SAFETY PLANNING IN THE ADOLESCENT POPULATION

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NO CONFLICT OF INTERESTS

I certify that I have no affiliations with or involvement in any organization or entity with any financial interest in the subject matter or materials discussed in this presentation.
LEARNING OBJECTIVES

1. Increase awareness of personal risk tolerance and acknowledge that tolerance varies by domain

2. Increase familiarity with discipline-specific, core competencies for the assessment and management of individuals at risk for suicide

3. Increase working knowledge regarding appropriate use of a standard suicide safety plan, as well as what modifications may be necessary based on patient age

4. Practice using safety plan (case example provided)

5. Increase awareness of resources available to both providers and patients
“THANKS, BUT NO THANKS…”

Seriously...

I'M NOT NERVOUS!
CASE EXAMPLE 1

“Dean” is a 16-year-old White male referred by his probation officer due to a sexual offense with his younger sibling. He was accepted into a group treatment program for adolescents with illegal sexual behaviors. Dean participated in sessions and appeared engaged in treatment. Through interactions with the family it was clear that there were issues within the relationship between Dean and his caregivers. Several months into treatment, the clinical team was alerted that the family found a concerning entry in Dean’s journal regarding suicidal ideation. The team planned a session to meet separately with Dean and his caregivers. During the meeting with Dean, he reported a desire not to be alive. When asked about a potential plan to achieve this he stated that he preferred not to answer the question. Dean reported frequent thoughts of not wanting to be alive. He could not identify when these thoughts began but that it was almost his “normal” way of thinking. Dean reported the negatives of life outweighed the positives. When his caregivers were presented with this information, they questioned the validity of Dean’s reported thoughts and cited a concern that he was seeking attention.

QUESTION: Would you immediately refer Dean to an inpatient psychiatric facility for an evaluation for admission?
“Jordan” is a 13-year-old White female being seen in a trauma clinic for TF-CBT and CBT for severe depression. Jordan has been attending sessions twice weekly for 4 weeks. She is followed by a local psychiatrist for her depression and a hx of ADHD and takes Clonidine, Vyvanse, Fluoxetine, and Abilify.

Three-and-a-half months prior to beginning therapy, Jordan attempted suicide via overdose and was subsequently admitted to an inpatient psychiatric facility for 3 days following medical stabilization. A month-and-a-half after her first attempt, Jordan’s father interrupted a second attempt via overdose. Jordan was subsequently hospitalized for approximately one week following second attempt.

During her intake appointment at the trauma clinic, Jordan and her father were active collaborators in her current safety plan. To date, Jordan presented weekly with moderate levels of wanting to be dead and low levels of urges to kill herself.
During week 4 of therapy, Jordan’s father calls her provider and reported Jordan had gone to the school counselor that morning saying she was in crisis and had written a suicide note. Per her school counselor, Jordan went to the counselor’s office during 1st period, crying and saying “she shouldn’t be on Earth anymore.” Jordan rated her suicidal ideation a 9/10 (0 being never going to commit suicide).

Jordan’s father brought her to provider immediately thereafter for further evaluation. Upon presenting in clinic, Jordan rated her desire to be dead as a 9/10 (extremely strong) and her urge to commit suicide as an 8/10 (very strong). After concluding a risk assessment with provider, Jordan and her father collaborated in creating a revised safety plan. By the end of the appointment, the provider reassessed her desire to be dead, which she rated a 7/10, her urge to commit suicide (rated at a 6/10), her intent to kill herself at home (rated at a 5/10), and intent to kill herself at school (rated at a 6/10).

**QUESTION:** Would you immediately refer Dean to an inpatient psychiatric facility for an evaluation for admission?
CASE EXAMPLE 3

“Omar” is a 15-year-old Black male attending a scheduled visit with his hematologist. Omar communicates concerns for depression and difficulty managing pain episodes secondary to his diagnosis of sickle cell disease. During the course of his visit, Omar endorsed suicidal ideation on three occasions in the past 3 months and that his suicidal thoughts occur when he is in severe pain. Omar stated that he wants the “pain to go away.” He endorsed having a plan, which involved overdosing on his pain medications (oxycodone, hydrocodone) prescribed for sickle cell disease, although he reported that because he is prescribed limited quantities, the amount of medication he has access to would not kill him. During the assessment he acknowledged that he had free access to his pain medications (i.e., parents do not distribute it to him); however, that he has never taken out more medication than necessary to manage his pain, even while experiencing suicidal thoughts. He denied current suicidal, homicidal, and self-injurious ideation. Omar cited his religious background, siblings, football team, and future goal of becoming a pediatric neurosurgeon as reasons to live.
When the provider discussed with Omar that she was concerned about his potential safety and wanted to help him talk with his mother about his suicidal ideation, Omar became very upset. He explained that his family was from Africa (i.e., Omar and his family moved to the U.S. from Nigeria when he was 4 years old) and that mental health is not well-understood or accepted by his parents or many individuals of his cultural background. Omar stated that he wished he had not told the provider about his suicidal ideation because now his mother would think he was “crazy,” as she did not know about his suicidal thoughts. Omar appeared to shut down (e.g., put headphones in, avoided eye contact, replied using 1-2-word responses), until the provider engaged in discussion about how to proceed from this point. He has a follow-up appointment already scheduled with the provider in two weeks.

**QUESTION:** During this visit, would you report Omar’s suicidal ideation to his mother?
WHAT ACTUALLY HAPPENED?

Case Example 1: Dean
• Provider consulted with colleagues and ultimately recommended Dean be evaluated at an inpatient psychiatric facility. Dean was not admitted.

Case Example 2: Jordan
• Provider consulted with supervisor and did not recommend Jordan be evaluated at an inpatient psychiatric facility. Provider established safety plan with school counselor, continued to see Jordan twice weekly, and monitored safety closely in conjunction with Jordan’s father.

Case Example 3: Omar
• Provider consulted with colleague and did not inform Omar’s mother of his suicidal ideation. Provider briefed Omar’s medical team and followed Omar in clinic.
SO, WHAT’S THE POINT?

We all have different levels of risk tolerance

AND

Your level of comfort/discomfort with suicide WILL affect the decisions you make regarding risk
Mental health providers identify client suicidal behaviors as one of the most stressful and impactful aspects of their job (Deutsch, 1984; McAdams & Foster, 2000).
WELL, I'M NOT A DOCTOR
BUT I CAN TELL YOU IT LOOKS WEIRD
In 2013, the Association for Suicidology published a policy paper targeting training for psychiatrists, social workers, psychologists, and counselors, but not for nurses (despite the fact that they are the largest workforce providing care to suicidal pts).

In 2014, APNA developed a parallel set of competencies for nurse-assessment and management of inpatient risk.
CORE COMPETENCIES

1. Understand suicide
2. Management of personal reactions, attitudes, and beliefs
3. Develop and maintain a collaborative, therapeutic relationship with pt
4. Collect accurate assessment information and communicate the risk to the treatment team and appropriate persons (e.g., nursing supervisor, M.D. on duty)
5. Formulate a risk assessment
6. Develop an ongoing nursing plan of care based on continuous assessment
7. Perform ongoing assessment of the environment in determining the level of safety and modify the environment accordingly
8. Understand legal and ethical issues related to suicide
9. Accurately and thoroughly document risk
MANAGEMENT OF PERSONAL REACTIONS, ATTITUDES, AND BELIEFS

- Demonstrate self-awareness of emotional reactions, attitudes, and beliefs related to previous experiences with suicide.
- Examine the impact on the patient of nurse’s emotional reactions, attitudes, and beliefs.
- Accept and regulate one’s emotional reactions to suicide.
- Discuss nurse’s reaction to patients who express suicidal ideation, attempt, die by suicide.
- Participate in staff debriefing following a suicide attempt or death by suicide.
- Attend to one’s of emotional safety and wellbeing.
American Psychiatric Nurses Association

Offer specific trainings:
https://www.apna.org/i4a/pages/index.cfm?pageid=5706

For PDF version of competencies:
https://www.apna.org/i4a/pages/index.cfm?pageid=5684
WHAT DO THE NUMBERS TELL US?

• On average, 45% of individuals who die by suicide have visited their primary care physician within a month of their death (Luoma, Martin, & Pearson, 2002).

• Statistics suggest that you are likely to encounter pts with suicidal behavior throughout your careers (and I’m sure already have)

• When in doubt, consult:
  • One of the commonalities between the three case examples presented
• No-suicide (AKA: No-harm) Contract: Document asking pts to “promise” not to kill themselves and to contact professionals during times of crisis

• Despite anecdotal observation that no-suicide contracts help to lower clinician anxiety, no empirical evidence to support the effectiveness of documents in preventing suicidal behavior (Kelly & Knudson, 2000; Reid, 1998; Shaffer & Pfeffer, 2001; Stanford et al., 1994).
NO-HARM CONTRACT

I, ___________________________, agree to not harm myself in any way, attempt to kill myself, or kill myself during the period from _____________ to _____________, (the time of my next appointment).

I agree that, for any reason, if the appointed session is postponed, canceled, etc., that this time period is extended until the next direct meeting with my counselor. In this period of time, I agree to care for myself; to eat well, and to get enough sleep each night.

I agree to make social/family contact with the following individuals:

__________________________________________
__________________________________________
__________________________________________
MAJOR DISTINCTION

• No-suicide/harm contracts tell pts what “not” to do, while safety plans offer several options regarding things that pts can try during times of crisis.

• Although none of the items are regarded as “cures” they are capable of providing modest relief, and most importantly keeping pt safe.
• **SPI = Safety Planning Intervention** (Stanley & Brown, 2006).
  - Originally developed for suicidal pts in the ED and other acute care settings
  - SPI → best practice
    - Suicide Prevention Resource Center/American Foundation of Suicide Prevention Best Practices Registry for Suicide Prevention ([www.sprc.org](http://www.sprc.org))
  - "Brief" (20 – 45 minutes)
  - Outlines a **prioritized** and **specific** set of coping strategies and sources of support
    - **Main focus is to lower pt’s imminent risk for suicidal bx**
  - Can be used in the context of ongoing outpatient tx or during inpatient care
• When suicidal pts evaluated and hospitalization not clinically indicated, often provided with a referral for outpatient MH tx (Allen et al., 2002)

• Between 11% and 50% of attempters refuse outpatient tx or drop out of tx very quickly (e.g., Kessler et al., 2005)

• Up to 60% of suicide attempters attend only 1 week of tx post-discharge (e.g., Granboulan et al., 2001)

• Of those individuals attending tx, 38% terminate within the first 3 months (Monti et al., 2003)

• Inevitable lag between an ED eval and outpatient MH appointments

• Conducting brief SPI when the pt is physically present is a valuable opportunity

• Importantly: suicidal crises are usually time-limited and consist of an ebb and flow of suicidal urges.
• Important to establish a collaborative, working relationship with pt
• Non-judgmental stance
• Use a “normalizing frame”
  • There is no evidence to support that asking about suicide will somehow put suicidal ideas in pt’s heads (e.g., Jobes, 2016)
Prior to conducting SPI it is important to consider optimal level of involvement of caregiver(s)

- Considerations for children vs. adolescents

Important for pts (and caregivers, if applicable) to understand rationale for and recommended use of SPI → poor understanding decreases likelihood of use

SPI is best developed with the pt following comprehensive risk assessment

- Provides a foundation for identifying personal warning signs
- Provides salient personal example for how suicidal crises develop and pass
- Helps to build rapport
Components of a safety plan:

- Warning signs of suicide/internal triggers
- Internal coping strategies
- Social contacts and social settings for distraction
- Friends and family to resolve crises
- Contacting MH professionals
- Restricting access to lethal means

STEP 1: WARNING SIGNS

• One of the most effective ways to avert suicidal crisis is to intervene with problem before it fully emerges

• Generate a list of personal warning signs (e.g., thoughts, behaviors, situations, emotional states) that precede a suicidal crisis (as specific as possible)
  • E.g., Emotions: irritability, depressed, hopelessness; thoughts: “I can’t take it anymore”, “I just want to escape”; problematic behaviors: social withdrawal, increased drinking/drug use, foregoing personal hygiene

• Can be helpful for providers to have made mental notes during risk assessment

• Youth vs. adult responses
STEP 2: INTERNAL COPING STRATEGIES

• Pts develop a list of internal coping strategies “on my own coping” they can employ by themselves to distract from suicidal crisis/thoughts
  • E.g., going for a walk, listening to inspirational music, watching a specific TV show/movie, taking a shower, playing with a pet, playing an instrument, practicing a sport, reading

• PRIMARY AIM: List activities that serve as a distraction
  • Activities should be distracting in a POSITIVE way.
  • Strength of distraction varies between people, so important to be collaborative
STEP 2: ADDITIONAL BENEFITS AND CONSIDERATIONS

• Identification of internal strategies can enhance pt’s self-efficacy and a sense of mastery over suicidal urges

• Can help pts experience a sense of pleasure

  DON’T FORGET → Problem-solving deficits

• Pts should have a range of strategies to use

• Help prioritize: the easier the strategy, the more likely to be used with success

  • Also consider context of use: strategies for when options may be limited (e.g., middle of the school day)

• Provider should collaboratively problem-solve possible roadblocks to use of strategies

  E.g., Watching TV → Do you own a TV?

• Support in generation of alternative strategies
STEP 3: SOCIAL SITUATIONS AND PEOPLE THAT CAN HELP DISTRACT ME

- If internal coping strategies ineffective for reducing SI, pts can utilize one or both types of socialization strategies:

  **Socializing with other people in natural social environment**
  - Socializing with friends/family members may assist in distracting pts from suicidal thoughts

  **Visiting healthy social settings**
  - E.g., coffee shops, places of worship, AA meetings, local parks, rec center
  - Encouraged to exclude environments in which alcohol/substances present

*This strategy is NOT intended as a means of seeking specific help with a suicidal crisis (i.e., not explicitly necessary to reveal suicidal state) but as a distraction and a means of increasing likelihood of experiencing feelings of social connectedness*
STEP 3: ADDITIONAL CONSIDERATIONS

- Adolescents, in particular, may be more likely to identify peers as opposed to adults in this step.
  - **IMPORTANT**: Encourage youth to select individual with whom they share a positive, stable relationship and those that may reliably be a good source of distraction
- Youth may also identify social media sites as social distractors. Providers should ensure that:
  - Activity involves interactions with others vs. merely viewing social media
  - They rule out social media as a conduit for bullying/previous trigger for SI
  - They discuss individual’s experiences with specific social media platforms/websites to explore how effective of a distraction activity is likely to be
**STEP 4: PEOPLE WHO I CAN ASK FOR HELP**

- If internal coping strategies or social contacts used in earlier steps offer little-to-no benefit, pts may choose to inform family members/friends that they are experiencing a suicidal crisis.

*REMINDER:* This step distinguished from the last in that pts explicitly reveal to others that they are in crisis and in need of support.

- People listed in this step should only include trusted adults with whom individuals perceive a positive and supportive relationship (individuals named in previous step may not be the best candidates for disclosure).
**STEP 4: ADDITIONAL CONSIDERATIONS**

- Degree of complexity associated with decision regarding whether to or not to disclose SI to others → Provider and pt should work collaboratively to formulate optimal plan
  - E.g., weighing pros and cons of disclosing SI to specific people
- Pts should be asked about likelihood that they will contact listed individuals *(elicit barriers)*
  - Talk through whether each individual listed may be helpful/has potential to exacerbate crisis
  - Pts may appear unable to identify someone because they may not feel comfortable sharing plan with individual → elicit reservations *(you can’t address them if you don’t know they exist)*
- For adolescents: listing of immediate family members may not be best selection (particularly those with whom they have frequent conflicts)
  - Sometimes easiest to survey for favorable traits (e.g., reliable, calming, trustworthy)
  - Relevant adults may even receive coaching
STEP 5: PROFESSIONALS/AGENCIES I CAN CONTACT DURING A CRISIS

- In this step, pts “generate” a list of professional resources they can contact for help.
- The emergency numbers of all treating clinicians whom pts are willing to contact in a suicidal crisis should be listed, in addition to other emergency resources (e.g., nearest ED)
- Safety plan should emphasize accessibility of each resource during crisis and (if applicable) how services may be obtained
CRISIS TEXT LINE

Text HELLO to 741741
Free, 24/7, Confidential
TrevorChat and TrevorText wait times may be higher than normal right now, thank you for your patience.

If you are thinking about suicide and in need of immediate support, please call the TrevorLifeline at 1-866-488-7386 or select TrevorChat below to connect with a counselor.

TrevorLifeline
1-866-488-7386
TrevorLifeline is a crisis intervention and suicide prevention phone service available 24/7.

TrevorChat
Confidential online instant messaging with a Trevor counselor, available 24/7.
Access through a computer, as you may have technical difficulties if using a smartphone or tablet.

TrevorText
Text START to 678678.
Confidential text messaging with a Trevor counselor, available 24/7/365.
Standard text messaging rates apply.
Reality: This step more likely to involve talking through recommended points of contacts/resources and answering relevant questions.

- Providers should be intentional about:
  - Discussing pt’s expectations when they contact professionals/agencies listed on plan.
  - Discussing potential roadblocks/challenges in utilizing resources.
  - Provides opportunity to address concerns.
    - E.g., not uncommon for pts fearing being hospitalized.
BEFORE WE GET TO STEP 6

• For adolescents for whom steps 1-5 were completed without caregiver involvement:
  • Providers should discuss how caregivers/supportive adults could best support pts in using the SPI
  • Providers may consider coaching pts (using role-plays or planning discussions) on how to share this information and describe use of plan when caregivers join visit
STEP 6: MAKING THE ENVIRONMENT SAFE

• The risk of suicide is amplified when pts report a specific plan to kill themselves that involves a readily available lethal method (Joiner et al., 2003)

• *Even if no specific plan is identified, identification and restriction to potential lethal means is key
  • E.g., Implementation of firearm safety procedures, restricting access to knives, safely storing/dispensing of medication

• Step 6 is addressed last because acknowledgement of a range of other options in responding to suicidal urges increases likelihood of pt engaging in discussion regarding restricting access to means

• Important to assess for “methods of choice” and address restricting access

• *Still important to routinely ask about access to firearms, regardless of whether considered “method of choice”
  • Firearms are the most common method of death by suicide
One recommendation is to end SPI with interventions aimed at boosting pt’s mood (e.g., development of list of reasons for living, listing of pt’s positive qualities/strengths; Cf. King et al., 2013; Linehan et al., 2012)

Following completion, providers should assess pt’s reactions and likelihood they will use SP

If reluctance detected, provider can collaborate and problem solve with pt to identify obstacles/difficulties

Once pt appears willing, original document is provided to pt and copy is kept in pt’s medical record

Provider should also consider discussing where safety plan will be kept/retrieved during crisis

*The overarching aim should be to make the SP document a process of conversation. This is a lot more helpful for pts
• SP should be viewed as a living document
• It is recommended that providers check in about SP use during follow-up contacts and problem solve barriers to use
• Providers should work with pts to update/modify SP, as appropriate
CASE EXAMPLE

Adapted from:


- Following case example is representative of a frequent clinical scenario in the ED.
A 28-year-old divorced male and father of two young children presented at the local hospital ED following a suicide attempt. The patient became depressed 2 months ago after his paternal grandfather died from pancreatic cancer. The patient, who cared for his grandfather during his illness, was fired from his job due to excess absences. In the past month, the patient began seeing a psychiatrist at the local community mental health clinic for depression.

During ED evaluation with the psychiatry resident, the patient stated that he “felt down” and sometimes wondered whether “life was not worth living.” He described that the onset of his depression coincided with his grandfather's death and loss of his job. Most recently, he stated that he had thoughts of killing himself following several intense arguments with his girlfriend who was considering leaving him because he was out of work.

Initial thoughts regarding warning signs (Step 1)?
Upon clinical interview, the resident found the patient's mood to be depressed. The patient reported feeling hopeless, especially about resolving the conflict with his girlfriend and finding a job. Although the patient reported working evening hours offering private guitar lessons, he acknowledged that the income from this would be insufficient to support his family long term.

He had no prior suicide attempts and no psychiatric admissions. He denied hallucinations, delusions, and homicidal ideation.

The patient reported a history of “problems with drinking” in the past but, until the suicide attempt, had been abstinent for the past year, having found AA meetings to be very helpful.

**Additional thoughts regarding warning signs?**

**What about thoughts on Step 2 (Internal Coping Strategies)?**
## SAFETY PLAN

### Step 1: Warning signs:

1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend
<table>
<thead>
<tr>
<th>Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Play the guitar</td>
</tr>
<tr>
<td>2. Watch sports on television</td>
</tr>
<tr>
<td>3. Work out</td>
</tr>
</tbody>
</table>
After the most recent argument, the patient impulsively ingested 4 to 6 (325 mg) tablets of acetaminophen and six 12-ounce beers with the intention of dying. However, immediately after he swallowed the pills, he thought about his two young children, realized he did not want to die, and went to the ED. Patient denied any current thoughts of wanting to kill himself or plans to do so. He regretted that he had made the attempt and stated that he realized he “could never do this to his children.”

His blood alcohol level, 8-panel drug test, acetaminophen and liver function test results were within normal limits.

The patient reported a history of “problems with drinking” in the past but, until the suicide attempt, had been abstinent for the past year, having found AA meetings to be very helpful.

Any thoughts regarding possible entries for Step 3 (Social situations/people who can help distract me)?
### Step 3: Social situations and people that can help to distract me:

<p>| | |</p>
<table>
<thead>
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<tbody>
<tr>
<td>1.</td>
<td>AA Meeting</td>
</tr>
<tr>
<td>2.</td>
<td>Joe Smith (cousin)</td>
</tr>
<tr>
<td>3.</td>
<td>Local Coffee Shop</td>
</tr>
</tbody>
</table>
The resident consulted with the attending psychiatrist about whether the patient should be admitted for a psychiatric hospitalization or discharged with a referral to his local mental health clinic.

The patient's risk for suicide was determined to be moderately high but not at imminent risk. Based on the consultation, the patient was discharged and scheduled for an appointment with his psychiatrist the next day. The patient agreed to attend daily AA meetings and increase contact with his AA sponsor. The patient's motivation to continue psychiatric treatment was ambivalent but he said he would attend the scheduled follow-up appointment. While it was determined that the patient could be safely discharged from the ED, the resident remained uneasy about the disposition.
### Step 4: People who I can ask for help:

1. **Name**: Mother
   **Phone**: 333-8666

2. **Name**: AA Sponsor (Frank)
   **Phone**: 333-7215

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

1. **Clinician Name**: Dr John Jones
   **Phone**: 333-7000
   **Clinician Pager or Emergency Contact #**: 555-822-9999

2. **Clinician Name**: 
   **Phone**: 
   **Clinician Pager or Emergency Contact #**: 

3. **Local Hospital ED**: City Hospital Center
   **Local Hospital ED Address**: 222 Main St
   **Local Hospital ED Phone**: 333-9000

4. **Suicide Prevention Lifeline Phone**: 1-800-273-TALK
A REPRESENTATIVE CASE

• This case illustrates a frequent clinical scenario in the ED
• As is the case with most ED interviews with a suicidal patient, the interaction focuses on suicide risk assessment and treatment disposition
• Settings such as the ED are ideally suited for implementation of a very brief psycho-social intervention that may increase the safety of this patient and similar patients, particularly during the interval between ED visit and follow-up appointments

Given the nature of this pt’s attempt, thoughts on Step 6 (Making the Environment Safe)?
Making the environment safe:

1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3. 

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**STEP 6**
**SAFETY PLAN**

**Step 1: Warning signs:**
1. Suicidal thoughts and feeling worthless and hopeless
2. Urges to drink
3. Intense arguing with girlfriend

**Step 2: Internal coping strategies - Things I can do to distract myself without contacting anyone:**
1. Play the guitar
2. Watch sports on television
3. Work out

**Step 3: Social situations and people that can help to distract me:**
1. AA Meeting
2. Joe Smith (cousin)
3. Local Coffee Shop

**Step 4: People who I can ask for help:**
1. Name: Mother Phone: 333-8866
2. Name: AA Sponsor (Frank) Phone: 333-7215

**Step 5: Professionals or agencies I can contact during a crisis:**
1. Clinician Name: Dr. John Jones Phone: 333-7000
   Clinician Pager or Emergency Contact #: 555-622-9999
2. Clinician Name: Phone:
   Clinician Pager or Emergency Contact #:
3. Local Hospital ED: City Hospital Center
   Local Hospital ED Address: 222 Main St
   Local Hospital ED Phone: 333-9000
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK

**Making the environment safe:**
1. Keep only a small amount of pills in home
2. Don't keep alcohol in home
3. 
**Making the Environment Safe (what I can do to make sure I am in safe situations)**

1. 
2. 
3. 
4. 

**Identifying Warning Signs** (at risk times for having suicidal thoughts, desire to self-harm, desire to harm others, depressed/irritable mood, and/or other unsafe behavior)

1. 
2. 
3. 
4. 

**"On My Own" Coping** (individual strategies I can use to manage my thoughts, feelings, and behavior without contacting another person)

1. 
2. 
3. 
4. 

**"Tell Someone" Coping** (people I would go to for help in managing my thoughts, feelings, and behavior)

1. 
2. 
3. 
4. 

**"With Someone" Coping** (things I can do with someone else to manage my thoughts and settings that provide distraction)

1. 
2. 
3. 
4. 

My reasons for living

1. 
2. 
3. 
4. 

It may be necessary to seek emergency psychological services and/or emergency medical services. Some options include:

- Cedar Ridge
  6501 N. E. 50th St., Oklahoma City, OK 73141
  (405) 605-6114

- St. Anthony Hospital
  1000 N Lee Ave, Oklahoma City, OK 73102
  (405) 272-5706

- Integris Mental Health Spencer
  2601 N Spencer Rd., Spencer, OK 73084
  (405) 951-2273

- Calling 911 or going to the nearest emergency room

If you are in crisis, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or contact the Crisis Text Line by texting TALK to 741741.
RESOURCES: HANDOUTS

• **Suicide Safer Home: Safety Proofing your Home**
  

• **Myths About Suicide**
  
  [https://d477a603-03ef-4898-b287-7b5ada24b447.filesusr.com/ugd/3dd2b2_b16431d48f9948b78cc74757d50d37d6.pdf](https://d477a603-03ef-4898-b287-7b5ada24b447.filesusr.com/ugd/3dd2b2_b16431d48f9948b78cc74757d50d37d6.pdf)

• **Suicide Prevention in High Schools – Toolkit SAMHSA**
  
  [https://d477a603-03ef-4898-b287-7b5ada24b447.filesusr.com/ugd/3dd2b2_93abeb546e7a426baba84e39fb0985b7.pdf](https://d477a603-03ef-4898-b287-7b5ada24b447.filesusr.com/ugd/3dd2b2_93abeb546e7a426baba84e39fb0985b7.pdf)
IS YOUR HOME SUICIDE-PROOF?

Even if you think your child is not at risk for suicide, why take chances?

These simple steps can help you suicide-proof your home and possibly save a teen's life.

SUPPORT

Listen and ask.
Fact: Millions of kids and teens seriously consider attempting suicide every year.

FIREARMS

Remove. Lock.
Fact: Firearms are used in close to half of teen suicide deaths.

MEDICATIONS

Lock and limit.
Fact: Teens who attempt suicide use medications more than any other method.

REMOVE FIREARMS FOR NOW

- Ask a trusted friend or family member to keep it temporarily.
- Your local police precinct or shooting club might offer temporary storage.
- At the very least, lock them securely away from ammunition.

LIMIT MEDICATIONS

- Don’t keep lethal doses on hand. A pharmacist can advise you on safe quantities.
- Consider locking up medications.
- Dispose of any medications you no longer need.

PROVIDE SUPPORT

- The warning signs of suicide are not always obvious.
- Pay attention to your teen’s moods and behavior.
- If you notice significant changes, ask them if they’re thinking about suicide.

HELP IS AVAILABLE IF YOU’RE CONCERNED THAT SOMEONE YOU CARE ABOUT IS AT RISK OF SUICIDE.

NATIONAL SUICIDE PREVENTION HOTLINE:
24/7 free and confidential. 1-800-273-TALK (8255)

IN CASE OF EMERGENCY:
Call 911 or visit your local emergency room.
YOUR SAFETY PLAN

Fill out your safety plan and reference it when you are having thoughts of suicide.

1. MY WARNING SIGNS
2. MY COPING STRATEGIES
3. MY DISTRACTIONS
4. MY NETWORK
5. KEEPING MYSELF SAFE
6. MY REASON TO LIVE

GET HELP NOW
Call the National Suicide Prevention Lifeline

CALL 911

EMAIL SAFETY PLAN
Stay Alive

Find Help Now
Get help from emergency or support services

Stay Alive
Advice and tools to help you stay safe

Worried About Someone
Identify the signs of suicide and how to help

Myths About Suicide
Common misunderstandings about suicide

About Stay Alive
About this app and how to use it

Thinking About Suicide?
Read our five simple steps on staying safe

My Safety Plan
Fill in a mini plan on how to stay safe

Reasons for Living
Select reasons that are important to you

My LifeBox
Add photos that help you to stay alive

Staying Safe for Now
Ideas for helping you stay safe right now

Self Help Ideas
How to cope with your thoughts and feelings

Breathing Exercises
Some people find these exercises helpful

Grounding Techniques
How to deal with anxiety, pain, or emotions

Looking After Yourself
Understand how better to look after yourself

Potential Warning Signs
Identify if someone could be suicidal

Practical Steps to Help
A useful list of practical steps you can take

Things to Avoid
Tips on what not to do or say

Supporter Resources
For when you are supporting someone suicidal

In a Public Place
What to do if you are in public
RESOURCES: WEBSITES

SAMHSA-HRSA Webpage:

Talking Points-Talking to your Kid about Suicide:
http://www.sptsusa.org/parents/talking-to-your-kid-about-suicide/

Counseling on Access to Lethal Means Course:
http://www.sprc.org/resources-programs/calm-counseling-access-lethal-means

With Help Comes Hope:
https://lifelineforattemptsurvivors.org
THANK YOU!