

Multisystemic Therapy

Suicidal and Substance Abuse Handouts

**Prepared by
Jeff Randall, Ph.D.**

Steps for MST Safety Planning

	Tools	Working Process	Time frame
Step 1: Safety Assessment	<ul style="list-style-type: none"> ○ Safety Checklist <ul style="list-style-type: none"> ○ Intake ○ Follow-Up ○ Fit on Safety Issues 	<ul style="list-style-type: none"> ○ <i>During the first home visit, complete the Intake Safety Checklist.</i> ○ <i>Review clinical records and interview youth, caregivers and relevant others to complete a fit of prior and present incidents of self-harm.</i> ○ <i>Complete the Follow-Up Safety Checklist one week after the Intake and immediately following each incident that threatens family/youth safety.</i> 	<ul style="list-style-type: none"> ○ Intake Safety Checklist – within the first week ○ Follow-Up Safety Checklist – one week after Intake and following each incident that threatens safety ○ Fit On Safety Issues – for past incidences that threaten safety and immediately following each incident during treatment
Step 2: Safety Data Prioritization	<ul style="list-style-type: none"> ○ Strengths & Barriers with Safety Emphasis 	<ul style="list-style-type: none"> ○ <i>Based on all data gathered to date, complete the Strengths & Barriers with Safety Emphasis.</i> ○ <i>Update the Strengths & Barriers with Safety Emphasis throughout treatment as new information is identified.</i> 	<ul style="list-style-type: none"> ○ Strengths & Barriers with Safety Emphasis – within the first week ○ Update immediately when new information is identified pertaining to safety strengths & barriers. ○ Revise and Improve – At end of weeks 2 and 3
Step 3: Safety Action Plan	<ul style="list-style-type: none"> ○ Safety Plan 	<ul style="list-style-type: none"> ○ <i>Develop and implement the Safety Plan based on the data from the Strengths & Barriers with Safety Emphasis.</i> ○ <i>Update the Safety Plan throughout treatment as new information is identified and summarized as either a safety strength or barrier.</i> 	<ul style="list-style-type: none"> ○ Safety Plan – within the first week ○ Update immediately when new information is identified pertaining to safety (i.e., Strengths & Barriers); be sure to note in the Safety Plan when safety issues are resolved and actions are no longer needed ○ Revise and Improve – At end of weeks 2 and 3 and as need throughout treatment

INTAKE SAFETY CHECKLIST- 1st Assessment of Youth's & Family's Home

Youth: _____ **MST Worker** _____ **Date:** _____

Family Member(s) Interviewed: _____

Address of Assessment: _____

To ensure youth and family safety, this version of the **Checklist** is to be done within the 1st week of the onset of treatment and at any time the youth moves, and the **Follow-Up Checklist** is to be done by the end of the 2nd week or sooner, if recommended by the supervisor and team.

Certain safety concerns as noted throughout will require that you discuss appropriate actions with your supervisor before leaving the home. Complete the **Checklist**, list relevant safety concerns to be discussed with your supervisor on the last page, and phone your supervisor to discuss appropriate actions **before leaving the house.**

MEDICATIONS

Explain to the caregiver that you need to list all medications that the youth takes and all other medications in the house for two reasons: 1) to ensure the safety of the youth and everyone in the house, and 2) to have a record of all medications in the event that a drug screen is positive.

Ask the caregiver to list all medications currently taken by the youth. Additionally, ask for a list of medications taken by others in the house. Have the caregiver show you all locations where medications are stored, and read the label on each bottle or container. Estimate the approximate quantity. Make sure you ask about and determine the location of the following due to their high risk of toxicity: antidepressants, sleeping pills, heart medications, aspirin, acetaminophen (Tylenol) and other pain relievers.

Medications in the house: (Put an asterisk * by those taken by the youth)

<i>Medication</i>	<i>Approx. Qty</i>	<i>Location</i>	<i>Action (#)</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Secure the following medications in a locked box w/ the caregiver's consent: all current psychiatric prescriptions, all current prescriptions for heart/blood pressure, all sleep aids, aspirin, acetaminophen (Tylenol), and ibuprofen (Advil, Motrin).

Discuss disposition of other medications, including old prescriptions and other OTCs, with your supervisor by listing this concern on the back page for discussion with your supervisor before leaving the house. Record actions you take below by putting the appropriate number in the column above, "Action (#)."

- 1) Medication disposed (i.e. flush down toilet)
- 2) Medication removed from home with caregiver's consent (*list where by whom*)
- 3) Medication supply placed in locked box (*only the caregiver has the key*)
- 4) Medication supply placed in safe place with restricted access (*describe*)
- 5) Attempted to take action, caregiver refused, supervisor/therapist notified
- 6) No action taken, supervisor's approval given to wait for additional input from _____.

DRUG USE/ALCOHOL

Ask caregiver(s) about alcohol and substance use by the youth and everyone else currently living in the home. Ask whether any dangerous acts (self-harm or suicidal) have ever been committed while under the influence, and if so, please list each incidence in the “**Dangerous Acts & Other Weapons/Material**” section below.

<i>Alcohol/Substance</i>	<i>Who</i>	<i>Frequency</i>	<i>Hx of dangerous acts while under the influence</i>
_____	_____	_____	Y_____ N_____
_____	_____	_____	Y_____ N_____
_____	_____	_____	Y_____ N_____
_____	_____	_____	Y_____ N_____

Ask caregiver to tell you what alcohol is in the home (including beer and wine) and where it is stored. Complete list below.

<i>Type of Alcohol</i>	<i>Amount</i>	<i>Location</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

DANGEROUS ACTS & OTHER DANGEROUS WEAPONS OR MATERIAL

Find out whether the youth or any family members have past history of self-harm. Check all that apply & note specific information in the questions that follow:

- Suicide check: _____ attempts _____ completions; who _____
- List below specific details about incidences of youth and family member’s **dangerous acts** (attempts or completions of suicide), including whether substances were involved:

<i>Dangerous Act (Include who involved)</i>	<i>Where</i>	<i>When</i>	<i>Weapons/Items, Substances</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Home Check:

Ensure that items listed above, “**Weapons/Items**“ used during prior dangerous acts, are NOT readily accessible in the home NOW. List each item below and check the home with the caregiver for EACH item. Discuss with the caregiver ways to dispose of weapons and/or secure items found and document below. List any concerns on the back page for discussion with your supervisor before taking action. Use the “**Medications**” section to document actions with medications. The **Home Check** and **Youth’s Room Search** (next section) may be done concurrently, but document separately.

<i>Weapons/Items</i>	<i>Found</i>	<i>Disposal/Secure</i>
----------------------	--------------	------------------------

- _____ Yes / No _____
- _____ Yes / No _____
- _____ Yes / No _____
- _____ Yes / No _____
- _____ Yes / No _____

***Never take illegal substances or drug paraphernalia into your own possession.
Dangerous items moved to another household should not be accessible to youth/children there.***

YOUTH’S ROOM SEARCH – With caregiver’s permission

Search the youth’s room with the caregiver for any items that could be used in dangerous acts and drugs, drug paraphernalia. Discuss with the caregiver ways to secure or dispose of confiscated items. Caregivers should follow through with these actions in your presence (i.e., flush drugs down toilet, put knife in a locked box until it can be disposed of safely or moved to another household, etc.).

Document the results of the search by listing items, names of drug(s), amount(s) and actions:

<i>Item/Drug</i>	<i>Description/Amount</i>	<i>Action Taken</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

GUNS - Ensure that all children/youth are NOT present when interviewing caregiver(s) about guns.

Ask all caregivers if guns are present in the home. Were guns present? Y____ / N____

If guns are present, put this concern on the list for discussion with your supervisor, and do not leave the home until you and your supervisor have established a safety plan and you have implemented it with the caregiver.

If guns were present, was the supervisor called? Y____ / N____

If guns were present, what plan was followed? _____

Family removed gun? Y____ / N____

If gun was removed, where was it placed? _____

Family placed lock on gun? (gun must be unloaded for this to be safe) Y____ / N____

Family put gun in locker or lock box Y____ / N____

If placed in locker or lock box, where are all keys to lock? _____

Please note below any other actions taken to ensure that the youth or other children do not have access to guns. If the gun goes to another household, actions should be taken to secure it from use by children/youth in that home. _____

Does the youth or any family members have access to guns in the community (i.e., friend or family member with gun,)? Y____/N____

Please note below all actions taken to limit the youth’s access to these guns (i.e., having relatives dispose of weapons, limiting access to peer with gun). _____

Strengths & Barriers with Safety Emphasis

Client _____ Therapist _____ Date _____

System <i>Include all systems</i>	Strengths	Barriers <i>*Address all SAFETY BARRIERS in the SAFETY PLAN</i>
Individual (Child)		<i>List all risks from the Safety Checklist + others noted</i>
Safety:		
Other:		
Caregiver (Individual Characteristics)		
Safety:		
Other:		
Caregiver-Child		
<u>Instrumental</u> (e.g., <u>Monitoring</u>)		
Safety:		
Other:		
<u>Affect</u> (e.g., <u>Conflict Management</u>)		
Safety:		
Other:		
Family		
Safety:		
Other:		

Client _____ Therapist _____ Date _____

System
Include all systems

Strengths

Barriers
**Address all SAFETY BARRIERS
 in the SAFETY PLAN*

Home Environment		<i>List all risks from the Safety Checklist + others noted</i>
Safety:		
Other:		
Peers		
Safety:		
Other:		
School/Work		
Safety:		
Other:		
Community		
Safety:		
Other:		

SAFETY PLAN

Client _____ Therapist _____ Date Case Opened _____ Date of Safety Checklist _____

System	<i>List each Safety Barrier Describe in 5 to 8 words</i>	Safety Action	Who	When	Where	Date of Review	Date Resolved
Individual (Child)							
Caregiver (Individual Characteristics)							
Caregiver- Child Instrumental (e.g., Monitoring) <i>Affect (e.g., Conflict Management)</i>							
Family							

Client _____

Therapist _____

Safety Plan, Continued

System	<i>List each Safety Barrier Describe in 5 to 8 words</i>	Safety Action	Who	When	Where	Date Of Review	Date Resolved
Home Environment							
Peers							
School/ Work							
Community							

DISCOVERING TRIGGERS OF YOUR SUBSTANCE USE FORM

Client: _____

Date: _____

1. List the **places** where you are most likely to use substances (e.g., *during trips to the mall, on the corner, under the bleachers at the park, restroom at school*).
 2. List the **people** with whom you are most likely to use substances (e.g., *like old friends who also use*).
 3. List any **times** or days when you are more likely to use substances (e.g., *at night, during lunch time at school, Friday nights, when my mother is at work*).
 4. List any **activities or events** that make it more likely that you will use substances (e.g., *going to the store, arguing with my parents, parties with friends*).
 5. Do you think that you use substances when you are **feeling** certain ways? Read through the following list and mark the ones that seem relevant to you. For those you have marked, list specific examples from your own experience.
 - a. **at the end of (or during) a tense day**
 - b. **when faced with something you fear**
 - c. **when you've failed to accomplish something you'd planned (e.g., a math test)**
 - d. **when you have been taken advantage of**
 - e. **when you are bored**
 - f. **when you are in a social situation**
 - g. **when you feel bad about yourself**
"I'll never be good enough"
 - h. **when you are depressed or feel sad**
 - i. **when you want to feel energized or high**
 - j. **when you are faced with a tough problem (e.g., breaking up)**
 - k. **when you want to be friendly**
 - l. **when you wish your personality was different (e.g., more outgoing, cool)**
 - m. **others not listed here feel**

 6. List the places where you are **unlikely** to use substances (e.g., *at home, at school*).
 7. List the people with whom you are **unlikely** to use substances (e.g., *family members, members of church youth group, girlfriend/boyfriend*).
 8. List the times or days when you are **unlikely** to use substances (e.g., *during the school day, when my mother is not working, on the weekend during the day*).
 9. List the activities you engage in when you are **unlikely** to use substances (e.g., *spending time with family in specific activities, attending church youth group, going to school*).
-

Name
Date
Drug of Choice

FUNCTIONAL ANALYSIS FORM

Use this form to help figure out the triggers, behaviors, and positive and negative consequences of your or drug use. Fill out one of these forms for the drug that you use primarily.

	<u>Triggers</u>	<u>Thoughts/Feelings</u>	<u>Behavior</u>	<u>Consequences</u>	
				<u>Positive</u>	<u>Negative</u>
1.					
2.					
3.					
4.					
5.					

Adapted from Budney, A. J., & Higgins, S. T. (1998). *A community reinforcement plus vouchers approach: Treating cocaine addiction*. Rockville, MD: National Institute of Drug Abuse.

SELF-MANAGEMENT PLANNING SHEET

Name: _____

Date: _____

Drug of Choice: _____

Use this form to figure out ways to rearrange or change triggers to your drug use. By doing this you will reduce the possibility that urges to use will happen and that you will use substances. Fill out one of these forms for the drug that you use primarily. Rate how difficult it will be to carry out each plan.

<u>Trigger</u>	<u>Plan</u>	<u>Expected Consequences</u>	<u>Difficulty</u> (1-10 Scale; 10=most difficult)
1. _____	a.	b.	
		c.	
2. _____	a.	b.	
		c.	
3. _____	a.	b.	
		c.	
4. _____	a.	b.	
		c.	
5. _____	a.	b.	
		c.	

Adapted from Budney, A. J., & Higgins, S. T. (1998). *A community reinforcement plus vouchers approach: Treating cocaine addiction*. Rockville, MD: National Institute of Drug Abuse.

