

DRAFT SAMPLE ADOLESCENT SAFETY/CALMING TOOL

Welcome to OUR PROGRAM! We realize that you have come here at a very difficult time in your life. We will work together with you to make this a time of hope and change!

One of the things that we help people with is new ways to feel and act safely. We believe that everyone is capable of taking more control of their behavior and their life, no matter what has happened in the past. We can help you with this, but it takes practice and hard work! This survey is one way that we can begin to work together on new ways to feel and act safely.

1. What are you good at? What do others say you are good at doing? What do you like to do? _____

2. Do you use these things to help you when you are upset? Yes No (circle one)

3. What skills do you use to help yourself? What else helps you, no matter what others may say or think about it? Please describe: _____

4. Are you willing to try new things? Yes No (circle one) Please check any of the following skills that you have used (HU) or are willing to try (WTT):

	WTT	HU		WTT	HU
Time alone, where? _____	<input type="checkbox"/>	<input type="checkbox"/>	Reading	<input type="checkbox"/>	<input type="checkbox"/>
If someone asks how I am doing	<input type="checkbox"/>	<input type="checkbox"/>	Talking on the phone with _____	<input type="checkbox"/>	<input type="checkbox"/>
Talking with a friend/kids	<input type="checkbox"/>	<input type="checkbox"/>	Having something in my hand to squeeze	<input type="checkbox"/>	<input type="checkbox"/>
Talking with a staff	<input type="checkbox"/>	<input type="checkbox"/>	Wrapping myself in a blanket	<input type="checkbox"/>	<input type="checkbox"/>
Talking with my family	<input type="checkbox"/>	<input type="checkbox"/>	Listening to music	<input type="checkbox"/>	<input type="checkbox"/>
Writing in a journal	<input type="checkbox"/>	<input type="checkbox"/>	Washing my face	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Taking a shower or bath	<input type="checkbox"/>	<input type="checkbox"/>
Deep Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Playing a game	<input type="checkbox"/>	<input type="checkbox"/>
10 seconds of quiet to cool down	<input type="checkbox"/>	<input type="checkbox"/>	Counting to 10	<input type="checkbox"/>	<input type="checkbox"/>
Walking and talking with _____	<input type="checkbox"/>	<input type="checkbox"/>	Jumping up and down	<input type="checkbox"/>	<input type="checkbox"/>
Pacing	<input type="checkbox"/>	<input type="checkbox"/>	Yelling/screaming in my room	<input type="checkbox"/>	<input type="checkbox"/>
Going outside	<input type="checkbox"/>	<input type="checkbox"/>	Encouragement from staff	<input type="checkbox"/>	<input type="checkbox"/>
Reminding myself of consequences	<input type="checkbox"/>	<input type="checkbox"/>	Sports (name) _____	<input type="checkbox"/>	<input type="checkbox"/>
Writing (thoughts, poetry, stories)	<input type="checkbox"/>	<input type="checkbox"/>	Ice/cool cloth	<input type="checkbox"/>	<input type="checkbox"/>
Using OT ball/stress ball	<input type="checkbox"/>	<input type="checkbox"/>	Games	<input type="checkbox"/>	<input type="checkbox"/>
Video games	<input type="checkbox"/>	<input type="checkbox"/>	Watching TV/videos	<input type="checkbox"/>	<input type="checkbox"/>
Drawing/painting	<input type="checkbox"/>	<input type="checkbox"/>	Meditation/prayer	<input type="checkbox"/>	<input type="checkbox"/>
Rubber bands	<input type="checkbox"/>	<input type="checkbox"/>	Using weighted blanket	<input type="checkbox"/>	<input type="checkbox"/>
Ripping paper	<input type="checkbox"/>	<input type="checkbox"/>	Crying	<input type="checkbox"/>	<input type="checkbox"/>
Dancing	<input type="checkbox"/>	<input type="checkbox"/>	Singing	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping	<input type="checkbox"/>	<input type="checkbox"/>
Use clay/modeling compound	<input type="checkbox"/>	<input type="checkbox"/>	Arts/crafts	<input type="checkbox"/>	<input type="checkbox"/>
Organizing/cleaning	<input type="checkbox"/>	<input type="checkbox"/>	Other: (please explain) _____	<input type="checkbox"/>	<input type="checkbox"/>

This Safety Tool was developed by: Stromberg, N. & LeBel, J. (2003) and the Massachusetts Department of Mental Health (MADMH) Restraint Reduction Initiative from the MADMH Task Force on the Restraint and Seclusion of Persons who have been Physically or Sexually Abused: Report and Recommendations (1996). MA DMH 25 Staniford Street, Boston, MA 02114 (617-626-8058).

Sample Adolescent Tool, continued, Page 2

5. What things upset you, set you off, lead to blow-ups (triggers)? Please check all that you think have to do with you.

- | | | | |
|------------------------|--------------------------|---------------------------|--------------------------|
| Being touched | <input type="checkbox"/> | Seeing others OOC | <input type="checkbox"/> |
| Being alone | <input type="checkbox"/> | Being forced to talk | <input type="checkbox"/> |
| Loud noises | <input type="checkbox"/> | Not having control | <input type="checkbox"/> |
| Others teasing me | <input type="checkbox"/> | Feeling misunderstood | <input type="checkbox"/> |
| Not being left alone | <input type="checkbox"/> | Being told what to do | <input type="checkbox"/> |
| Not being listened to | <input type="checkbox"/> | Feeling embarrassed | <input type="checkbox"/> |
| Anniversaries/holidays | <input type="checkbox"/> | Being tired | <input type="checkbox"/> |
| Visits | <input type="checkbox"/> | Being hungry/thirsty | <input type="checkbox"/> |
| Phone calls | <input type="checkbox"/> | Losing a game | <input type="checkbox"/> |
| Feeling lonely | <input type="checkbox"/> | Tests | <input type="checkbox"/> |
| Medical appointments | <input type="checkbox"/> | Meetings | <input type="checkbox"/> |
| School | <input type="checkbox"/> | Meeting new people | <input type="checkbox"/> |
| Trying new things | <input type="checkbox"/> | Talking in a group | <input type="checkbox"/> |
| Being in closed spaces | <input type="checkbox"/> | Going in to the community | <input type="checkbox"/> |

6. What questions/concerns do you have about being here? What can we (you and us) do to help?

7. Have you been restrained in the past? Yes No (circle one) If yes, how/when? Physical
Mechanical Chemical (circle all used) Please explain: _____

8. Can you tell when you are getting upset? Yes No Sometimes (circle one) What have you or others noticed about you when you get upset? Please describe:

- | | | | |
|----------------------|--------------------------|--------------------|--------------------------|
| Sweating | <input type="checkbox"/> | Swearing | <input type="checkbox"/> |
| Sleeping a lot | <input type="checkbox"/> | Racing heart/pulse | <input type="checkbox"/> |
| Very active | <input type="checkbox"/> | Rapid breathing | <input type="checkbox"/> |
| Pacing | <input type="checkbox"/> | Red face | <input type="checkbox"/> |
| Crying | <input type="checkbox"/> | Singing/humming | <input type="checkbox"/> |
| Being rude to others | <input type="checkbox"/> | Very watchful | <input type="checkbox"/> |
| Eating more | <input type="checkbox"/> | Easily distracted | <input type="checkbox"/> |
| Eating less | <input type="checkbox"/> | Other: _____ | |
| Unable to rest/sleep | <input type="checkbox"/> | _____ | |
| Unable to talk | <input type="checkbox"/> | _____ | |

9. Is there anything else that you think we (you and us) need to know that would be helpful in working together during your stay here? Yes No (circle one). Please explain:

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My Personal Protection Plan

Date: -----



Sign Name:



Things that really upset me!

1)

2)

3)



LOOK

COOL

Things that help me to calm
down when I am upset:

1)

2)

3)



When I am having a
meltdown:

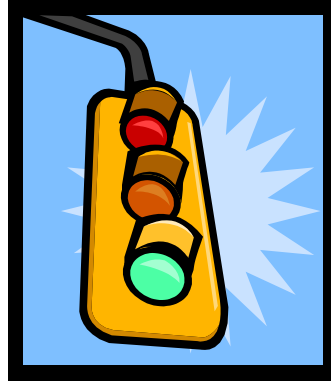
Please don't do this:



1)

2)

3)



Please do this:

1)

2)

3)

EXAMPLES of CHILD/ADOLESCENT SAFETY/CALMING TOOLS

The following pages include examples of Safety Tools adapted for children and adolescents.

The Children's Safety Tool is adapted from the DMH Adult Safety tool and the former DMH Special Care Unit.

The Adolescent Safety Tool is credited to:

Boston Medical Center
Intensive Medical Treatment Program
85 East Newton St.
Boston, MA 02118

For further information, please contact: Dr. Janice Le Bel or Nan Stromberg, MA DMH, janice.lebel@dmh.state.ma.us,
Nan.Stromberg@state.ma.us

**EXAMPLE OF SAFETY/CALMING TOOL FOR
CHILDREN**

My Safety Tool

**Adapted from the
Massachusetts Department of Mental Health
Safety Tool**

To be completed by Child with help from Family Member and Staff

What Makes You Feel Better?

(Circle all that help you)



Reading



Watching TV



Talking on the Phone



Playing on a
Playground



Playing a game



Writing



Listening to music



Singing a song



Taking a bath



Getting a hug

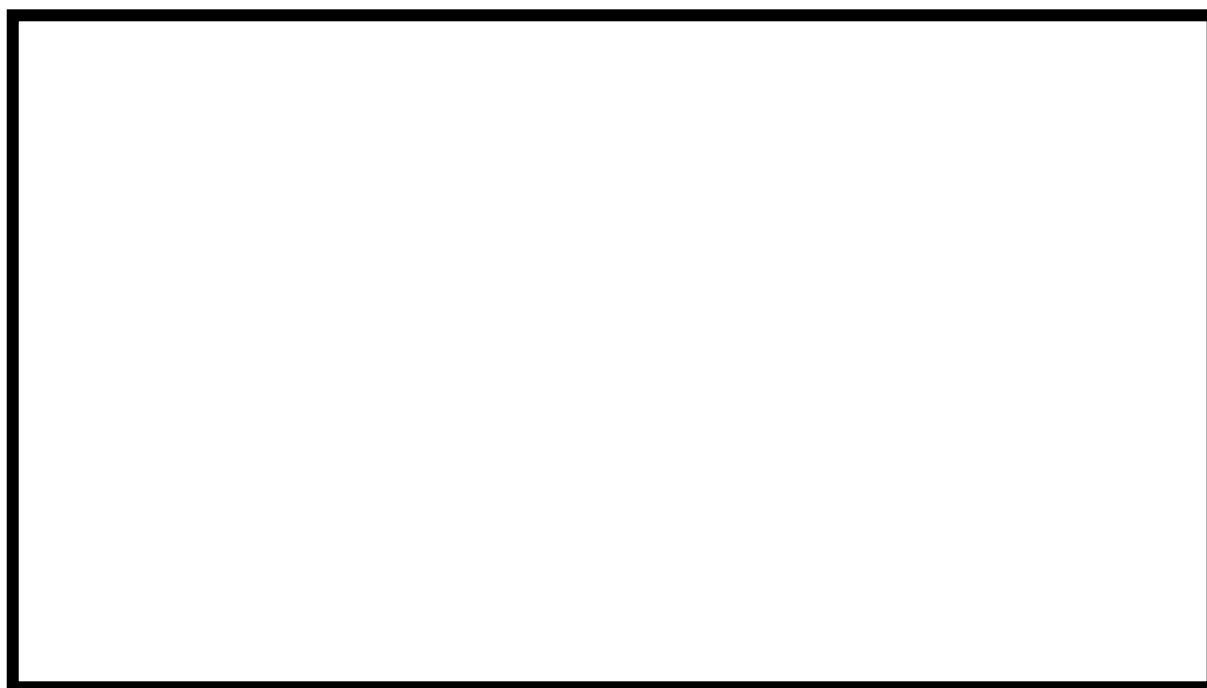


Hanging out with my family



Playing with my toys

Something else? Draw it here:



What Makes You Afraid or Upset?

(Circle all that make you scared)



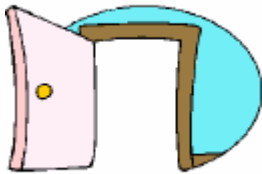
Being left alone



Being sick



Having a fight with my friend



Having my bedroom door open



Loud noise



Too many people



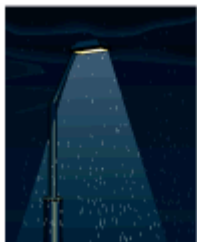
Thunderstorms



Being touched



Yelling



Darkness



Certain time of year



Certain time of day

EXAMPLE OF SAFETY/CALMING TOOL FOR ADOLESCENTS

Personal De-escalation Plan

Youth Name: _____

Date: _____

PROBLEM BEHAVIORS: What type of behaviors are problems for you?

- | | | |
|--|--|--|
| <input type="checkbox"/> Losing control | <input type="checkbox"/> Assaultive behavior | <input type="checkbox"/> Restraints/Seclusion |
| <input type="checkbox"/> Feeling unsafe | <input type="checkbox"/> Running away | <input type="checkbox"/> Feeling suicidal |
| <input type="checkbox"/> Injuring yourself | <input type="checkbox"/> Suicide attempts | <input type="checkbox"/> Drug or alcohol abuse |
| <input type="checkbox"/> Other: _____ | | |

TRIGGERS: What type of things (triggers) make you feel unsafe or upset?

- | | | |
|---|--|---|
| <input type="checkbox"/> Not being listened to | <input type="checkbox"/> Feeling pressured | <input type="checkbox"/> Being touched |
| <input type="checkbox"/> Lack of privacy | <input type="checkbox"/> People yelling | <input type="checkbox"/> Loud noises |
| <input type="checkbox"/> Feeling lonely | <input type="checkbox"/> Arguments | <input type="checkbox"/> Not having control |
| <input type="checkbox"/> Darkness | <input type="checkbox"/> Being isolated | <input type="checkbox"/> Being stared at |
| <input type="checkbox"/> Being teased or picked on <input type="checkbox"/> Contact with family _____ | | |
| <input type="checkbox"/> Particular time of day/ night: _____ | | |
| <input type="checkbox"/> Particular time of year: _____ | | |
| <input type="checkbox"/> Other: _____ | | |

WARNING SIGNS: Please describe your warning signs, for example what other people may notice when you begin to lose control?

- | | | |
|--|---|---|
| <input type="checkbox"/> Sweating | <input type="checkbox"/> Breathing hard | <input type="checkbox"/> Racing heart |
| <input type="checkbox"/> Clenching teeth | <input type="checkbox"/> Clenching fists | <input type="checkbox"/> Red faced |
| <input type="checkbox"/> Wringing hands | <input type="checkbox"/> Loud voice | <input type="checkbox"/> Sleeping a lot |
| <input type="checkbox"/> Bouncing legs | <input type="checkbox"/> Rocking | <input type="checkbox"/> Pacing |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Can't sit still | <input type="checkbox"/> Swearing |
| <input type="checkbox"/> Crying | <input type="checkbox"/> Isolating/ avoiding people | <input type="checkbox"/> Hyper |
| <input type="checkbox"/> Not taking care of self | <input type="checkbox"/> Hurting myself | <input type="checkbox"/> Hurting others or things |
| <input type="checkbox"/> Singing inappropriately | <input type="checkbox"/> Sleeping less | <input type="checkbox"/> Eating less |
| <input type="checkbox"/> Eating more | <input type="checkbox"/> Being rude | <input type="checkbox"/> Laughing loudly/giddy |
| <input type="checkbox"/> Other: _____ | | |

INTERVENTIONS: What are some things that help to calm you down or keep you safe?

- | | | |
|---|---|---|
| <input type="checkbox"/> Time out in your room | <input type="checkbox"/> Time out in the Quiet room | <input type="checkbox"/> Listening to music |
| <input type="checkbox"/> Reading a book | <input type="checkbox"/> Sitting with staff | <input type="checkbox"/> Watching TV |
| <input type="checkbox"/> Pacing | <input type="checkbox"/> Talking with peers | <input type="checkbox"/> Talking with staff |
| <input type="checkbox"/> Coloring | <input type="checkbox"/> Exercising | <input type="checkbox"/> Calling a friend _____ |
| <input type="checkbox"/> Hugging a stuffed animal | <input type="checkbox"/> Writing in a journal | <input type="checkbox"/> Calling family _____ |
| <input type="checkbox"/> Taking a hot shower | <input type="checkbox"/> Taking a cold shower | <input type="checkbox"/> Molding clay |

INTERVENTIONS (continued):

- | | | |
|---|--|---|
| <input type="checkbox"/> Blanket wraps | <input type="checkbox"/> Running cold water on hands | <input type="checkbox"/> Humor |
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Ripping paper | <input type="checkbox"/> Screaming into pillow |
| <input type="checkbox"/> Using cold face cloth | <input type="checkbox"/> Using ice | <input type="checkbox"/> Punching a pillow |
| <input type="checkbox"/> Deep breathing exercises | <input type="checkbox"/> Having your hand held | <input type="checkbox"/> Crying |
| <input type="checkbox"/> Getting a hug | <input type="checkbox"/> Going for a walk | <input type="checkbox"/> Speaking with therapist |
| <input type="checkbox"/> Drawing | <input type="checkbox"/> Snapping bubble wrap | <input type="checkbox"/> Being read a story |
| <input type="checkbox"/> Making a collage | <input type="checkbox"/> Bouncing ball in QR | <input type="checkbox"/> Being around other people |
| <input type="checkbox"/> Playing cards | <input type="checkbox"/> Male staff support | <input type="checkbox"/> Female staff support |
| <input type="checkbox"/> Video games | <input type="checkbox"/> Using the gym | <input type="checkbox"/> Doing chores/ special jobs |
| <input type="checkbox"/> Other: _____ | | |

What are some things that **do not** help you calm down or stay safe?

- | | | |
|--|---|--|
| <input type="checkbox"/> Being alone | <input type="checkbox"/> Loud tone of voice | <input type="checkbox"/> Humor |
| <input type="checkbox"/> Not being listened to | <input type="checkbox"/> Having many people around me | |
| <input type="checkbox"/> Being disrespected | <input type="checkbox"/> Peers teasing | <input type="checkbox"/> Being ignored |
| <input type="checkbox"/> Other: _____ | | |

STRENGTHS: What are your strengths when feeling out of control?

SKILLS: What skills do you have/ what are you good at?

OTHER:

Are you able to communicate to staff when you are having a hard time? If not, what can staff do at these moments to help??

What kinds of incentives work for you?

SPECIAL PLANS: List any special plans that help you (things you have used in the past or would like to try).

Youth Signature: _____

Date: _____

Staff Signature: _____

Date: _____