

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: _____