:		Here are places I can go or people I can be around to distract me or provide a change of scenery:	
One thing that is important to me and worth living for is:			
<b>Friends and family for assistance when I'm feeling bad/overwhelmed/suicidal</b>			
Name:		Number:	
Name:		Number:	
Name:		Number:	
<b>Professional and Agency contacts to help resolve crises (24/7)</b>			
Facility Contact (Name/position) :		Number:	
Therapist:		Number:	
Hospital:		Number:	
Crisis Line:		Number:	
<b>Making the Environment Safe</b>			
Here is my plan for keeping myself away from _____			
_____ (support person) reports that _____ (patient) does not have access to prescription medications for use other than as prescribed or access to weapons, lethal medications and/or other means of self-harm.			
<b>Firearms Safety Plan</b> If you have access to firearms, please take some time to make a plan for safety below.			
I have firearms in my home? <input type="checkbox"/> No <input type="checkbox"/> *YES→ If YES, complete below			
What type of firearm(s)?			
Where is it (they) stored?			
Who will dispose of or safely store your firearms before you are discharged?		<input type="checkbox"/> Family Member: (name and phone#)	<input type="checkbox"/> Friend: (name and phone#)
		<input type="checkbox"/> Legal Authorities: (name and phone#)	<input type="checkbox"/> Other: (name and phone#)

## SAMPLE CRISIS SUPPORT PLAN

FOR: \_\_\_\_\_ DATE: \_\_\_\_\_

I understand that suicidal risk is to be taken very seriously. I want to help \_\_\_\_\_ find new ways of managing stress in times of crisis. I realize there are no guarantees about how crises resolve, and that we are all making reasonable efforts to maintain safety for everyone. In some cases inpatient hospitalization may be necessary.

Things I can do:

- Provide encouragement and support
  - \_\_\_\_\_
  - \_\_\_\_\_
- Help \_\_\_\_\_ follow his/her Crisis Action Plan
- Ensure a safe environment:
  1. Remove all firearms & ammunition
  2. Remove or lock up:
    - Knives, razors, & other sharp objects
    - Prescriptions & over-the-counter drugs (including vitamins & aspirin).
    - Alcohol
    - Illegal drugs & related paraphernalia
  3. Make sure someone is available to provide personal support and monitor the client at all times during a crisis and afterwards as needed.
  4. Pay attention to the client's stated method of suicide/self-injury and restrict access to vehicle, ropes, flammables, etc., as appropriate.
  5. Limit or restrict access to vehicle/car keys as appropriate.
  6. Identify people who might escalate risk for the client and minimize their contact with the client.
  7. Provide access to things client identifies as helpful and encourage healthful behaviors such as good nutrition and adequate rest.
- Other \_\_\_\_\_

If I am unable to continue to provide these supports, or if I believe that the Crisis Action Plan is not helpful or sufficient, I will contact [name of therapist or therapy practice] immediately and express my concerns.

If I believe \_\_\_\_\_ is a danger to self or others, I agree to:

- Call [name of therapist or therapy practice & phone number]
- or call 911
- or help \_\_\_\_\_ get to a hospital.

I agree to follow by this plan until \_\_\_\_\_.

Support signature: \_\_\_\_\_

Client signature: \_\_\_\_\_

Therapist signature: \_\_\_\_\_