Guidelines and Resources for the Position of New Hampshire Hospital Aftercare Coordinator

A Part of the New Hampshire Nexus Project

Funded by the Garrett Lee Smith Memorial Youth Suicide Prevention Program of the Substance Use and Mental Health Services Administration

Written By: Elizabeth Corley, Dana Vitrano, James Fauth, Ph.D.
Antioch University New England
Center for Behavioral Health Innovation (BHI)

In Conjunction with Shannon Murano, M.S.
Aftercare Coordinator
New Hampshire Hospital
# Table of Contents

Introduction 4  
- Roles of Aftercare Coordinator 4  
- Who Is Eligible to Receive these Services? 5  
Introduction Resources 6  
  - Resource 1: Logic Flow of NAMI Nexus Project 6  

Chapter 1: Initial Meeting 7  
- Fidelity Tool 7  
- Crisis/Relapse Evaluation and Safety Planning 7  
- Distribution of Consent and Release Forms 8  
- Explanation of Program and Psychoeducation Regarding Available Resources 8  
- Space for Questions and Feedback 8  
- Establishing Rapport 8  
- Introduction to Dashboard 9  
Initial Meeting Resources 10  
  - Resource 2: Fidelity Tool for Initial Meeting 10  
  - Resource 3: Safety Planning Checklist 11  
  - Resource 4: Safety Plan Template 12  
  - Resource 5: Patient Release of Information 13  
  - Resource 6: Handout on AC Program 14  
  - Resource 7: Warning Signs Psychoeducation Handout 16  
  - Resource 8: Family Support Handout 17  
  - Resource 9: Family Support Handout 19  
  - Resource 10: Family Support Handout 20  
  - Resource 11: My3 Mobile App Handout 21  
  - Resource 12: AC Referral Form 22  

Chapter 2: Home Visits 24  
- Fidelity Tool 24  
- Relapse/Crisis Evaluation and Safety Plan Review 24  
- Discussion of Progress and Ongoing Psychoeducation 25  
- Activities/Identification of Wellness Options 25  
- Building and Maintenance of Rapport and Space for Feedback and Questions 25  
- General Home Visit Safety Tips 26  
Home Visit Resources 28  
  - Resource 13: Fidelity Tool for Home Visits 28  
  - Resource 14: Preparedness Assessment Tool 29  
  - Resource 15: Preparedness Assessment Guide 31  
  - Resource 16: Activities and Wellness Options 33  
  - Resource 17: Activities and Wellness Options 35  
  - Resource 18: Activities and Wellness Options 36  

Chapter 3: Telephone Conversations 37  
- Fidelity Tools 37
Relapse/ Crisis Evaluation and Safety Plan Review 37
Discussion of Progress and Psychoeducation 37
Space for Questions and Feedback 38
Maintenance of Rapport 38
Telephone Conversations Resources 39
  Resource 19: Fidelity Tool for Telephone Conversations 39

Chapter 4: Ongoing Contact with Treatment Providers and Supports 40
  Fidelity Tool 40
  Frequency of Contact 40
  Safety Plan Review and Discussion of Progress 41
  Maintenance of Rapport and Psychoeducation 41
  Space for Questions and Feedback 42
  Ongoing Contact with Supports Resources 43
    Resource 20: Fidelity Tool for Ongoing Contact with Supports 43
    Resource 21: Guidelines for Interacting with Different Types of Supports 44

Chapter 5: Final Meeting 45
  Fidelity Tool 45
  Frequency of Notifications and Final Review of Safety Plan 45
  Addressing Youth's Progress 46
  Providing Space for Questions and Feedback 46
  Guidelines for Terminating Therapeutic Relationships 46
  Final Meeting Resources 47
    Resource 22: Fidelity Tool for Final Meeting 47

Chapter 6: Additional Guidelines and Considerations 48
  Required Documentation 48
  Guidelines for Addressing Self Harm Behaviors 48
  Concluding Remarks 49
  Additional Guidelines and Considerations Resources 51
    Resource 23: Risk and Protective Factors Handout 51
    Resource 24: Alternatives to Self Harm Handout 52
Introduction

In 2013, NAMI NH branch partnered with New Hampshire Hospital (NHH) in the design of an Aftercare Coordination role, as part of a Statewide effort to prevent youth suicide. Resource 1 provides a logic model of the organizations involved in the Nexus project and their roles.

According to 2014 data from the Center for Disease Control and Prevention, suicide was the second leading cause of death for individuals between the ages of 10 and 34 (National Center for Injury Prevention and Control, 2014). High risk populations include youth struggling with substance abuse, individuals with previous military experience, LGBTQ populations, young adults not attending college, youth involved in the justice system, and youth who have experienced an inpatient psychiatric admission.

Role of Aftercare Coordinator

Among youth who have experienced an inpatient psychiatric admission, the highest risk for suicide attempts and related death occurs within the first 30 days after discharge from the hospital (Suicide Prevention Resource Center, 2013). During this post-discharge period, the youth must transition from the supports provided under supervised hospital care, back into the communities they left in crisis just a short time ago. Their safety and healthy functioning depends on an adequate plan of care, including connections to relationships and services in their home communities that will support their health (Suicide Prevention Resource Center, 2013).

Risk of suicide is reduced with increased hope, self-management, and social support and connections (Jacobson & Greenley, 2001). The role of the Aftercare Coordinator (AC) is to elevate these safety factors through direct engagement with at-risk youth and their families during their stay in the hospital, and then to maintain contact for 90 days after discharge to support their care plan. While the youth is still in the hospital, the AC consults with youth and family to develop a plan for coping with crisis situations. This plan includes mapping support relationships with professionals and other community members, and planning for how to use those relationships to stay safe and well. The AC will assist the youth in reaching out to those supports to negotiate their roles in the post-discharge care plan. Finally, the AC maintains contact with both the youth and community-based supports for 90 days after discharge, to facilitate a smooth transition. These contacts alternate between in-person visits and telephone conversations, during which the AC reviews the safety plan, addresses concerns or questions, and helps to make any needed adjustments to the plan.
This manual operationalizes the aftercare coordination model, including pre and post discharge activities that are conducted in person and/or by phone. Checklists and self-assessment tools are included in this manual in order to help prompt and support high quality aftercare coordination. These tools are also intended to provide media for ongoing feedback and reflection. These tools and additional resources (such as required forms and handouts) can be found at the end of each chapter they correspond to.

**Who Is Eligible to Receive these Services?**

Individuals must be between 10 and 24 years of age in order to qualify for this program. They must have made a suicide attempt and/or be at risk for readmission, as determined by the youth’s treatment team. The youth must be in NHH at the time of program enrollment. Priority is given to at risk subpopulations, such as those in the 18-24 age range who are not in college, those with refugee status, those with co-occurring disorders, those who are LGBTQ, current and former members of the military, etc. Geographically, the Lakes, Capital, and Manchester regions are considered priority areas.

The youth selected must be ready and willing to engage in follow up and benefit from the AC intervention. In other words, they must be interested in participating and having regular contact with the Aftercare Coordinator. This characteristic is determined early in the admission process by the team and the Need/Readiness Tool. The Preparedness Assessment Tool (Chapter 2, Resource 14) is used to determine an individual’s baseline preparedness for discharge, and in order to monitor their progress over time.

Additionally, there are exclusionary criteria for the program. Individuals should not currently be eligible for or enrolled in the Fast Forward program. They must not be discharged out of the state of New Hampshire, or to a residential setting or a similar setting where the AC intervention would be a duplication of services.

**References**


Resource 1: Logic Model for NH Hospital Aftercare Coordination

Note: In this diagram the Aftercare Coordinator is referred to as the “GLS Liaison,” an earlier title for the role.
Chapter 1: Initial Meeting

Once it has been determined that a youth is eligible for services (see Resource 12, AC referral form) they will be matched with an Aftercare Coordinator. The AC will meet the youth and family in the hospital before discharge. The goal of the initial meeting is to introduce the program, develop a safety plan, and establish a working alliance that will continue to grow throughout the next 90 days. Each of these tasks helps the youth and family feel more prepared for discharge, and educates them on what to expect when the youth is transitioning back to their everyday life.

Fidelity Tool

Resource 2 provides a fidelity tool for assessing the AC’s performance during the first meeting regarding each of the key intervention areas. These areas will be described in detail in the subsequent paragraphs. The AC should rate themselves using this tool immediately or soon after the initial meeting. The tool includes eight critical components or interventions that should be addressed in the initial meeting. For each critical component or intervention, there are four potential ratings. A score of zero is representative of an unacceptable level of adherence to the intended critical component or intervention. Scores of one or two indicate a slightly acceptable or generally satisfactory level of care. Finally, a score of three corresponds with the ideal (or “gold”) standard of care. It should be noted that even if an AC meets some of the criteria for a particular rating, they must have also met or surpassed all of the criteria in the lower rating categories in order to earn the full score. For example, under “Distribution and Release of Consent Forms,” if the AC allowed for questions and discussion, but failed to explain the forms to begin with, then they cannot receive the highest score of three.

Crisis/Relapse Evaluation and Safety Planning

The construction of a safety plan allows the youth and family to develop a response plan to crisis. During the completion of the safety plan, the AC should obtain information about the youth’s initial suicide attempt. This background information should be used to evaluate the youth’s current risk for relapse or crisis. Framing the safety plan in terms of previous experiences might be helpful in order to encourage the youth and family to consider what resources and supports they retrospectively wish they had had during the crisis. The development of the plan should be a collaborative process, incorporating the input of as many family members and supports as possible.

The safety plan contains seven sections. The overall goal of the safety plan is to encourage the youth and family to identity potential supports, resources, and coping strategies. This plan should be documented in writing, and multiple copies should be provided to the youth and family members in order to ensure immediate access during emergency situations. Resource 3 includes a list of questions for the AC to consider when prompting the family to complete each area of the safety plan. The AC can use this as a checklist if they so desire in order to assess their own comprehensiveness. In addition, a safety plan template is provided in Resource 4. This document can be printed, completed, and used as the youth’s safety plan. A copy of the safety plan should
be distributed to the youth, each family member, and each of the listed supports. Additionally, the AC should maintain a copy on file.

As part of the safety plan, the AC should discuss available community resources, options, and supports for the youth and their family. If the youth currently has professional or natural supports in the community, the AC should record their contact information and reach out to them. Successful recovery is more likely when the youth has a strong support system, so it is important for the AC to ensure that all supports are involved and informed of the youth's current status.

**Distribution of Consent and Release Forms**

Before formal treatment begins, the AC must obtain the appropriate releases from the youth and family. These releases will allow for communication between the AC and various professional and community supports (e.g., teachers, primary care physicians, psychiatrists). The AC should be sure to explain the meaning and intentions behind each form in a comprehensible way to the youth and family. Concerns presented by the youth and family should be validated and discussed in a thoughtful manner.

The Patient Release of Information form, which can be found in Resource 5, authorizes NHH to release information about the youth’s hospitalization to the AC for treatment purposes. The youth and family might feel some discomfort over sharing this medical information. Thus, the matter should be discussed with sensitivity. The youth and family should be reassured that this information will only enhance their treatment and that the AC will maintain full confidentiality.

**Explanation of Program and Psychoeducation Regarding Available Resources**

To orient the youth and family to the program, the AC should provide various handouts on what to expect over the following 90 days. Resource 6 gives an overview of the services and supports provided by the NHH AC. Additionally, the AC should provide psychoeducation about typical warning signs of crisis (Resource 7) as well as available state level and national resources, such as the National Suicide Hotline (1-800-273-TALK). The My3 mobile app (see Resource 11) is an alternative resource that provides the youth with immediate access to their supports. Resources 8 through 10 provide additional informational resources that might be particularly helpful for family members or primary caregivers.

**Space for Questions and Feedback**

As a general principle, the AC should seek feedback about their performance and role. The AC should also provide space for questions and allow adequate time to respond. When necessary, and if possible, the AC should seek out additional resources in order to fully address youth and family questions.

**Establishing Rapport**

Building rapport is one of the most essential components to successful aftercare coordination. The AC should start to build the youth and family's trust and respect during the initial meeting in
the hospital. The AC should spend some time explaining their role and how they will be of service to the youth and family in the next 90 days. They should get to know both the youth and family, and express interest in the youth as a person. Additionally, when providing information about the program and its procedures, it is essential that the AC be up-front and honest with the youth and family regarding what will happen and what to expect next.

**Introduction to Dashboard**

Throughout the entire Aftercare Coordination process, the AC is expected to regularly update and consult with the youth’s Dashboard profile. The Dashboard is an interactive excel workbook that allows for the tracking of data pertaining to the youth’s progress over time. It can also be a helpful location in which the AC can store important notes. Because the Dashboard contains protected health information (PHI), under US law, it must be HIPAA-compliant. The identity of the youth must be protected using a special numerical case code.
## Initial Meeting Resources

### Resource 2: Fidelity Tool for Initial Meeting

<table>
<thead>
<tr>
<th>Domain</th>
<th>Critical Component</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Completion of Safety Plan</strong></td>
<td>Safety plan is not completed at all or is only completed by the AC.</td>
<td>Safety plan is completed in collaboration with the youth.</td>
<td>Safety plan is completed in collaboration with the youth and at least one family member.</td>
<td>Safety plan is completed with youth and multiple family members and/or supports.</td>
<td></td>
</tr>
<tr>
<td><strong>Relapse/Crisis Evaluation</strong></td>
<td>AC does not make any effort to reassess with youth, family, and/or community providers around the circumstances that may have contributed to a relapse or crisis.</td>
<td>AC briefly checks in and discusses the circumstances that may have contributed to a relapse or crisis.</td>
<td>AC discusses the circumstances that may have contributed to a relapse/crisis and problem-solves/provides support/guidance around this.</td>
<td>AC works with the youth, family, and/or community providers to come up with an updated crisis plan including how to manage a relapse or crisis in the future and what resources or supports to reach out to, etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Distribution of Release and Consent Forms</strong></td>
<td>The youth and family/guardian decline to sign consent and release of information forms.</td>
<td>Signatures of youth and parent are obtained on consent and release of information forms. Forms are briefly explained.</td>
<td>Forms are explained in a thorough yet accessible manner.</td>
<td>Space is made for questions and discussion regarding consent and release of information.</td>
<td></td>
</tr>
<tr>
<td><strong>Explanation of Program</strong></td>
<td>Purpose and expectations of the program are not explained.</td>
<td>AC provides handouts on the purpose and expectations of the program.</td>
<td>AC briefly explains the purpose and expectations of the program.</td>
<td>AC explains the purpose and expectations of the program in a thorough yet accessible manner.</td>
<td></td>
</tr>
<tr>
<td><strong>Psychoeducation</strong></td>
<td>Psychoeducation and resources to the youth and family are not provided.</td>
<td>Youth and family are provided with handouts detailing several community resources, such as the suicide prevention hotline and My3 app.</td>
<td>AC provides personalized resources to youth and family that reflect their interests and demographics.</td>
<td>AC consulted with community organizations, agencies, etc., to facilitate psychoeducation including dissemination of materials, trainings, presentations, webinars, etc.</td>
<td></td>
</tr>
<tr>
<td><strong>Rapport Building</strong></td>
<td>AC does not make any efforts to build rapport with youth and family and/or actively alienates them.</td>
<td>AC is polite and shows curiosity toward the youth and family's current difficulties.</td>
<td>AC engages youth and family in an engaging discussion that extends beyond the immediate issues at hand.</td>
<td>Discussion incorporates the youth and family's personal interests and is sensitive to the family's culture and norms.</td>
<td></td>
</tr>
<tr>
<td><strong>Space for Youth and Family Questions</strong></td>
<td>Space for the youth and family to ask questions is not provided.</td>
<td>Space is provided for the youth and family to ask questions.</td>
<td>AC briefly responds to the youth and family's questions.</td>
<td>Discussion incorporates the youth and family's personal interests and is sensitive to the family's culture and norms.</td>
<td></td>
</tr>
<tr>
<td><strong>Space for Youth and Family Feedback</strong></td>
<td>Feedback is not requested.</td>
<td>AC requests youth and family feedback regarding the program.</td>
<td>AC responds to feedback and engages youth and family in discussion.</td>
<td>AC discusses ways to integrate the feedback into future meetings.</td>
<td></td>
</tr>
<tr>
<td>Category</td>
<td>Questions to Ask</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Warning Signs of a Crisis</td>
<td>What do you experience when you start to think about suicide or feel extremely distressed? How do you know when the safety plan should be used?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Coping Strategies</td>
<td>What can you do, on your own, if you become suicidal again, to keep yourself from acting on your thoughts/urges? How likely do you think you would be able to use this step during a time of crisis? What might stand in the way of you thinking of these activities or doing them?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People and Social Settings for Distraction</td>
<td>Who or what social settings help you take your mind off of your problems at least for a little while? Who helps you feel better when you socialize with them?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People Whom I Can Ask for Help</td>
<td>Among your friends/family, whom do you think you could contact for help during a crisis? Who is supportive of you/who do you feel that you can talk with when you're under stress?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professionals or agencies I can contact During Crisis</td>
<td>Who are the Mental Health professionals that we should identify to be on your safety plan? Are there other health care providers?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Making the Environment Safe</td>
<td>What means do you have access to, to make a suicide attempt or to kill yourself? How can we go about developing a plan to limit your access to these means?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conclusion</td>
<td>Where will you keep your safety plan? How will you remember that you have a safety plan when you're in crisis?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Patient Safety Plan Template

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1._________________________________________________________________________
2._________________________________________________________________________
3._________________________________________________________________________

Step 2: Internal coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1._________________________________________________________________________
2._________________________________________________________________________
3._________________________________________________________________________

Step 3: People and social settings that provide distraction:
1.Name____________________ Phone________________________
2.Name____________________ Phone______________________
Place 1________________________ Place 2________________________

Step 4: People whom I can ask for help:
1.Name____________________ Phone________________________
2.Name____________________ Phone________________________
3.Name____________________ Phone________________________

Step 5: Professionals or agencies I can contact during a crisis:
1.Clinician Name____________________ Phone________________________
Clinician Pager or Emergency Contact #______________________________
2.Clinician Name____________________ Phone________________________
Clinician Pager or Emergency Contact #______________________________
3. Local Urgent Care Services________________________________________
Urgent Care Services Address________________________________________
Urgent Care Services Phone________________________________________
4. Suicide Prevention Lifeline Phone: 1-800-273-TALK (8255)

Step 6: Making the environment safe:
1._________________________________________________________________________
2._________________________________________________________________________

The one thing that is most important to me and worth living for is:

Safety Plan Template ©2008 Barbara Stanley and Gregory K. Brown, is reprinted with the express permission of the authors. No portion of the Safety Plan Template may be reproduced without their express, written permission. You can contact the authors at bhs2@columbia.edu or gregbrow@mail.med.upenn.edu.
NEW HAMPSHIRE HOSPITAL
36 Clinton St. Concord, NH 03301
Telephone 603-271-5300

Patient’s Name  Date of Birth

MR#  

I (Print Name of Patient or Legal Representative)

hereby authorize NH Hospital to exchange my protected health information as described below for the purposes of
enhanced discharge planning and follow-up care coordination and support to ensure community connections are
maintained.

Dates of contact from _______ to _______
(date of most recent discharge)  (date not to exceed 6 months after discharge date)

This authorization is valid only for verbal exchange of information between

New Hampshire Hospital Aftercare Liaison and

Name
Street
City/State
Phone Number:

Requests for copies of protected health information (medical records) requires a separate authorization

By signing this Authorization for Disclosure of Protected Health Information, I understand that:

1. A Photocopy of fax of this authorization shall be as valid as the original.
2. This Authorization for Disclosure of Protected Health Information is not a required condition for treatment.
3. If the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the disclosed information
   may be re-disclosed and would no longer be protected by federal privacy regulations.
4. Under the NH Division of Behavioral Health regulation, 10-3.111, (after May 1982): NH Hospital is obliged to disclose any information in its
   possession with a properly executed authorization
5. The Authorization to Disclose Protected Health Information for the specific purpose of verbal exchange for ensuring community connections
   following discharge from New Hampshire Hospital shall be effective for a period of six (6) months.
6. Information disclosed may include psychiatric, substance abuse, HIV infection, AIDS, or tests for HIV
7. This authorization may be revoked at any time. The request to revoke this authorization must be in writing and delivered to the Health
   Information Department of NH Hospital. Upon receipt of written revocation, NH Hospital must immediately cease disclosure of medical
   information, except to the extent information has been disclosed prior to the date of revocation
8. I am entitled to a copy of this authorization after I sign it.

Complete this section ONLY if a minor has been treated for a sexually transmitted disease pursuant to RSA 141-C: 18, II

A competent minor aged 14 or older may consent to treatment for a sexually transmitted disease. Therefore, specific authorization of the minor is
required for the disclosure of that information. If the parent/guardian authorized the treatment they would also authorize the disclosure of
information.

Patient Initials   Yes or No   OR   Parent/Guardian Initials   Yes or No

Signature of Patient/Legally Authorized Representative  Relationship if not signed by the patient  Date

NEW HAMPSHIRE HOSPITAL
Authorization for Disclosure of
Protected Health Information
Aftercare Liaison- Verbal Exchange Only

PATIENT IDENTIFICATION

Patient’s Name  Date of Birth

MR#  

MR # 001c
Revised 10/17/14
File in Post Discharge Follow-up section
Services/supports provided by the New Hampshire Hospital Aftercare Coordinator:

You are receiving this document because you have been referred to the Aftercare Coordinator by your treatment team and are ready/willing to engage in follow-up care and receive support from the New Hampshire Hospital Aftercare Coordinator.

Prior to Discharge:
- Aftercare Coordinator will meet with you and/or family members/other identified supports during hospitalization to establish a professional relationship, build trust, and provide education on standard suicide prevention information.
- Aftercare Coordinator will work with you to develop, complete, and implement a safety plan; a copy of which will be given to you along with your Community Mental Health Center (if applicable) and any other identified family members/supports. A copy of the Safety Plan will also be included in your New Hampshire Hospital discharge packet.
- Aftercare Coordinator will collaborate with you, your New Hampshire Hospital treatment team, support system, and community treatment team to identify wellness options/resources/supports to be explored and/or established.
- Aftercare Coordinator will obtain releases of information to communicate with other key stakeholders for post discharge contact (i.e. mental health and key supports chosen by you).
- Prior to discharge, you and Aftercare Coordinator will schedule two face to face and two telephone contacts as needed in each of the first two months post-discharge to assess the transition, level of hope, connections/engagement with resources, needs identified by you and/or family; and discuss a plan to reduce contact to four telephone contacts in the third month if you are stable and engaged.

Post Discharge:
- During scheduled meetings, you and Aftercare Coordinator will conduct an ongoing review of warning signs, potential triggers, coping mechanisms, and emergency resources with family and/or identified support system; update safety plan as necessary.
- Upon discharge, Aftercare Coordinator will identify components of support system that would benefit from general suicide prevention education and consult with NAMI NH and the Community Mental Health Center on facilitating this education.
- In the event of a relapse or crisis, Aftercare Coordinator will reassess with community providers and you/family around the circumstances that may have contributed to the crisis/relapse and modify resources/safety plan accordingly.
- Aftercare Coordinator will document and report progress and other evaluation data as required and as necessary.
• Aftercare Coordinator will collect, enter, and utilize evaluation data and obtain your consent (if agreeable) to research uses of your data by completing (or having parent/guardian complete) the New Hampshire Hospital Evaluation Research consent form (Please see attached consent form).

• If you continue to make progress, reassess (in 90 days) need for continued contact/other follow-up evaluation.

If you have questions/concerns at any time throughout this process, please do not hesitate to contact me at the below telephone number:

**Name of Aftercare Coordinator**
Aftercare Coordinator
New Hampshire Hospital
36 Clinton Street
Concord, NH 03301

**AC Telephone Number**
Recognize the Warning Signs for Suicide to Save Lives!

Sometimes it can be difficult to tell warning signs from “normal” behavior, especially in adolescents. Ask yourself, is the behavior I am seeing very different for this particular person? Also, recognize that sometimes those who are depressed can appear angry, irritable, and/or hostile in addition to withdrawn and quiet.

Take action if you see any of the following warning signs:

- Talking about or threatening to hurt or kill oneself
- Seeking firearms, drugs, or other lethal means for killing oneself
- Talking or writing about death, dying, or suicide
- Direct Statements or Less Direct Statements of Suicidal Intent: (Examples: “I’m just going to end it all” or “Everything would be easier if I wasn’t around.”)
- Feeling hopeless
- Feeling rage or uncontrollable anger or seeking revenge
- Feeling trapped - like there’s no way out
- Dramatic mood changes
- Seeing no reason for living or having no sense of purpose in life
- Acting reckless or engaging in risky activities
- Increasing alcohol or drug use
- Withdrawing from friends, family, and society
- Feeling anxious or agitated
- Being unable to sleep, or sleeping all the time

For a more complete list of warning signs and more information on suicide prevention, please consult the Connect website at http://www.theconnectprogram.org and click on Understanding Suicide.

If you see warning signs and/or are otherwise worried that this person:

Connect with Your Loved One, Connect Them to Help

1) Ask directly about their suicidal feelings. Talking about suicide is the first step to preventing suicide!
2) Let them know you care.
3) Keep them away from anything that may cause harm such as guns, pills, ropes, knives, vehicles
4) Stay with them and get a professional involved.
5) Offer a message of hope - Let them know you will assist them in getting help.
6) Connect them with help:
   - National Suicide Lifeline (24/7) 1-800-273-TALK (8255) (press “1” for veterans)
   - Headsrest – For teens and adults (24/7) 1-800-639-6095 or your local community mental health center.
   - For an emergency, dial 911.

For more information about suicide prevention training and resources in NH:

www.theconnectprogram.org
Resource 8: Family Support Handout

Support, Education, Advocacy and Leadership Training for
Parents and Primary Caregivers of
Children and Adolescents with Serious Emotional Disorders

Support

One to One Time Limited Individual Support – support, education and resource information is provided to families of children and adolescents with Serious Emotional Disorders. An “illness-wise” family member will work with the family in the areas they identify as a need – e.g., help family members to learn how to navigate the service delivery system, improve their advocacy skills and/or decrease their family’s isolation by encouraging them to make connections with other NAMI NH programs. There is no fee for this confidential support program provided by NAMI NH and funded through a grant.

One to One Intensive Individual Support – support and education is provided to families with children and adolescents with Serious Emotional Disorders who are enrolled in the F.A.S.T. Forward initiative using a Wraparound Approach to treatment. An “illness-wise” family member will work with the family who is enrolled in Wraparound as they go through this process and in the areas they identify as a need. The families are encouraged to make connections with other NAMI NH programs. There is no fee for this confidential support program provided by NAMI NH and funded through a federal grant.

Family Support Groups – NAMI NH builds and helps to maintain a strong support group network made up of people who have “been there” – they have personal experience with mental illness and can offer education and “HOPE”. The groups are facilitated using a nationally recognized model and led by trained facilitators who are parents. A statewide listing can be found on our website – click on Support and then Family/Friends of Children.

On-Line Support Group – a “live” on-line support group meets twice a month using a nationally recognized support group model to assist parents/primary caregivers in connecting with others who share similar experiences, provides education and resources. The group is led by a trained facilitator who is a parent. Register for the group by going to our website, click on Support and then NAMI NH Online Support Groups.

Message Board – an opportunity for family members to share and learn from one another, post questions, learn about resources and encourage one another. Join by going to our website – click on Support and then Join the Parents Message Board.

Education

Parents Meeting the Challenge – is an 8-session education program that provides tools, strategies and information to help parents and caregivers meet the challenges of parenting/taking care of a child with emotional and behavioral disorders, to navigate the system and learn effective advocacy skills. The program is delivered by family members who have completed a training program. Registration is
required. If you do not see the program offered in your area, register online and you will be notified when the program will be available.

**Website** – visit [www.NAMINH.org](http://www.NAMINH.org) to learn about our programs, upcoming events, information and resources.

**Mental Health Resource Center** – is available 9 a.m. to 5 p.m. Monday through Friday, at 85 North State Street, Concord, NH. Resources include NIMH (National Institute on Mental Illness) literature, publications and a Lending Library is available to NAMI NH members.

**Leadership Training**

**“It’s Your Move”** – is a public policy advocacy training that provides participants with the skills and confidence to engage their local representatives one-on-one or within a group such as a legislative forum in their community. Participants learn about the New Hampshire political structure; the most effective methods of communication and messaging; and how to counter negative thinking on the part of decision makers.

**Parents Meeting the Challenge Teacher Training** – is a 4-part series that will prepare volunteers, who are parents/primary caregivers of children and adolescents with emotional and behavioral disorders, to teach the program in their community. This model of “families helping families” is very effective and has been successful in New Hampshire and across the country.

**Parents Meeting the Challenge Support Group Facilitation Training** – provides participants with the tools and techniques to facilitate a peer-run family support group. Participants learn facilitation skills and the specific methods of the NAMI support group model. This model keeps the group positive and constructive while allowing for group members to share their current concerns and emotions.

**Life Interrupted Speaker Training** – is for family members who are interested in presenting their story to groups and organizations in their communities or around the state. By speaking about their own experiences, the presenters are able to address mental illness stigma and educate communities about mental illness recovery, how mental illness impacts family members and the resources that are available to family members.

**For more details about these Support, Education, Advocacy and Leadership Programs for families of adults or older adults**

Visit the NAMI NH Website: [www.NAMINH.org](http://www.NAMINH.org)

Or

Call our Information and Resource Line (I&R): 1-800-242-6264, ext. 4

The calls are responded to within 2 business days – Monday-Friday, 9 a.m. to 5 p.m.

*Please Note: The I&R Line is not a crisis response line.*

85 NORTH STATE STREET · CONCORD, NH 03301 · (603)225-5359 · [www.NAMINH.org](http://www.NAMINH.org)
Find Help, Find Hope!

Information and Resource Line...

is available for callers to leave a confidential message at any time. Your call will be returned within two business days – Monday through Friday, 9:00am to 5:00pm.

A trained NAMI NH staff member will help answer your questions by providing information on specific NAMI NH programs and supports along with guidance on other available local and national resources.

Please note: This is not a hotline or a crisis service, but it is a resource for families and individuals affected by mental illness/emotional disorders.

Family and Community Support...

provides free and confidential, time-limited, one-on-one support and education to individuals and/or families with loved ones of any age with emotional disorders or mental illness.

It is not counseling or advocacy but it is an opportunity to meet with a trained, illness-wise family member in a private and confidential place of your choice.

To access either of these services or for more information on any of our education or support programs, please contact our office at (800) 242-6264 or (603) 225-5359 or visit our website at www.NAMINH.org.

improving lives affected by mental illness

New Hampshire

National Alliance on Mental Illness

85 NORTH STATE STREET • CONCORD, NH 03301 • TEL: (603) 225-5359 • www.NAMINH.org
Family Support and Information
Is Just a Click Away!

Make important connections to others who have a loved one with a serious emotional disorder or mental illness who:

- Understand the challenges you face and the opportunities ahead
- Feel the same way you do
- Have had the same experiences
- Will help you learn new coping skills
- Will share their successes and strategies with you

Two ways to participate in the online supports:

On-Line Message Boards

Parents/Caregivers of Children/Adolescents with Serious Emotional Disorders


OR

Find Us On Facebook

Parents and Loved Ones of Children with Serious Emotional Disorders can find us at http://on.fb.me/1MAyMls

Family and Friends of Adult Loved Ones with Mental Illness can find us at http://on.fb.me/1Aw8zl

New Hampshire

85 North State Street • Concord, NH 03301 • (603)225-5359 • www.NAMINH.org

These programs are financed under an Agreement with the State of NH, DHHS, Division of Behavioral Health, with funds provided in part or in whole by the State of NH and/or U.S. Department of Health and Human Services.
STAY CONNECTED TO YOUR SUPPORT NETWORK WHEN YOU ARE HAVING THOUGHTS OF SUICIDE.

CREATE YOUR SUPPORT SYSTEM
Simply add the contact information for people who know and care about you and can help when you are experiencing thoughts of suicide.

BUILD YOUR SAFETY PLAN
You can customize a safety plan by identifying your warning signs, coping strategies, distractions and personal networks to help keep yourself safe.

ACCESS IMPORTANT RESOURCES
Personalize MY3 by adding other suicide prevention resources and websites that help you feel better and stay safe. A number of different resources are also already listed in MY3.

If you need to talk to someone about your suicidal thoughts, please contact the National Suicide Prevention Lifeline at **1-800-273-TALK (8255)**. Trained counselors are available to provide free, confidential help, day or night.

Download MY3 for free on iPhone App Store or Google Play Store. Search for MY3-Support Network.

www.MY3App.org
Resource 12: AC Referral Form

**AFTECARE COORDINATOR POST DISCHARGE SUPPORT REFERRAL FORM**

**Directions:** This referral information can be completed by any NHH clinical staff assigned to the patient, based on information in the record and the consensus clinical judgment of the treatment team. This information will be used by the Aftercare Coordinator to prioritize those patients most likely to profit from enhanced post discharge support.

1. **REFERRAL DATE:**

2. **REFERRING TEAM/STAFF:**

3. **PATIENT NAME:**

4. **PATIENT AGE:**

5. **PATIENT NHH INTAKE DATE:**

6. **PUBLIC HEALTH REGION OF RESIDENCE** (please circle): Concord, Manchester, Laconia, Other

7. **PATIENT NEED FOR POST DISCHARGE SUPPORT** (please circle)

   - 1=No/Low Need
   - 2 = Moderate Need
   - 3= High Need

   Patient no/low risk for suicide and readmission
   Patient moderate risk for suicide and readmission
   Patient high risk for suicide and readmission

8. **PATIENT WILLINGNESS/READINESS FOR POST DISCHARGE SUPPORT** (please circle)

   - 1=No/Low Readiness
   - 2=Moderate Readiness
   - 3=High Readiness

   Patient/family is unreceptive to post discharge support
   Patient/family is ambivalent about post discharge support
   Patient/family is receptive to post discharge support

   Post discharge support clearly unwarranted and/or contraindicated for this patient/family
   No clear contraindications for post discharge support for this patient/family
   Post discharge support clearly appropriate for this patient/family
9. ADDITIONAL NOTES/COMMENTS (OPTIONAL):

Aftercare Coordinator use only **Final Disposition** (circle one): Accepted  Not Accepted  Declined
Chapter 2: Home Visits

The AC should visit the youth and family in their home on a biweekly basis for the first 30-45 days. However, if the youth and family are doing well and are well-connected, these meetings may become less frequent, happening perhaps every three weeks or once a month. Conversely, if the youth is not doing well, the AC can meet with them more frequently, even weekly, if necessary. Home visits provide an opportunity for the AC to see the youth and family in their own environment and to have more in-depth conversations about their progress. Before each home visit, the AC should review the worksheets from previous sessions and check Dashboard to review the client’s progress.

Fidelity Tool

Resource 13 provides a fidelity tool for assessing the AC’s performance during home visits regarding each of the key intervention areas. These areas will be briefly described in the subsequent paragraphs. The AC should rate themselves using this tool immediately or soon after each home visit. The tool includes eight critical components or interventions that should be addressed during home visits. For each critical component or intervention, there are four potential ratings. A score of zero is representative of an unacceptable level of adherence to the intended critical component or intervention. Scores of one or two indicate a slightly acceptable or generally satisfactory level of care. Finally, a score of three corresponds with the ideal (or “gold”) standard of care. It should be noted that even if an AC meets some of the criteria for a particular rating, they must have also met or surpassed all of the criteria in the lower rating categories in order to receive the score in question.

Relapse/Crisis Evaluation and Safety Plan Review

The AC should spend the first few minutes of the meeting reconnecting with the youth and family. Specific follow-ups from the previous week should be addressed. In addition, the AC should measure the youth’s preparedness using the Preparedness Assessment Tool. A copy of this tool, as well as a guide for using the tool can be found in Resources 14 and 15.

As a general rule, it might be helpful to take notes on the youth’s general mood, behavior, and attitudes regarding progress. This can be done during or shortly following the meeting, depending on the AC’s preferences. Additionally, the AC should ask the youth if they still feel comfortable with the safety plan; if not, necessary revisions should be made. It is essential for the safety plan to remain updated in the event that a crisis arises. Whenever the safety plan is significantly revised, it is the AC’s responsibility to ensure that all family members receive updated versions. It is generally expected that the youth and family will update supports regarding any safety plan revisions. However, if may be helpful for the AC to verbally inform them of any significant changes during telephone conversations (so long as a release of information has been obtained). Regular communication about the safety plan ensures that everyone involved is on the same page if an emergency occurs.
Discussion of Progress and Ongoing Psychoeducation

The AC should be sure to specifically check in with the youth. This should be done on an individual basis, if possible. In order to ensure privacy, the AC and youth might need to converse in a separate room. On some occasions, it might be helpful for the youth and AC to take a brief walk outside of the house. The youth and AC should discuss any challenges or successes the youth has had over the past week. The AC should seek to empower the youth by commending any progress (e.g., practicing self-care, using coping skills, engaging in communication, etc.). While the AC is a resource for the youth, their role is not the same as that of a therapist, and clinical work should be done with the youth’s assigned clinician.

The AC should also spend some time with the family to discuss how they perceive the youth’s progress. This is especially important if the youth is shy or has trouble discussing their experiences. The family can reveal any issues that the youth did not address. The family may also be able to give an update on any medical changes regarding medications or therapy. In addition, through observing family interactions, the AC might come to better understand the youth’s behavior, living environment, and family relationships. It should be noted, however, that the interactional patterns observed during home visits might not always be fully representative of the youth’s everyday life. Thus, the AC should be careful not to make too many generalizations.

Activities/Identification of Wellness Options

The AC should strive to make home visits feel comfortable and non-intimidating to the youth. Home visits provide the opportunity to engage the youth in a fun or relaxing activity, which can strengthen their working alliance with the AC. Activities can include going for a walk instead of sitting in the house or playing a game with the youth while they discuss their week.

Activities should emphasize self-regulation and coping skills. Activities might encourage mindfulness and other relaxation strategies. Journaling and drawing can also encourage the expression of ideas in a non-threatening manner. Some potential activities and handouts are provided in Resources 16 through 18. However, the AC should feel free to employ their own creative skills in designing or applying various activities. Although activities are primarily intended for the benefit of the youth, opportunities may be taken to include other family members, particularly siblings, if they are eager to join. When activities include multiple individuals, they might serve as opportunities to promote further discussion, strengthen collaborative and communication skills, and build rapport with everyone involved. However, participation in activities should be optional for other family members. It might also be helpful for the AC to provide the youth with multiple options for activities in order to further enhance trust and collaboration.

Building and Maintenance of Rapport and Space for Feedback and Questions

It is likely that rapport will be naturally built through engaging the youth and family in activities. However, additional efforts should be made to ensure that the family and youth feel confident in the AC’s abilities. They should also feel comfortable sharing their thoughts, experiences, and
feedback with the AC. In order to foster and maintain a strong working alliance, the AC should convey respect, openness, curiosity, and authenticity. They should be honest with the youth and family and eager to listen. The AC should express a sincere curiosity toward the interests, perceptions, and experiences of the youth and family. In addition, the AC should observe the rules of the home and act in a way that is sensitive toward the family’s cultural, religious, and political traditions and practices.

The AC should also provide space for the youth and family to ask questions about resources and the general Aftercare Coordination process. The AC should be generous in sharing their knowledge, providing additional resources as necessary. When the AC is uncertain of the answer to a question, they should acknowledge their uncertainty and offer to perform additional research into the matter. Additional guidelines for home visits, particularly as they pertain to safety, are outlined in the following section.

**General Home Visit Safety Tips**

Some basic considerations should be kept in mind when visiting someone within the confines of their own home. First and foremost, it is their space, so it is necessary to be respectful of the rules and norms governing their home. When in doubt, the AC should ask. Second, it may be more difficult to extract oneself from an uncomfortable situation when one is not within the confines of one’s own office or institution. Therefore, it is important for the AC to use extra discretion. If the AC feels uncomfortable, it is better for them to leave prematurely than to wait for a situation to fully escalate. It is also important to be prepared for emergencies, such as physical confrontations, animal attacks, or car troubles. Some general guidelines are listed below with the intention of increasing the safety and comfort of everyone involved in home visits.

**The AC should/may want to:**

- Make sure someone else from their organization (e.g., their supervisor) knows the specific addresses of the places they’ll be visiting and the dates and times they’ll be visiting them. If the AC’s schedule changes, they should be sure to update someone. Shared calendars, notebooks, or dry erase boards can facilitate this process.

- Make sure their cell phone is easily accessible to them at all times during the visit. Ensure it is charged ahead of time. It is also important to be aware of the cell phone coverage limitations in certain areas.

- Have the phone number for the local law enforcement dispatcher readily available on their phone in case a dangerous situation arises.

- Review agency and criminal history of adult members of the household prior to their visit, if they are feeling apprehensive about a new situation.

- Have a co-worker accompany them for the visit if they are particularly worried about a situation in advance.
● Deliberately drive by the actual address at first upon the initial visit, in order to assess the surroundings. This might help the AC determine the most accessible place to park their vehicle. It might also allow them to determine if there are hazards such as unrestrained animals.

● Always be vigilant of their surroundings, both inside and outside a client’s home. Trust their intuition.

● Knock in a non-threatening but authoritative way. The AC should try to refrain from “peeking” in windows, even when the door is not immediately answered.

● Call in advance to confirm a visit in order to ensure that clients will be home when the AC arrives at their house, particularly if the AC is traveling a long distance to get there. The closer to the visit the AC calls, the better, although if the AC waits too last minute, they may not be guaranteed a timely response.

● Once in the home, the AC should follow the family’s lead. The AC should ask to be seated and follow the family’s instructions regarding where to sit. The AC should be observant and respectful of rules of the house, such as shoes by the door. When in doubt, the AC should explain that they’re a guest and ask clients how they would like them to behave.

● Be aware of potential entrances and exits to the home. When possible, the AC should sit in a location where they can observe the door.

● Be aware of pets, such as dogs. If necessary, the AC may ask the client to restrain their animal during a visit.

● Know that it is permissible to ask clients the names of unfamiliar individuals who enter and exit the house. Try to convey these questions with a tone of curiosity rather than a tone of nosiness or judgment.

● Wear comfortable clothes and shoes, especially if the AC is traveling in remote regions and may get stranded. The AC should prepare for certain types of inclement weather, as well.

● In the case of inclement weather, the AC may make an informed decision not to travel to the youth’s home. However, the AC must give the family proper notice.
# Home Visit Resources

**Resource 13: Fidelity Tool for Home Visits**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Critical Component</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Safety Plan Review</strong></td>
<td>AC fails to review or discuss safety plan with youth and family.</td>
<td>Safety plan is briefly reviewed with youth and family.</td>
<td>Safety plan is fully reviewed.</td>
<td>AC collaborates with youth and family to revise safety plan as needed.</td>
</tr>
<tr>
<td></td>
<td><strong>Relapse/Crisis Evaluation</strong></td>
<td>AC does not make any effort to reassess with youth, family, and/or community providers around the circumstances that may have contributed to a relapse or crisis</td>
<td>AC briefly checks in and discusses the circumstances that may have contributed to a relapse or crisis</td>
<td>AC discusses the circumstances that may have contributed to a relapse/crisis and problem-solves/ provides support/guidance around this</td>
<td>AC works with the youth, family, and/or community providers to come up with an updated crisis plan including how to manage a relapse or crisis in the future and what resources or supports to reach out to, etc.</td>
</tr>
<tr>
<td><strong>Home Visits</strong></td>
<td><strong>Maintenance of Rapport</strong></td>
<td>AC does not make any efforts to build rapport with youth and family and/or actively alienates them.</td>
<td>AC is polite and shows curiosity toward the youth and family’s current difficulties.</td>
<td>AC engages youth and family in an engaging discussion that extends beyond the immediate issues at hand.</td>
<td>Discussion incorporates the youth and family's personal interests and is sensitive to the family's culture and norms.</td>
</tr>
<tr>
<td></td>
<td><strong>Ongoing Psychoeducation</strong></td>
<td>Psychoeducation and resources to the youth and family are not provided.</td>
<td>Youth and family are provided with handouts detailing several community resources.</td>
<td>AC provides personalized resources to youth and family that reflect their interests and demographics.</td>
<td>AC consulted with community organizations, agencies, etc., to facilitate psychoeducation including dissemination of materials, trainings, presentations, webinars, etc.</td>
</tr>
<tr>
<td></td>
<td><strong>Discussion of Progress</strong></td>
<td>AC does not engage youth and family in a discussion of progress.</td>
<td>AC engages youth and family in a general discussion of progress.</td>
<td>AC engages youth and family in a thorough discussion of progress.</td>
<td>AC collaborates with youth and family to determine future steps for ensuring the youth's progress.</td>
</tr>
<tr>
<td></td>
<td><strong>Activities</strong></td>
<td>AC does not engage youth in an activity.</td>
<td>AC engages youth in a brief, general activity regardless of demographic considerations.</td>
<td>AC selects or designs an activity that is sensitive to the youth’s interests and demographics.</td>
<td>Family participation is encouraged in the activity.</td>
</tr>
<tr>
<td></td>
<td><strong>Space for Youth and Family Questions</strong></td>
<td>Space for the youth and family to ask questions is not provided.</td>
<td>Space is provided for the youth and family to ask questions.</td>
<td>AC briefly addresses youth and family’s questions.</td>
<td>AC answers questions in a thorough yet accessible way.</td>
</tr>
<tr>
<td></td>
<td><strong>Space for Youth and Family Feedback</strong></td>
<td>Feedback is not requested.</td>
<td>AC requests youth and family feedback regarding the program.</td>
<td>AC responds to feedback and engages youth and family in discussion.</td>
<td>AC discusses ways to integrate the feedback into future meetings.</td>
</tr>
</tbody>
</table>
## HOPE

<table>
<thead>
<tr>
<th>HOPE</th>
<th>1=No/Low Hope</th>
<th>2 = Moderate Hope</th>
<th>3= High Hope</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient cannot</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>identify any spiritual,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>educational, familial,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or personal resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient cannot</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>identify any goals or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>something to look</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>forward to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient has made</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hopeless comments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient can identify</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>one or two spiritual,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>educational, familial,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or personal resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient can identify</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>something to look forward to upon leaving the hospital OR can identify a personal goal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient has made</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ambivalent comments about hope</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient can identify</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>more than two spiritual,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>educational, familial,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or personal resources</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient expresses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>enthusiasm for some event in the future and can identify any short or long-term goal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Patient has made</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>hopeful comments</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## SUPPORT

<table>
<thead>
<tr>
<th>SUPPORT</th>
<th>1=No/low Support</th>
<th>2=Moderate Support</th>
<th>3=High Support</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pervasive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>interpersonal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>problems, family</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>dysfunction, no close</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>friends or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>meaningful</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>relationships,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>problems at school</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>and with peers,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>tendency to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>withdraw and/or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>become isolated,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reported stigmatization and inability to identify any sources of support.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Multiple problem</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>areas and few</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>connections/support.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>One or two problem</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>areas and strong</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>connections/support.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient’s family is</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>engaged and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>participates in</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>treatment plan. The</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>patient has one or two friends regarded as close and is engaged in activities.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Support=
<table>
<thead>
<tr>
<th>SELF MANAGEMENT</th>
<th>1=No/Low Self Manage</th>
<th>2= Moderate Self Manage</th>
<th>3= High Self Manage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient and family does not know the patient’s diagnosis, symptoms, and medications</td>
<td>Patient and family’s understanding is minimal</td>
<td>Patient and family knows the patient’s diagnosis, symptoms, and medications</td>
<td></td>
</tr>
<tr>
<td>Patient and family cannot identify early warning signs and triggers or describe crisis plan</td>
<td>Patient and family are somewhat confident in their ability to manage at home</td>
<td>Patient and family can identify early warning signs and triggers, and describe crisis plan</td>
<td></td>
</tr>
<tr>
<td>Patient and family are not confident in their ability to manage at home</td>
<td></td>
<td>Patient and family are confident in their ability to manage at home</td>
<td></td>
</tr>
</tbody>
</table>

Total Preparedness Score (Hope + Support + Self Management)/3 =
Hope: A feeling that change is possible, the future is worth living, and that events will turn out for the best

Assessment is informed by patient responses regarding his/her experience of hope. The following questions can be used as a guide. Feel free to use unsolicited comments from the patient regarding hopelessness/hopefulness.

1. Tell me about any sources of strength or support, whether spiritual, educational, familial, or personal? [The focus of this assessment question is the patient’s ability to identify these things, though the information can also be used in the assessment of connections/support].
2. What are you looking forward to upon leaving the hospital?
3. What are your future wishes and goals?

Connections/Support: The number of people with whom the patient interacts and the quality of those relationships

Assessment is informed by your experience of the patient, collateral information obtained through the patient’s family, educators and other relevant parties, as well as patient records. Please consider interpersonal problems, family dysfunction (i.e. over- or under-involvement, conflict, abuse, stability of living situation), size and quality of support network, problems at school or with peers, whether the patient has a history of being withdrawn and/or isolated, and any indication that the patient feels stigmatized because of his/her mental illness. The following questions can be used as a guide:

For patient:
1. What are your relationships like with family and friends?
2. In what ways are your friends and family supportive?
3. In what ways can your friends and family be more supportive?
4. How do you feel judged by others because of your mental health challenges?

For family:
1. Does your child tend to be withdrawn?
2. Have there been any recent stressors or significant changes in the family?
3. How would you rate the quality of your child’s friendships?
4. How would you describe the atmosphere of your home?

Self-Management: The patient and family’s ability to manage at home

Assessment is informed by the patient and family’s ability to convey an understanding of his/her diagnosis, triggers, and early warning signs of symptoms and harmful behavior, medications, and crisis plan, as well as the patient and family’s level of confidence in managing at home.

1. Ask the patient and family to name the patient’s diagnosis and symptoms of that diagnosis
2. Ask the patient and family to name the patient’s medications, the dosage and purpose of each medication, and what time of day the medications are to be taken.
3. Ask the patient and family to explain triggers or early warning signs of symptoms and harmful behaviors, and explain in their own words the details of the patient’s crisis plan.
4. Self-efficacy can be assessed by asking the following questions:

   - Are you confident in your ability to…take your medications regularly?…ask for help?…refrain from problem behaviors [insert specific behaviors]?
   - Did you find the structure you were provided at the hospital helpful? What might get in the way of you creating this structure at home?
   - What else have you learned from being in the hospital that might help you better manage at home?
Grounding Techniques

Grounding is a technique that helps keep someone in the present. They help reorient a person to the here-and-now and in reality. Grounding skills can be helpful in managing overwhelming feelings or intense anxiety. They help someone to regain their mental focus from an often intensely emotional state.

Grounding skills occur within two specific approaches: Sensory Awareness and Cognitive Awareness

1. Sensory Awareness

**Grounding Exercise #1:**

Begin by tracing your hand on a piece of paper and label each finger as one of the five senses. Then take each finger and identify something special and safe representing each of those five senses. For example: Thumb represents sight and a label for sight might be butterflies or my middle finger represents the smell sense and it could be represented by lilacs.

After writing and drawing all this on paper, post it on your refrigerator or other safe places in the home where it could be easily seen and memorize it.

Whenever you get triggered, breathe deeply and slowly, and put your hand in front of your face where you can really see it – stare at your hand and then look at each finger and try to do the five senses exercise from memory.

Source: www.stardrift.net/survivor/senses.html

**Grounding Exercise #2:**

- Keep your eyes open, look around the room, notice your surroundings, notice details.
- Hold a pillow, stuffed animal or a ball.
- Place a cool cloth on your face, or hold something cool such as a can of soda.
- Listen to soothing music
- Put your feet firmly on the ground
- FOCUS on someone’s voice or a neutral conversation.

Sensory Awareness Grounding Exercise #3:
Here’s the 54321 “game”.

- Name 5 things you can see in the room with you.
- Name 4 things you can feel (“chair on my back” or “feet on floor”)
- Name 3 things you can hear right now (“fingers tapping on keyboard” or “tv”)
- Name 2 things you can smell right now (or, 2 things you like the smell of)
- Name 1 good thing about yourself

(Source: www.ibiblio.org/rcip/copingskills.html)

2. Cognitive Awareness Grounding Exercise:
Re-orient yourself in place and time by asking yourself some or all of these questions:

1. Where am I?
2. What is today?
3. What is the date?
4. What is the month?
5. What is the year?
6. How old am I?
7. What season is it?
Imagery

1. Imagery is just daydreaming, but a little more structured and purposeful. It can be very helpful when you’re upset or stressed out. The rule of thumb for imagery should be “more than a minute, less than an hour.” It is a short escape from an upsetting situation.

2. There are lots of ways to use imagery to relax. You can imagine any one of these: a. Relaxing place, b. Soothing person, c. Secret lock box

3. There are two KEYS to effective imagery:
   a. Get all your senses involved: sight, sound, taste, touch, smell. The more sensorily-rich your imagery is, the more effective and relaxing it can be.
   b. Breathe deeply and calmly throughout

4. For relaxing place: Think of a place you have been to, or seen in a movie, or read about in a book, or otherwise imagined. This place should be safe. Some people like to think of the beach, a forest, or grandma’s porch swing, for example. Once you have that place in mind, really focus on what it feels like to be there. What are you wearing? What do you hear? What are the smells? Focus on the space between your feet and the floor. Now what do you hear? Is there a taste in your mouth? Focus on the space between your teeth and tongue. Are there people around? Is there a breeze? Ask and answer these questions gently, as they come up. And if you don’t like the answers, imagine them changing.

5. For soothing person: Imagine someone who is kind, sees the best in you, and is never cruel. (Crushes don’t work for this; the person is probably an adult or close friend). This might be someone in your life right now. Or a fictional character. Or, if you believe in a higher power, it could be this, too. Once you have the person in mind, imagine in detail what they look like, what they are saying, and what you feel like with them.

6. For secret lockbox: Imagine—in great detail—a place in your mind where you keep what is most special to you: your favorite memories, your good feelings, your hopes and dreams. Very clearly construct in your mind what the lockbox looks like, and where you keep it. Open the box (do you need a key? A code? Is it at the bottom of the ocean?) and sift through the lockbox, finding some or all of the pleasant things you keep in there.
Progressive Muscle Relaxation

1. Progressive Muscle Relaxation is good to do when you are stressed out, sad, angry, or nervous. It buys you time to calm down and prepare good solutions to your problems. You can do it quickly (in a couple minutes), or take your time (20 minutes). You can do this in public, since it’s not very noticeable. However, it is usually more effective when you’re alone. (If you’re in a crowded place, steal away to a restroom stall, if possible...)

2. Sit or stand comfortably, but straight.

3. Close your eyes. (Oops, once you have the rest of this memorized...)

4. Take three deep breaths—in and out—through your nose.

5. Starting at your feet, feel them TOTALLY relax, and become even floaty-feeling.

6. Then, think of each body part as you move up your body. As you do, each part relaxes.

7. VERY SLOWLY, think of and relax—ankles, calves, shins, knees, thighs, hamstrings, bottom, abdomen, lower back, stomach, middle back, spine, chest, upper back, shoulders, upper arms, lower arms, wrists, hands, fingers, neck, chin, tongue, eyes, forehead, top-of-your-head.

8. If you want to go back down again, that can be even better.

9. The only way Progressive Muscle Relaxation can be effective is if you practice it when you’re not upset. That way it becomes a kind of habit. You can train yourself to automatically think of it when you’re stressed out, mad, sad, angry, or nervous. It’s also a great way to fall asleep...

10. When you’re upset, your brain has difficulties coming up with good ideas. It is usually not how upset you feel that makes a situation terrible. What makes things really bad is when you react to situations while you’re upset. It is absolutely worth it to take a couple minutes to do Progressive Muscle Relaxation. Then, come back to the situation with a clearer head, and problem-solving is a little easier.
Chapter 3: Telephone Conversations

The AC is responsible for scheduling and conducting regular telephone conversations with the youth and family. The AC communicates solely with the parent/guardian if the youth is under the age of 16 (unless the youth asks to speak with the AC). Otherwise, if the youth is over the age of 16, the AC will communicate with both the youth and their parents/guardians. Phone conversations should initially occur on a biweekly basis, alternating with meeting weeks. However, the frequency of phone calls may be reduced if the youth appears to making significant progress. The necessary frequency of phone calls should be agreed upon by the youth and AC per the AC’s professional opinion.

The AC will use telephone conversations as opportunities to check in with the youth and see how their week has been since the meeting. Telephone calls should generally be scheduled a week in advance. Scheduling can occur at the end of each home visit. It might be helpful to provide the youth and family with an appointment card. It is not always necessary to provide additional reminders as the appointment approaches. However, phone reminders might be helpful for some families (e.g., those who have particularly busy or unpredictable schedules).

Fidelity Tool

Resource 19 provides a fidelity tool for assessing the AC’s performance during telephone conversations regarding each of the key intervention areas. These areas will be briefly described in the subsequent paragraphs. The AC should rate themselves using this tool immediately or soon after each home visit. The tool includes seven critical components or interventions that should be addressed during telephone conversations. For each critical component or intervention, there are four potential ratings. A score of zero is representative of an unacceptable level of adherence to the intended critical component or intervention. Scores of one or two indicate a slightly acceptable or generally satisfactory level of care. Finally, a score of three corresponds with the ideal (or “gold”) standard of care. It should be noted that even if an AC meets some of the criteria for a particular rating, they must have also met or surpassed all of the criteria in the lower rating categories in order to earn the rating in question.

Relapse/Crisis Evaluation and Safety Plan Review

Similar to home visits, the AC will review the safety plan with the youth or family members during telephone conversations. Any necessary revisions should be made. Although it might be difficult to physically revise the safety plan over the phone, the AC can note any recommended changes and provide the youth and family with updated versions during the next home visit. The AC can encourage the youth and family to take their own notes, as well.

Discussion of Progress and Psychoeducation

The AC should first speak to the youth, inquiring about their week and general progress.
If possible, the AC should also converse with at least one family member in order to see if they need any additional support or resources. It might be helpful to gain a sense of family members’ perspectives of the youth’s week, particularly if the youth is reluctant to share information.

**Space for Questions and Feedback**

As usual, the AC should be open to questions and feedback about the process and their role. They should provide specific opportunities for the youth and family to share their personal opinions on relevant topics, and should express a desire to improve their own performance as an AC.

**Maintenance of Rapport**

It may be more difficult to connect with the youth and family through the telephone. Therefore, special efforts should be made to convey attentiveness, interest, and concern. The AC can indicate their engagement by occasionally paraphrasing or reflecting back what the youth and family members are conveying. The AC should be particularly mindful of the content, cadence, intonation, and pacing of their speech. Since normal visual cues are not available to the youth and family members, it might be more difficult for them to interpret the authenticity of the AC’s sentiments. The AC can maintain an amiable relationship with the youth and family through asking about casual topics, particularly those that pertain to the youth and family’s interests and skills.
### Telephone Conversation Resources
Resource 19: Fidelity Tool for Telephone Conversations

<table>
<thead>
<tr>
<th>Domain</th>
<th>Critical Component</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Plan Review</td>
<td>AC fails to review and discuss safety plan with youth and family.</td>
<td>Safety plan is briefly reviewed.</td>
<td>Safety plan is fully reviewed.</td>
<td>AC collaborates with youth and family to revise safety plan as needed.</td>
<td></td>
</tr>
<tr>
<td>Relapse/Crisis Evaluation</td>
<td>AC does not make any effort to reassess with youth, family, and/or community providers around the circumstances that may have contributed to a relapse or crisis.</td>
<td>AC briefly checks in and discusses the circumstances that may have contributed to a relapse or crisis.</td>
<td>AC discusses the circumstances that may have contributed to a relapse/crisis and problem-solves/supports/guidance around this.</td>
<td>AC works with the youth, family, and/or community providers to come up with an updated crisis plan including how to manage a relapse or crisis in the future and what resources or supports to reach out to, etc.</td>
<td></td>
</tr>
<tr>
<td>Maintenance of Rapport</td>
<td>AC does not make any efforts to build rapport with youth and family and/or actively alienates them.</td>
<td>AC is polite and shows curiosity toward the youth and family’s current difficulties.</td>
<td>AC engages youth and family in an engaging discussion that extends beyond the immediate issues at hand.</td>
<td>Discussion incorporates the youth and family’s personal interests and is sensitive to the family’s culture and norms.</td>
<td></td>
</tr>
<tr>
<td><strong>Telephone Conversations with Youth and Family</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing Psychoeducation</td>
<td>Psychoeducation and resources to the youth and family are not provided.</td>
<td>Youth and family are provided with handouts detailing several community resources.</td>
<td>AC provides personalized resources to youth and family that reflect their interests and demographics.</td>
<td>AC consulted with community organizations, agencies, etc., to facilitate psychoeducation including dissemination of materials, trainings, presentations, webinars, etc.</td>
<td></td>
</tr>
<tr>
<td>Discussion of Progress</td>
<td>AC fails to engage youth and family in a discussion of progress.</td>
<td>AC engages youth and family in a general discussion of progress.</td>
<td>AC engages youth and family in an in-depth discussion of progress.</td>
<td>AC collaborates with youth and family to determine future steps for ensuring the youth’s progress.</td>
<td></td>
</tr>
<tr>
<td>Space for Youth and Family Questions</td>
<td>Space for the youth and family to ask questions is not provided.</td>
<td>Space is provided for the youth and family to ask questions.</td>
<td>AC briefly responds to the youth and family’s questions.</td>
<td>AC answers questions in a thorough yet accessible way.</td>
<td></td>
</tr>
<tr>
<td>Space for Youth and Family Feedback</td>
<td>Feedback is not requested.</td>
<td>AC requests youth and family feedback regarding program.</td>
<td>AC responds to feedback and engages youth and family in discussion.</td>
<td>AC discusses ways to integrate the feedback into future meetings.</td>
<td></td>
</tr>
</tbody>
</table>
Chapter 4: Ongoing Contact with Treatment Providers and Supports

The Aftercare Coordinator should maintain regular contact with the youth’s treatment providers, community supports, and natural supports throughout the 90 days. Treatment providers include psychologists, psychiatrists, primary care physicians, and any other professionals that are treating the youth’s physical or mental health needs. Community supports include coaches, religious leaders, significant teachers, community leaders, etc., to whom the youth looks for guidance. Natural supports include family, friends, and other non-professional supports in the youth’s life. It is essential that each of these supports understand and feel comfortable in their role. By continuing to check in and provide guidance to the youth, these professionals and community members create a supportive environment for the youth. Before discussing confidential details of the youth’s case with any supports, the AC must first obtain written consent on the appropriate release forms from the youth and a guardian.

Fidelity Tool

Resource 20 provides a fidelity tool for assessing the AC’s performance during their ongoing contact with supports, regarding each of the key intervention areas. These areas will be described in detail in the subsequent paragraphs. The AC should rate themselves using this tool immediately or soon after the initial meeting. The tool includes seven critical components or interventions that should be addressed in contacts with supports. For each critical component or intervention there are four potential ratings. A score of zero is representative of an unacceptable level of adherence to the intended critical component or intervention. Scores of one or two indicate a slightly acceptable or generally satisfactory level of care. Finally, a score of three corresponds with the ideal (or “gold”) standard of care. It should be noted that even if an AC meets some of the criteria for a particular rating, they must have also met or surpassed all of the criteria in the lower rating categories in order to obtain the score in question.

Frequency of Contact

While it is not necessary for the AC to contact all of the youth’s supports after each meeting, the AC should reach out to those who were discussed in the meeting and relay any relevant information. For example, the psychologist will likely be notified after each meeting to provide updates on the youth’s mood and if there are changes to his/her suicidal thoughts. The psychiatrist should be notified if the youth notices any negative side effects from medications they are taking. Relevant community and natural supports should be notified if they are addressed in the conversation, and the youth notes ways that they can be more helpful. However, frequency of contact may vary depending on how the youth is doing. If the youth feels well-supported, the AC may contact the youth’s supports less often. Additionally, it is possible that some supports do not wish to be highly involved in the program, and may request to be contacted less frequently.
If the youth continues to need additional support, the AC should reach out to as many supports as may be available in order to provide the needed care. This might take place following a home visit or telephone conversation with the youth and family. During these conversations, the AC should ask the youth if there are any particular supports that they would find most helpful for their current situation. The AC should then work to contact these supports and work with them to become more involved with the youth. For example, if the youth is feeling left out on their baseball team, the AC may reach out to the coach, and brainstorm ways for the youth to feel more involved. Although the AC is intended to act as a liaison between the youth and various supports, they should also empower the youth and family to reach out to supports on their own as needed. This can promote feelings of self-efficacy, strength, and purpose and make it easier for the youth and family to sustain their progress after the program ends.

While many youth may need this additional network of supports, some may feel well-supported after their transition. In this situation, the AC may not need to contact as many supports following home visits and telephone conversations. The AC may occasionally check in with various supports to gain information and about the youth’s progress. The AC should use the appropriate fidelity tool for ongoing contacts with supports (provided in Resource 21) as needed.

**Safety Plan Review and Discussion of Progress**

Following the receipt of consent, the AC may discuss the youth’s progress with appropriate supports. These supports should have an understanding of the youth’s safety plan and the role they may play in it. For example, if the school guidance counselor is referenced as a resource on the Safety Plan, the AC should review different tools they may use in a crisis situation.

In addition to reviewing the Safety Plan, the AC should update the supports on the youth’s progress and ask for any updates the support may want to share. This provides another source of information regarding how the youth is coping with the transition back into everyday life. The AC and support may collaborate to devise ways to make the transition successful.

**Maintenance of Rapport and Psychoeducation**

Establishing rapport is an essential component to any professional relationship. The AC should work to build the supports’ trust and respect. They should convey respect, openness, curiosity, and authenticity. Genuinely listening and incorporating the supports’ opinions and input will help build a strong alliance. In addition, the AC should communicate in a way that is sensitive toward the supports’ cultural, religious, and political traditions and practices.

Another way to convey expertise and build rapport is through psychoeducation. The AC should provide supports with any relevant information or literature that may be helpful. This may include general information about a youth’s diagnoses or guidelines to providing support in a crisis situation. This information may make the support feel more competent and ready for a crisis situation.
Space for Questions and Feedback

As with any meeting, the AC should provide additional space for the support’s questions and feedback. This will allow the support to feel more engaged and involved in the process, as well as serving to build rapport.
### Ongoing Contact with Supports Resources

Resource 20: Fidelity Tool for Ongoing Contact with Supports

<table>
<thead>
<tr>
<th>Domain</th>
<th>Critical Component</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>AC fails to contact or meet with any of the listed supports.</td>
<td>AC contacts or meets with one of the listed supports.</td>
<td>AC contacts or meets with half of the listed supports.</td>
<td>AC contacts or meets with all of the listed supports.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>AC fails to review and discuss safety plan with support.</td>
<td>Safety plan is briefly reviewed.</td>
<td>Safety plan is thoroughly reviewed.</td>
<td>AC and support address how support can fulfill their specific role in the safety plan.</td>
</tr>
<tr>
<td></td>
<td>Maintenance of Rapport</td>
<td>AC does not make any efforts to build rapport with support or actively alienates them.</td>
<td>AC is polite and expresses curiosity about the support’s opinion.</td>
<td>AC engages support in an engaging discussion that extends beyond the immediate issues at hand.</td>
<td>Discussion is sensitive to the youth and support’s interests, skills, culture, and context.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ongoing Psychoeducation</td>
<td>Psychoeducation and resources with supports are not provided.</td>
<td>Support is provided with handouts detailing several community resources.</td>
<td>AC provides personalized resources to supports that reflect their interests and demographics.</td>
<td>AC consulted with community organizations, agencies, etc, to facilitate psychoeducation including dissemination of materials, trainings, presentations, webinars, etc.</td>
</tr>
<tr>
<td></td>
<td>Discussion of Progress</td>
<td>AC fails to engage support in a discussion of progress.</td>
<td>AC engages support in a general discussion of progress.</td>
<td>AC engages support in an in-depth discussion of progress.</td>
<td>AC collaborates with the support to determine additional measures for ensuring the youth’s progress.</td>
</tr>
<tr>
<td></td>
<td>Space for Youth and Family Questions</td>
<td>Space for the youth and family to ask questions is not provided.</td>
<td>Space is provided for the support to ask questions.</td>
<td>AC briefly responds to the support’s questions.</td>
<td>AC answers the support’s questions in a thorough yet engaging manner.</td>
</tr>
<tr>
<td></td>
<td>Space for Youth and Family Feedback</td>
<td>Feedback is not requested.</td>
<td>AC requests support’s feedback regarding the program.</td>
<td>AC responds to feedback and engages support in discussion.</td>
<td>AC discusses ways to integrate the feedback into future actions and correspondences.</td>
</tr>
</tbody>
</table>
## Resource 21: Guidelines for Interacting with Different Types of Supports

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Potential Topics for Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Treatment Providers</strong></td>
<td></td>
</tr>
<tr>
<td>Professional Support (Psychologist, Social Worker, Therapist)</td>
<td>Mental health status, Everyday Functioning (diet, sleep hygiene, physical appearance, exercise), parasuicidal behavior (self-harm)</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>Difficulties with medication, side effects, parasuicidal behavior</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>Changes in weight, appetite, sleep patterns, physical injuries</td>
</tr>
<tr>
<td><strong>Community Supports</strong></td>
<td></td>
</tr>
<tr>
<td>Sports Coach</td>
<td>Physical health concerns, energy/fatigue, potential contingency participation</td>
</tr>
<tr>
<td>Religious Leader</td>
<td>Spiritual issues, involvement in religious activities (e.g., youth groups, services, etc.)</td>
</tr>
<tr>
<td>Teacher</td>
<td>Getting reports about classroom behavior, peer interactions, providing insight on conducive learning environments for the youth</td>
</tr>
<tr>
<td><strong>Natural Supports</strong></td>
<td></td>
</tr>
<tr>
<td>Immediate Family</td>
<td>For under 18 year olds, check in about child’s behavior and if changes have occurred. Over 18, provide appropriate amount of information respecting confidentiality</td>
</tr>
<tr>
<td>Extended Family</td>
<td>Observations, insight on how they can help</td>
</tr>
<tr>
<td>Friends</td>
<td>Observations, social interactions, interests</td>
</tr>
</tbody>
</table>
Chapter 5: Final Meeting

The termination of aftercare coordination can be a difficult time for youth and families. The AC should approach this matter in an authentic and sensitive manner, being honest about the impending termination, yet mindful of the difficulties inherent in closing any meaningful relationship. Throughout the process, it is likely that the youth and family will become somewhat attached to the AC. Additionally, the AC may feel some attachment to the youth and family. It is important to recognize the significance of this relationship while encouraging the family to continue their therapeutic progress in a more independent manner. Termination should be viewed as its own significant part of the Aftercare process.

Fidelity Tool

Resource 22 provides a fidelity tool for assessing the AC’s performance during the final meeting regarding each of the key intervention areas. These areas will be described in detail in the subsequent paragraphs. The AC should rate themselves using this tool immediately or soon after the initial meeting. The tool includes five critical components or interventions that should be addressed in the final meeting. For each critical component or intervention there are four potential ratings. A score of zero is representative of an unacceptable level of adherence to the intended critical component or intervention. Scores of one or two indicate a slightly acceptable or generally satisfactory level of care. Finally, a score of three corresponds with the ideal (or “gold”) standard of care. It should be noted that even if an AC meets some of the criteria for a particular rating, they must have also met or surpassed all of the criteria in the lower rating categories in order to obtain said rating.

Frequency of Notifications and Final Review of Safety Plan

It is essential that the youth and family be provided proper notice regarding the ending of the Aftercare Coordination process. The exact date of termination might not be immediately known; however, once the AC has a good idea of when the end is approaching, they should be sure to inform the family. More notice is better. The AC should consider reminding the family of how many meetings or weeks they have left after each meeting or conversation. If this feels excessive, the AC might decide to remind the family of their amount of time remaining on a biweekly or triweekly basis. Above all, the family must be adequately aware of their projected ending date and the time-limited nature of the intervention. This will prompt them to make greater progress toward self-sufficiency and prevent any distressing surprises.

Additionally, time should be spent during the last few meetings discussing what to expect and strategies for continued progress toward health. The AC should also contact the supports and inform them that services are ending. The supports should feel comfortable continuing their role. The AC should answer any questions they may have about supporting the youth.

The AC should lead the family in a final review of the Safety Plan, so that it is up to date and the youth feels knowledgeable about what to do in crisis. The AC should also provide instructions on how the youth and family can update their Safety Plan on their own in the future.
**Addressing Youth’s Progress**

One key component to termination is the recognition and commemoration of the youth’s progress throughout the program. The youth, family, and AC should take time to review the changes and improvements they have noticed in the previous months. It is important that the youth and family themselves identify the accomplishments they have achieved. It may be beneficial for the youth to self-describe the changes they have seen, in addition to having family members share the improvements they have witnessed. These conversations may help empower the youth and family to create additional change in the future.

**Providing Space for Questions and Feedback**

Because termination can be an anxiety-provoking event, the AC should provide extra space for youth and family questions during this time. They may have concerns about taking their care into their own hands, and the AC should provide support and empowerment for this process.

The AC should also solicit feedback from the youth and family regarding their experience in the program. While this information is not likely to affect the particular youth or family in question, it may help the AC hone their skills and make adjustments for future youth and families. The AC should encourage the youth and family to be honest, creating a space that is open for constructive criticism as well as glowing reviews.

It should be noted that if the AC strongly feels that the youth and family could benefit from additional support, they may extend the process by a few more weeks. However, this should only be done if it is determined to be clinically necessary. This necessity should be based on the AC’s clinical judgment and consultation with other professionals.

**Guidelines for Terminating Therapeutic Relationships**

The closing of a caring relationship can be difficult for both the youth and family, so continued rapport is essential. The AC should:

- Be open and honest about expectations and should allow time for any discussion or questions.
- Focus on the progress made and the youth’s strengths, as well as relapse planning and prevention. This can help in bolstering the youth’s confidence in making continued progress.
- Ask the youth and family about their thoughts and feelings about termination, address them in a validating manner, and allow for discussions in order to process these thoughts and feelings.
- Review tools and supports available to the youth and family in times of need.
- Recognize their own feelings toward termination, as it is also a difficult process for a care coordinator.
## Final Meeting Resources
Resource 22: Fidelity Tool for Final Meeting

<table>
<thead>
<tr>
<th>Domain</th>
<th>Critical Component</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency of Discontinuation of Care Notifications</td>
<td>AC fails to remind youth and family of discontinuation of care until final meeting.</td>
<td>AC reminds youth and family of discontinuation of care once termination date is set.</td>
<td>AC reminds youth and family of discontinuation of care at the second-to-last home visit.</td>
<td>AC reminds youth and family of discontinuation of care at the third-to-last home visit.</td>
</tr>
<tr>
<td></td>
<td>Final Review and Revision of Safety Plan</td>
<td>AC fails to review and discuss safety plan with youth and family.</td>
<td>Safety plan is reviewed</td>
<td>Youth and family collaborate with AC to update safety plan.</td>
<td>AC ensures that youth and family feel equipped to update the safety plan on their own in the future.</td>
</tr>
<tr>
<td></td>
<td>Addressing Youth’s Progress</td>
<td>AC fails to address progress.</td>
<td>AC reviews the progress made by youth and family.</td>
<td>AC elicits youth and family’s input regarding the progress they have noticed.</td>
<td>AC commends previous progress and empowers the youth and family to achieve further success.</td>
</tr>
<tr>
<td></td>
<td>Space for Youth and Family Questions</td>
<td>Space for the youth and family to ask questions is not provided.</td>
<td>Space is provided for the youth and family to ask questions.</td>
<td>AC briefly responds to the youth and family’s questions.</td>
<td>AC answers questions in a thorough yet accessible way and encourages further discussion.</td>
</tr>
<tr>
<td></td>
<td>Space for Youth and Family Feedback</td>
<td>Feedback is not requested.</td>
<td>AC requests youth and family feedback regarding program.</td>
<td>AC responds to feedback and engages youth and family in discussion.</td>
<td>AC expresses gratitude for feedback.</td>
</tr>
</tbody>
</table>
Chapter 6: Additional Guidelines and Considerations

Required Documentation
The Aftercare Coordinator should be sure to document the following information. This can be accomplished with the assistance of the Dashboard tool. Both the Dashboard and the excel spreadsheets should be updated between every visit, telephone conversation, or contact with a support.

Preparedness Monitoring
- Hope (Score + Open ended: what contributed to that score)
- Support and Connections (Support score + Open ended: What contributed to that score)
- Self Management (Self management score + Open ended: What contributed to that score)

Adverse Events (“outcomes,” or indicators that supports/plan are not functioning as intended)
- Self-harm (yes/no, explain any yes’s)
- Behavioral health hospitalization/Emergency Dept (yes/no, explain any yes’s)
- Medication errors or major side effects (yes/no, explain any yes’s)
- School disciplinary or other action targeting patient (yes/no, explain any yes’s)
- Occupational disciplinary or other action targeting patient (yes/no, explain any yes’s)
- Other risky/impulsive judgments, behaviors, relationships (yes/no, explain any yes’s)
- Law enforcement intervention (yes/no, explain any yes’s)

Progress and Plan
- Summary of current status/progress on preparedness to date
- Actions Taken/Planned
- Support/Problem Solving/Psychoed with youth/family (yes/no, explain yes’s)
- Facilitation of natural/indigenous supports (yes/no, explain yes’s)
- Enhanced referral/coordination (non-urgent) with professional supports/services (yes/no, explain yes’s)
- Activate urgent/emergency response (yes/no, explain yes’s)
- Consultation/Technical Assistance with another professional (yes/no, explain yes’s)
- Any communication with additional parties (yes/no, explain yes’s)

Guidelines for Addressing Self Harm Behaviors
There is a high correlation between individuals who engage in self harm behavior and those who make suicide attempts. Between 50 and 85% of individuals who self harm attempt suicide at least once (Kerr, Muehlenkamp, & Turner, 2010). For this reason, it is essential for the AC to be able to identify and react appropriately to signs of self harm.
● The AC should discuss self harm behaviors with a non-judgmental style. Many youth are afraid their actions will be seen as “attention seeking” or “crazy” (Kerr, Muehlenkamp, & Turner, 2010).

● During the initial visit, the AC should ask the youth if he/she has ever engaged in non-suicidal self harm behaviors. If yes, the AC should continue to monitor these behaviors. They should ask the youth at each meeting if they have engaged in any self harm that week.

● When notified that self harm occurred, the AC should inform the youth’s individual psychologist or therapist. This will increase the amount of support the youth will receive.

● When self harm behaviors occur, it is a time for additional supports. The AC should review the available resources and supports, so that the youth can reach out to them when they feel the urge to self harm. These supports should be individuals that the youth feels safe and comfortable talking to about self harm.

● While many self harm actions are non-suicidal, if self harm markings appear on the youth, the AC should complete a risk assessment to evaluate the youth’s risk for further harm and/or suicide.

● The AC should meet with the whole family to develop additional methods of support for the youth.

● The AC should work with the youth to develop coping strategies, such as stress relief or thought stopping, when they feel the urge to self harm.

● The AC should work with youth to develop a list of alternative behaviors/actions they can do when they feel the urge to self harm. This may include exercise and other ways to relieve stress. Resource 24 provides a list of safer alternatives that the youth can use when they have urges to self harm.

● The AC should note any self harm behaviors on the Dashboard and within the youth’s file.

**Concluding Remarks**

This manual has attempted to operationalize the role of an Aftercare Coordinator. Although this position has been primarily performed at New Hampshire Hospital, it is likely to spread to different geographic locales, settings, and populations. Data are being collected on the effectiveness of this intervention. Future users of this manual should be aware that the strength of an intervention lies largely in faithful adherence to its practices. Opportunities for feedback and self-assessment should be regularly created. However, perhaps that most effective Aftercare Coordinator is one who is able to stay loyal to the practice, while also maintaining a sense of creative flexibility and passion.
References
Risk and Protective Factors for Suicide

Risk factors may be thought of as leading to or being associated with suicide; that is, people “possessing” the risk factor are at greater potential for suicidal behavior. Protective factors, on the other hand, reduce the likelihood of suicide. They enhance resilience and may serve to counterbalance risk factors. Risk and protective factors may be biopsychosocial, environmental or sociocultural in nature. Although this division is somewhat arbitrary, it provides the opportunity to consider these factors from different perspectives.

Understanding the interactive relationship between risk and protective factors in suicidal behavior and how this interaction can be modified are challenges to suicide prevention (Moscicki, 1997). Unfortunately, the scientific studies that demonstrate the suicide prevention effect of altering specific risk or protective factors remain limited in number.

However, the impact of some risk factors can clearly be reduced by certain interventions such as providing lithium for manic depressive illness or strengthening social support in a community (Baldessarini, Tando, & Hennen, 1999). Risk factors that cannot be changed (such as a previous suicide attempt) can alert others to the heightened risk of suicide during periods of the recurrence of a mental or substance abuse disorder or following a significant stressful life event (Oquendo et al., 1999). Protective factors are quite varied and include an individual’s attitudinal and behavioral characteristics, as well as attributes of the environment and culture (Plutchik & Van Praag, 1994). Some of the most important risk and protective factors are outlined below.

Protective Factors for Suicide

- Effective clinical care for mental, physical and substance use disorders
- Easy access to a variety of clinical interventions and support for help-seeking
- Restricted access to highly lethal means of suicide
- Strong connections to family and community support
- Support through ongoing medical and mental health care relationships
- Skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self preservation

However, positive resistance to suicide is not permanent, so programs that support and maintain protection against suicide should be ongoing.
SI URGES

What to do instead ..................

Angry, frustrated, restless?
- Slash an empty plastic soda bottle, piece of cardboard, old shirt or sock.
- Flatten aluminum cans for recycling, seeing how fast you can go.
- Hit a punching bag.
- Use a pillow to hit a wall, pillow-fight style.
- Rip up an old newspaper or phone book.
- On a sketch or photo of yourself, mark in red ink where you want to cut.
- Make Play-Doh or Sculpey or other clay models and cut or smash them.
- Throw ice against something hard enough to shatter it.
- Break sticks.
- Crank up some music and dance.
- Go for a walk/jog/run.
- Play a physical sport.

Sad, depressed, unhappy?
- Do something slow and soothing, like taking a hot bath.
- Light sweet-smelling incense.
- Listen to soothing music.
- Smooth nice body lotion into the parts of yourself you want to hurt.
- Call a friend and just talk about things that you like.
- Visit a friend.

Craving sensation, feeling unreal?
- Squeeze ice cubes hard.
- Put a finger into a frozen food (like ice cream).
- Rub liniment under your nose.
- Slap a tabletop hard.
- Snap your wrist with a rubber band.
- Take a cold bath.
- Focus on how it feels to breathe. Notice how your body moves.

Wanting to see blood?
- Draw on yourself with a red felt-tip pen.
- Take a small bottle of liquid red food coloring and warm it slightly by dropping it into a cup of hot water for a few minutes. Uncap the bottle and press its tip against the place you want to cut. Draw the bottle in a cutting motion while squeezing it slightly to let the food color trickle out.
- Draw on the areas you want to cut using ice that you’ve made with red food colouring.
- Paint on yourself with red tempera paint or a red lip-liner pen.

Wanting to see scars or pick scabs?
- Get a henna tattoo kit. You put the henna on as a paste and leave it overnight; the next day you can pick it off as you would a scab and it leaves an orange-red mark behind.

selfharm-support.tumblr.com