The Adolescent Safety Zone Tool
The Massachusetts Department of Mental Health

Date: __/__/__ Name: _____

We would like to make your stay with us a safe and therapeutic one. Please read the following questions and answer all that apply to you. This will assist us in making this a more positive experience for you. Please let us know if there is anything else we can help you with. Thank you!

Do you have a history of:
☐ Losing control ☐ Feeling unsafe ☐ Restraint or seclusion ☐ Running away
☐ Assaultive behavior ☐ Feeling suicidal ☐ Injuring your self ☐ Suicide attempts
☐ Physical abuse ☐ Sexual abuse ☐ Drug or alcohol abuse
☐ Other behaviors Please describe these:

_____
_____
_____

What type of facility are you in now? ☐ Hospital ☐ Residential ☐ Group Home ☐ Home

Have you ever been restrained before? ☐ Yes (If yes, please check those that apply) ☐ No:
☐ Physical ☐ Mechanical ☐ Chemical

What worries you about being here? _____
_____
_____

How can we help you transition from a one program to the next program?
_____
_____

How long have you been restraint free? ☐ 0-1 week ☐ 2 weeks – 2 months ☐ 3-5 months
☐ 6 months or more

When was the last time you were restrained? _____

Do you remember why you needed to be restrained?
_____
_____

When do most of your restraints occur? ☐ Day ☐ Evening ☐ Night ☐ Anytime

How often do you get restrained? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Never

Do you have any medical conditions that place you at greater risk during a restraint? ☐ Yes ☐ No
If yes, please describe:
_____
_____

If you are in danger of hurting yourself or someone else, we may need to use mechanical (safety coat) or chemical (medication to calm you down) restraint or seclusion. We may not be able to offer you all of these but we would like to know what you prefer or have used before? Please check all that apply. ☐ Prefer or ☐ Used Before
☐ ☐ Quiet room or area ☐ ☐ Open door seclusion ☐ ☐ Closed door seclusion
☐ ☐ Chemical restraint ☐ ☐ 4 point restraint ☐ ☐ Safety Coat ☐ ☐ Blanket wrap
☐ ☐ Physical holds ☐ ☐ Mitts

What helps you to stay safe? Please check all that apply:

☐ Yelling	☐ Writing	☐ TV/Movie	☐ Music
☐ Male staff support	☐ Female staff support	☐ Support from Peers	☐ Walking
☐ Reading	☐ Ice	☐ Video Games	☐ Talking
☐ Exercise/Sports	☐ Drawing/Coloring	☐ Other_____	

Are you able to communicate about your safety level? For example can you tell staff when you are struggling? ☐ Yes ☐ No ☐ Sometimes

_____

_____

What kind of space is most comfortable when you need it?

☐ Quiet area ☐ Your room ☐ Safety room ☐ In bed ☐ Other _____

Do you see a safe place you can use here? ☐ Yes ☐ No Describe:_____

Please describe your warning signs, for example what your body feels when you are losing control and what other people can see changing?

☐ Sweating	☐ Breathing hard	☐ Racing heart	☐ Clenching teeth	☐ Clenching fists
☐ Red faced	☐ Wringing hands	☐ Loud voice	☐ Sleeping a lot	☐ Bouncing legs
☐ Rocking	☐ Pacing	☐ Squatting	☐ Can't sit still	☐ Swearing
☐ Crying	☐ Isolating	☐ Hyper	☐ Singing inappropriate songs	
☐ Sleeping less	☐ Eating less	☐ Eating more	☐ Being rude	

☐ Other _____

What are your triggers?

☐ Being touched	☐ Being isolated	☐ Bedroom door open	☐ People in uniform	☐ Yelling
☐ Time of year? (when)	☐ Particular time of day		☐ Loud noise	
☐ Not having input	☐ Being forced to talk	☐ Being around men	☐ Being around women	
☐ Specific person (who)	☐ Anniversaries	☐ Seeing others out of control	☐ Other	

_____

_____

What helps you stay in control?

_____

_____

What has helped you to stay in control in the past?

_____

_____

What positive alternative behaviors can you use?

_____

_____

What kind of incentives works for you?

_____

_____

Is there anything else you can tell us that you think would be helpful?

_____

Family notification plan complete? ☐ Yes ☐ No Thank you for completing this form. We will update it with you in three months. Please sign: Adolescent:_____

Staff: _____