Safety Tools

Jean MacLachlan, MS, OTR/L

Nan Stromberg, MSN, APRN, BC

> “It is more fun to talk with someone who doesn’t use long difficult words but rather short easy words like ‘What about lunch?’”
>
> *Pooh’s Little Instruction Book*,
> inspired by A.A. Milne

Safety Tools

The Safety Tool was developed as a proactive intervention plan, the purpose of which is to help the client avoid or mitigate a crisis by considering strategies in advance that would be most helpful. Originally developed by consumers and clinicians as part of a DMH *Task Force on the Restraint and Seclusion of Persons who have been Physically or Sexually Abused,* Safety Tools were expected to help individuals in psychiatric hospitals avert behavioral difficulties and ultimately prevent the use of S/R, after a typically re-traumatizing and damaging experience (Carmen et al., 1996).

Central to the approach of early planning is the full inclusion of the child and family in a collaborative process with treatment providers. Young children and children with cognitive limitations may require more input from families and caregivers as well as clinical assessment and observation by staff to gather pertinent information.

To be as useful as possible, the information obtained must be personalized and capture the child's unique history, strengths, vulnerabilities, needs, and preferences. The components of the Safety Tool should minimally include:

- **Triggers:** Antecedents or "threat cues" that could cause a child to get upset, angry, aggressive, or self-injurious. Common triggers include: loud noises, being touched, being spoken to in a harsh tone, being ignored by adults, being teased by other children, certain times of the day, or being hungry.
- **Warning Signs:** Physical precursors to escalation. Bodily changes that indicate increased agitation such as, shortness of breath, heart pounding, head throbbing, sweating, clenching fists, and pacing. People are sometimes unable to identify discrete triggering events but can describe or notice what happens in their body when they start to get upset. Developing an awareness of this state change can cue the child that he/she may be in need of immediate help.

- **Strategies:** Individualized mechanisms used to manage stress and upset feelings that are discussed and addressed before the crisis erupts. These may be calming or alerting and should be based on the distinct emotional, behavioral, environmental, and sensory needs of the child. "One size fits all" planning should be avoided. Strategies might include reading a story, getting a back rub, bouncing on a trampoline, playing basketball, listening to music, pounding on clay, looking at pictures, writing, using a weighted blanket, talking with staff or using a fidget tool or stress ball.

Implementation Guidelines:

- Conduct an interview and obtain the information necessary to complete the Safety Tool for every child. Include the family, current external caregivers, and past providers as soon as possible after the admission.
- If the child is too young or cognitively impaired, obtain information from other sources as well as clinical assessment and observation of the child in the milieu.
- Develop a Safety Tool for each child. Ensure that it meets the developmental stage of the child and is child-friendly and easy to understand.
- Decide how to best incorporate each child's Safety Tool into the day-to-day milieu (daily meetings, treatment reviews, "check sheets," etc.).
- Schedule times to regularly review each child's Safety Tool, such as treatment team, rounds or shift report meetings, but maintain the flexibility to review it immediately, if necessary.
- Revise the tools after a "near miss" episode to capture what helped in the situation.
- Revise the Safety Tool as an outcome of the debriefing process post-incident if a S/R or other adverse event takes place.
- The child should have a copy of his/her Safety Tool.

The origin of the Safety Tool

In 1994 Susan Stefan, a mental health attorney, and Bill Crane, the Director of Human Rights for the Massachusetts DMH, approached Eileen Elias, the DMH Commissioner at the time, regarding concerns about the damaging effects of S/R on persons with histories of trauma treated in the psychiatric inpatient system. A request was made for DMH to formally address this issue, and Commissioner Elias authorized the formation of a task force of stakeholders representing consumers, adult and child clinicians, attorneys, administrators, and human rights personnel in 1995. The *Massachusetts DMH Task Force on the Restraint and Seclusion of Persons who have been Physically or Sexually Abused* was formed and charged with reviewing the impact of S/R on individuals with trauma histories, evaluating the extent of the problem, and making recommendations. The Task Force was co-chaired by Elaine Carmen and Bill Crane, and included Laura Prescott, Susan Stefan, Nan Stromberg, Pat Rieker, Steve Holochuck and Margaret Dunnicliff.

The Task Force produced a groundbreaking report (Carmen et al., 1996) that provided a comprehensive review of the re-victimization experience of consumers in a variety of psychiatric settings in which excessive force, inappropriate treatment, and inadequately trained staff inflicted further damage on people with histories of abuse. This was one of the first documents to address the negative impact and damaging consequences of a triggering (non-trauma-informed) environment in the public mental health sector on the

consumers served. That is, the very setting expected to be healing was, in fact, inflicting further pain and harm (Carmen et al., 1996; Prescott, 2000). In addition, task force members identified that the presence of trauma and trauma-related disorders were grossly under-estimated by psychiatric clinicians, and that this reflected a failure in appropriately assessing, diagnosing, and therefore treating consumers. To improve the experience of consumers in hospital, emergency room, and community settings, several practice improvements were recommended, including:

- The need to conduct trauma assessments with all consumers admitted to psychiatric facilities to develop effective treatment plans, provide more appropriate treatment, and collect diagnostic data to assist in planning future programs.
- The need to develop and use a De-escalation Form (later called Crisis Prevention Plans, Safety Tools, and Personal Safety Plans) as part of the hospital and community admission process to identify triggers and proactive strategies that, if identified and used in advance, could mitigate escalation and help avoid the use of S/R. The process of obtaining this information was recognized as a valuable step at the beginning of treatment to build a collaborative alliance and set the stage for further clinical work.

Importantly, the Task Force, through its composition and process, reflected the necessary partnership between consumers, legal advocates, and clinicians in evaluating the lack of trauma sensitivity and making recommendations. In addition, there was commitment by the Task Force members to follow through with an implementation plan.

The support of key executive leaders in DMH was invaluable. Clinical guidelines reflecting the task force recommendations were developed under the direction of Commissioner Eileen Elias after the task force report was completed in 1996. The most significant outcome was the decision by DMH Commissioners to codify these recommendations into DMH regulation. The requirement that Safety Tools be performed on all patients with a history of abuse who are admitted to the hospital was instituted under the leadership of Commissioner Marylou Sudders in 1998. The expansion of this requirement that Safety Tools be performed on *all* patients who are admitted to the hospital, not just those with documented histories of abuse, was instituted under the leadership of Commissioner Elizabeth Childs in 2006. Thus, the original task force recommendations addressing specific trauma-sensitive practice expectations became a legal mandate applicable to all DMH state hospitals, licensee hospitals, and intensive residential treatment programs (DMH 104 CMR 27.12, 2018).

Safety Tools have been implemented throughout the country in a variety of settings (Champagne & Stromberg, 2004). In fact, most treatment programs that have reduced the use of S/R made Safety Tool implementation an important part of their prevention approach (LeBel, Stromberg, Duckworth et al., 2004; Jonikas et al., 2002; Carmen et al., 1996; NETI, 2005).

In programs that use Safety Tools, individualized assessments of triggers, warning signs, and coping strategies are translated into functional plans. Staff members learn how to talk with children about their triggers, how to recognize individual warning signs for each child, and how to role-play and practice using coping strategies. During this process, staff members learn how to use the Safety Tool to help individual children calm down when they are upset, frustrated, angry, or overwhelmed at the earliest possible stage. The information is then integrated into the child's treatment plan.

Addressing each child's strategies and triggers and developing supportive interventions helps children improve their self-esteem and develop coping skills that they can use after they leave the program. Some programs have expanded the original focus on the tool itself to the incorporation of multiple components into a richer milieu.

Group programming, sensory rooms, and available physical spaces all offer immediate support to help children calm and learn. The use of Safety Tools improves child-staff communication and provides a vehicle by which treatment can be individualized in such a way that new skills and strategies enable the child to feel more competent and more able to avoid or manage difficult emotional states.

Sensory-based strategies

Staff in psychiatric care systems increasingly appreciate the contribution of sensory-based interventions in the treatment of children and recognize that each person has unique sensory preferences that provide self-organization and self-regulation. Please refer to the *Sensory Approaches* chapter of the *Resource Guide* for more information. Incorporating sensory strategies into the Safety Tool can offer calming, or alternatively, alerting experiences that can be immediately helpful to the individual. For example, adolescents with traumatic disorders who self-mutilate may not necessarily have the ability to verbally process their experience and may require an alternative that offers intense alerting and orienting sensation, such as holding ice or snapping a rubber band against one's wrist. (Champagne & Stromberg, 2004; Mazelis, 2003). A young child who becomes extremely agitated may find rocking or swinging soothing and calming. These and other kinds of sensory based strategies should be identified on the Safety Tool and used at key times.

Suggestions/guidelines for using Safety Tools

Programs should develop several versions of their Safety Tool to accommodate different developmental levels and learning needs. Programs may also want to have their Safety Tools translated into other languages so family members and children who do not read English can fully participate in the process of developing an individualized treatment and safety plan. It is helpful to include pictures on the Safety Tools to make them easy to understand.

Every program that uses Safety Tools should develop guidelines for each of the following areas (each area will be discussed in more detail in this chapter):

- Terminology
- Safety Tool intake interview and review
- Communication and evaluation
- Integration into the milieu
- Staff training

Terminology

Administrators, clinical staff, children, and family members often use different names to describe Safety Tools. Some of these include Safety Tools, crisis prevention plans, personal safety plans, de-escalation tools and “my plan.”

The DMH regulations (104 CMR 27.12, 2006) identify these as "crisis prevention plans." Common elements and terms associated with these tools include:

- Triggers, stressors, stimulants, "what sets you off," threat cues, trauma reminders
- Early warning signs, body symptoms, how does your body feel, body state changes, noticeable behavior
- Strategies, coping skills, symptom relief, relaxation techniques, calming strategies, alerting strategies

It is important that staff members, children, and family members have a common understanding of the terms used. Programs should decide on the terms that they plan to use and ensure that they are used consistently in their program. Staff members should avoid using jargon that is not commonly understood.

Safety Tool intake interview and review

The Safety Tool interview should take place as soon as possible after the child's admission. The interview is a process in which the child identifies stressors and triggers that are precursors to losing control. The child should be asked to identify those things adults have used in the past to help them calm down as well as their own successful coping and self-soothing strategies. It is important for staff members to be aware of the child's trauma history and the possibility that just asking about triggers may, in fact, be triggering for the child.

For example, if the child has been abused in a certain setting, such as their bedroom, he/she may be upset by seeing pictures of a bedroom on the Safety Tool. In addition, staff members should be taught to phrase questions in a gentle, non-threatening manner and to know when to stop asking questions.

During the interview, it is important to consider the least traumatizing type of S/R based on the child's history (sitting up, empty space, cushioned space, etc.). For example, if a child has a history of being locked in a closet, seclusion could be emotionally damaging and should be avoided. Staff members must also identify any current or past medical problems or recent surgeries that could adversely effect the child if a restrictive procedure were used. Knowledge of such medically-related issues should help determine the safest way for the child to be handled, including positioning, if S/R must be used. Children with short attention spans may need to meet over the course of several sessions to complete the interview.

Programs should create guidelines for Safety Tool interviews and reviews. These guidelines should determine the following:

- Which staff members will be involved in meeting with the child and family to complete the Safety Tool and help individualize it for the child.
- When and where the Safety Tool interview will take place.

- How trauma sensitive information and relevant medical history will be obtained and incorporated into the Safety Tool.
- How critical information obtained from the Safety Tool interview process will be shared with all staff members.

Communication and evaluation

Once a child's Safety Tool intake is complete, the information should be clearly documented and shared with the child, his/her family, and other staff members. As the tool is revised, updated, and modified, the information must be communicated to staff, clinicians, and the child's family. The child and his/her family members should have the most updated copy of the plan. There are a number of ways to ensure that staff has access to the most up-to-date information gleaned from the Safety Tool. In addition, staff and children can share a communication system.

The following represents some of the most commonly used communication methods:

- The Nursing Kardex
- Staff blackboard or bulletin board or board in the nurse's station
- Safety Tools attached to checks sheets
- "Coping Tree" or other large graphic placed directly in milieu that displays each child's unique methods for calming down

- Posting of Safety Tools on wall of bedroom or above bed
- Make laminated cards for each child/family that summarizes the child's triggers, warning signs, and strategies
- Incorporate personalized Safety Tools on the back of the child's daily schedule
- Meet with children at the end of each day to review a coping strategy they tried that day and evaluate its effectiveness

Treatment programs should evaluate Safety Tools for individual children regularly to ensure that the tool is useful for the child. A child's Safety Tool should be reviewed and changed after serious incidents or when new strengths have been identified. When treatment providers, children, and families find coping strategies that work effectively for the child, it is important to practice them as much as possible in the program, at home, and in the community and to share the information with school personnel and community providers who will be working with the child and family after discharge.

The following are common review venues:

- weekly team meetings,
- change of shift meetings,
- treatment groups that focus on calming strategies,
- individual therapy sessions,
- family meetings,

- daily child check-ins at the beginning and end of the day,
- most importantly, individual reviews with children when coping strategies do not work well and when they are successful. These individual reviews provide opportunities to clarify and pinpoint important safety strategies for staff members and children.

Integration of Safety Tools into the milieu

There are many ways to integrate Safety Tools into the milieu and daily programming. When children practice their coping strategies daily, it increases their ability to use them in other settings and provides them with safe opportunities to explore new coping skills.

- **Groups**
  - Provide opportunities for children to learn and practice their coping skills
  - During morning goals groups each child can identify a safety strategy he/she is going to practice during the day
  - Incorporate a relaxation technique into the last five minutes of group or sports activities
  - Develop a sensory-based group that allows children to explore new coping techniques that may be added into his/her repertoire if he/she determines that they are helpful

- **Sensory approaches**
  - Allow children to explore the sensory options at the program (such as a sensory room, comfort room, special space, or mobile cart) to learn about the variety of coping tools that are available
  - Provide groups that explore sensory tools that are either calming or alerting
- **Individual treatment sessions**
  - Review Safety Tools with the child during treatment sessions, evaluating what has been most and least helpful
  - Have the child identify how their body feels and identify the emotions they are experiencing at the start and end of their session
- **Off-unit privileges**
  - Remind staff and children about Safety Tools they can use to keep themselves safe outside of the program. Provide fanny or back packs with items identified in their Safety Tools that they can take with them in to self-manage
- **School**
  - Use Safety Tools and coping strategies during transitions or at other times when frustration or agitation develops. Use more physically based strategies provide children a way to "blow off steam" after sitting in a classroom for several hours

- **Home and discharge**
  - Educate the family about the Safety Tool and coping strategies that have been effective at the program
  - Provide the child, family, and community treatment providers with the most updated Safety Tools and coping strategies when the child is discharged
  - Assist the family to integrate Safety Tools and coping strategies into daily routines and difficult transition points.

Staff training and staff self-care

Once programs determine how they will conduct Safety Tool interviews and implement Safety Tools for every child, staff members must be fully trained in all aspects of Safety Tool implementation. They must learn how to effectively complete the interview with the child and family and how to support each child in using his/her individual coping strategies (e.g., gentle reminders or encouragement).

Staff members need to be taught to identify potential triggers for different children (e.g., loud noises, sitting for long periods of time, phone call from parent in afternoon) and help each child use his/her coping strategies before becoming emotionally overwhelmed. Training for staff may incorporate an experiential component and may include role-playing.

Staff should be encouraged to develop their own safety plans and identify personal triggers, warning signs, and coping strategies. This enables them to develop a greater understanding of the process as well as expand their own self-care resources.

All staff members should understand how the development of a child's Safety Tool can serve as a foundation for his/her relationship with the program and involvement in treatment. The initial Safety Tool meeting should set the stage for sensitive attention to the individual child's needs, empower the child and family, and underscore the commitment by the program to a collaborative process that fully supports the child's healing.

What do adolescents say about what helps?

DMH staff involved in the S/R Prevention Initiative realized that it was important to hear directly from the children about what they felt helped and hurt them during their hospitalizations. In January 2003, 185 adolescents in 19 Massachusetts hospitals were asked their feedback on a number of questions (DMH, 2003). The adolescents who had been involved in S/R were asked to think about the time(s) they were restrained or secluded and provide feedback on what staff members could have done differently to help them avoid these incidents.

Some of the adolescents gave more than one response to the question. The most common responses were the following:

- 80 adolescents replied, “Talk to me.”
- 75 adolescents said, “Leave me alone.”
- 54 adolescents said, “Distract me.”

The adolescents suggested other things that would help them when they were upset, including:

- Offering kids music or dancing
- Letting kids read or sing
- Staff members making kids laugh
- Staff members keeping negative or sarcastic comments to themselves
- Providing more activities or sports opportunities
- Permitting children to draw

What does this survey tell us?

Adolescents in this survey shared that there are a number of things staff members could have done (and can do in the future) to help them avoid S/R. It was evident from their responses that what might be useful for one child may be triggering for another, so interventions *must* be individualized. The adolescents also gave feedback about what would help them if they were already upset (such as talking and not being sarcastic) and what would prevent them from getting upset in the first place (such as having enough activities, going outside, or having creative opportunities like music and dance).

Safety Tools have traditionally focused on triggers (i.e., what gets them upset) and strategies to help them stay calm. The adolescents who were interviewed for the survey reported that it is just as important to find out what they like to do every day and the kinds of activities that will keep them positively engaged and less likely to become stressed and upset.

Additional resources

At the end of this section, there are sample Safety Tools from several Massachusetts programs. The first tool is from the Massachusetts DMH. It was created for younger children and uses simple pictures and brief descriptions to help children identify things that make them feel upset, what happens to their bodies when they feel upset, and things that make them feel better. The second tool is a "personal protection plan" from the Child Assessment Unit at Cambridge Hospital, and it is also intended for use with younger children.

The third tool is a "personal safety plan" for adolescents created by the Boston Medical Center Intensive Residential Treatment Program. The plan individualizes treatment by immediately assessing for a history of trauma, identifying possible triggers and warning signs, and requesting input from the adolescent on ways that staff members can help him/her to calm down. The fourth Safety Tool, "Safety Zone Tool," is from the UMass Transitions Intensive Residential Treatment Program and the UMass Connections Behavioral Intensive Residential Treatment Program, and it was also designed for use with adolescents.

The final tool is a school safety tool created by Mary Anne Gapinksi, MSN, RN, NCSN, and a group of other professionals. The school safety tool helps students and their parents/ guardians identify possible triggers or warning signs as well as self-soothing strategies. The full article, Protocol for School Nurses in the Prevention and Reduction in the Use of Restraint

and Seclusion in the School Setting, is included as an additional resource at the end of Chapter 9, Transforming School Culture.

The Safety Tools included in the Resource Guide may be used with permission from the programs that created them. Program contact information is included in Chapter 11, *Additional Resources, Safety Tools* section of the *Resource Guide*. Because contact information may change over time, if permission is not possible, then source attribution on the document is expected.

Suggestions/Guidelines for using Safety Tools

Descriptions:

- **Triggers tool:** A one page document of pictures and words to help the child recognize triggers or situations that create fear, sadness, anger, etc. The triggers tool is divided into sensory categories to help staff and children identify circumstances that create upset more easily.
- **Warning sign tool:** A one page document of pictures and words to help the child make the "cause and effect" connection between triggers, their reaction to triggers and how the situation physically effects their body.
- **Safety Tool:** A two page document of pictures and words to help the child identify sensory-based calming (coping) tools. Blank spaces are included to add personalized tools not included on the list.

Initial Safety Tool Use:

- Tools should be filled out within the first 24-48 hours of admission
- Information for the tools should be obtained from the child and their family/people who know the child best; though not necessarily at the same time.
- Safety Tools can be completed in more than one session.

Important History:

- Understand the child's trauma history to be sure Safety Tool interventions are not re-traumatizing. For example, has the child been locked in bedrooms or closets; has he/she been abused by specific objects that may invoke re-traumatization.

- Have the child identify the least traumatizing style of containment based on their history. (Face-down, face-up, empty space, cushioned space, etc.)
- Does the child have a history of asthma, a recent fracture or pre-existing medical condition that may be further impacted by the use of restraint or seclusion?

Staff Training:

- Protocols should be in place to train staff on the implementation, integration and communication of the information obtained from the Safety Tools.
- Consistency of terminology must be used for safety/calming tools, treatment plans, coping strategies, etc. so that staff, family and consumers have a similar understanding of what different tools and strategies are and how they are being utilized.

Integration on the unit:

- Provide copies of the Safety Tools to each child
  - Hang copies on the child's room door (with consent of the family and child)
  - Post calming strategies on bulletin boards and highlight skills that are utilized during the day
  - Create laminated pocket size Safety Tool cards for children to carry with them
  - Incorporate personalized Safety Tools on the back of the child's daily schedule

- Revise and update Safety Tools on a frequent basis
  - At the end of the day, have children identify to their "check in person" a Safety Tool strategy that they tried that either worked or did not work

- Provide time for the Safety Tool information to be reviewed from shift to shift
- During individual treatment sessions, assist children with the integration of triggers, warning signs and sensory-based coping skills (MA DMH Safety Tool, August 2006)

- Groups and program integration
  - Offer groups that incorporate a variety of sensory-based Safety Tools to help calm and organize the child during transitions
  - Incorporate sensory-based activities after sports or active groups to calm and ground children prior to their next group
  - Provide role-play situations for children to practice using identified Safety Tool strategies
  - Provide environments (quiet room, unit, corners, etc.) with sensory-based activities to foster exploration and incorporation of Safety Tool strategies into daily experiences

- Education
  - Educate children about the importance of Safety Tools and the use of the Safety Tool information to assist with calming, grounding and organizing themselves on a day to day basis
  - Educate child's family members about the Safety Tool information and how it has been useful to the child
  - Educate the treatment team and staff at potential discharge settings about Safety Tool strategies that were useful (and not useful) in helping the child feel safe

- Discharge
    - Promote carry over of the skills the child has learned and used by providing a copy of the Safety Tool to appropriate community-based clinicians working with the child and family
    - Every child should receive a copy of their up to date Safety Tool to take with them upon discharge
    - Parents/guardians should receive an updated copy of the child's Safety Tool
    - If a child is being transferred to another treatment program, a copy of the Safety Tool should be clearly identified and attached to the transfer paperwork.

What helps you feel better?

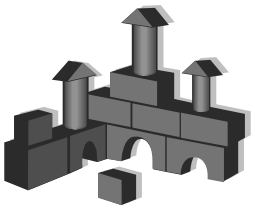
(Circle all that help you)

Touch

Writing

Fidget tools

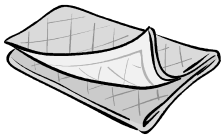
Games



Toys or Blocks

Bath or Shower

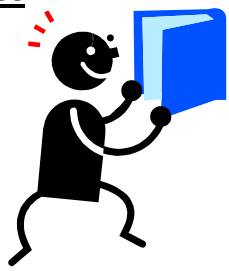
Stress ball or clay



Special blanket or cloth

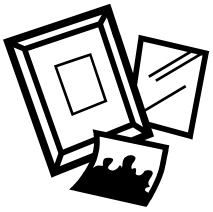
Any other objects you touch or hold that help you feel better? _____

See



Reading

Watching TV



Looking at pictures

Using a computer

Any other objects you like to look at that help you feel better? _____

Movement

Using a rocking chair

Swinging

Dancing

Sports
(kickball, basketball, soccer, etc)

Any other movements you like that help you feel better? _____

Hear

Talking on the telephone

Listening to music

Singing or humming

Quiet place

Counting to ten

Do you prefer music that is: ☐ Loud or ☐ Soft

What type of music do you prefer: _____

Any other sounds or noises that help you feel better? _____

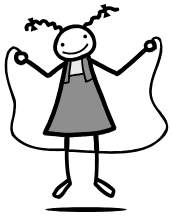
Pressure touch

Hugging a stuffed animal

Sitting in a bean bag chair

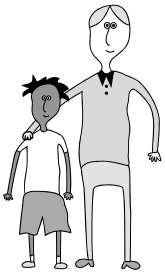
Using a weighted blanket

Climbing on a jungle gym



Exercise

Sitting on a therapy ball



Getting a hug

Any other activities that help you feel better? _____
(Examples: blowing bubbles, deep breathing, etc.)

Smell

Any smells that help you feel better? _____
(Examples: peppermint, popcorn, cookies, flowers, etc.)

Taste

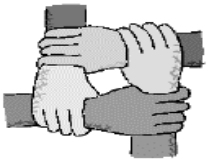
Any certain tastes that help you feel better? _____
(Examples: chewy, crunchy, salty, sour, spicy, etc.)

Are there times that it is important or helpful for you to eat? _____

What makes you feel upset?

(Circle all that make you feel sad, mad, scared or other feelings)

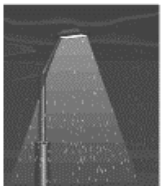
Touch



Being touched

Too many people

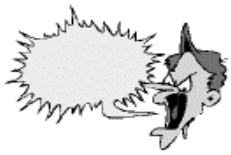
See



Darkness

Hear

Loud noises



Yelling

Thunderstorms

Other

Missing someone

Being left alone

Being surprised

Having a fight with a friend

Not having visitors

Being hungry

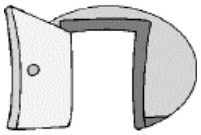
Being tired

Someone being mean

Being sick

Certain time of year

Certain time of day/night



Having my bedroom door open

Anything else that makes you feel upset? _____

NOTE: The following are general triggers for people
Being <u>told</u> what to do rather than <u>asked</u>;
Being told <u>no</u> rather than being given <u>choices</u>.

What happens to my body when I am angry, scared or upset?

(Circle all that apply)


Cry


Clench teeth


Loud voice


Red/hot face


Laughing/giggling


Being mean or rude


Swearing


Racing heart


Breathing hard


Wringing hands

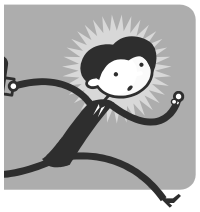

Clenched fists


Upset stomach


shaking or tapping


Jumping up and down or stamping feet


Rocking


Hyper


Running or pacing

My Personal Protection Plan

Date: ----------

Sign Name:

Things that really upset me!

1)

2)

3)

- 

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

1)

2)

3)

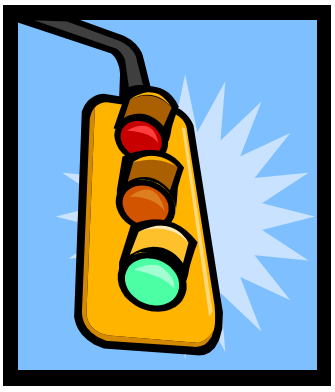
When I am having a meltdown:

Please don’t do this:

1)

2)

3)

Please do this: 

1)

2)

3)

Boston Medical Center IRTP SAFETY PLAN

Patient Name:_____ **Date**:_____

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

❑ Losing control ❑ Assualtive behavior ❑ Restraints/Seclusion ❑ Feeling unsafe ❑ Running away
❑ Feeling suicidal ❑ Injuring yourself ❑ Suicide attempts ❑ Drug or alcohol abuse
❑ Other:_____

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

❑ Not being listened to ❑ Feeling pressured ❑ Being touched ❑ Lack of privacy ❑ People yelling
❑ Loud noises ❑ Feeling lonely ❑ Arguments ❑ Not having control ❑ Being stared at
❑ Being isolated ❑ Darkness ❑ Being teased or picked on ❑ Particular time of day/ night:_____
❑ Particular time of year:_____ ❑ Contact with family_____
❑ Other:_____

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

❑ Sweating ❑ Breathing hard ❑ Racing heart ❑ Clenching teeth ❑ Clenching fists
❑ Red faced ❑ Wringing hands ❑ Loud voice ❑ Sleeping a lot ❑ Sleeping less
❑ Hyper ❑ Swearing ❑ Bouncing legs ❑ Rocking ❑ Cant sit still
❑ Being rude ❑ Pacing ❑ Crying ❑ Squatting ❑ Eating less
❑ Eating more ❑ Hurting others or things ❑ Hurting myself ❑ Not taking care of self
❑ Isolating/ avoiding people ❑ Laughing loudly/ giddy ❑ Singing inappropriately
❑Other:_____

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

❑ Time out in your room ❑ Time out in the Quiet room ❑ Listening to music ❑ Reading a book ❑ Sitting with staff
❑ Pacing ❑ Talking with peers ❑ Talking with staff ❑ Coloring ❑ Molding clay ❑ Humor
❑ Exercising ❑ Calling family (who?) ❑ Writing in a journal ❑ Punching a pillow ❑ Hugging a stuffed animal
❑ Taking a hot shower ❑ Taking a cold shower ❑ Playing cards ❑ Snapping bubble wrap
❑ Being around other people ❑ Using ice ❑ Doing chores/ special jobs ❑ Running cold water on hands
❑ Lying down ❑ Ripping paper ❑ Screaming into pillow ❑ Crying
❑ Using cold face cloth ❑ Bounce a beach ball in QR ❑ Male staff support ❑ Female staff support
❑ Deep breathing exercises ❑ Speaking with therapist ❑ Drawing ❑ Being read a story ❑ Making a collage
❑ Other:_____

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

❑ Being alone ❑ Loud tone of voice ❑ Humor ❑ Not being listened to ❑ Peers teasing
❑ Being disrespected ❑ Being ignored ❑ Having many people around me
❑ 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 your safety to staff? For example can you tell staff when you are struggling? If no, what can staff do to help you communicate this?

_____

What kind 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).

_____

Patient Signature:_____ **Date**:_____ ____
Staff Signature:_____ **Date**:_____ ____
Updated Date & Staff Signature:_____

Updated Date & Staff Signature:_____ _____

Updated Date & Staff Signature:_____ _____

Updated Date & Staff Signature:_____ _____

Updated Date & Staff Signature:_____ _____

Updated Date & Staff Signature:_____ _____

Updated Date & Staff Signature:_____ _____

The Adolescent Safety Zone Tool
UMass Medical School
Transitions IRTP & Connections BIRT Adolescent Services

Name:_____ Date:_____

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 below)

_____

_____

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

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

What worries you about being here? _____

_____

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 others, we may need to use a mechanical (safety coat) or a 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 ☐ / ☐ Used Before	**Prefer ☐ ☐ Used Before**	**Prefer ☐ ☐ Used Before**
☐ ☐ Quiet room or area	☐ ☐ Open door seclusion	☐ ☐ Closed door seclusion
☐ ☐ Chemical restraint	☐ ☐ 4 point restraint	☐ ☐ Safety Coat
☐ ☐ Physical holds	☐ ☐ Mitts	☐ ☐ Blanket wrap

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

If no, please describe where you believe you would feel safe:_____

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	☐ Sleeping less	☐ Eating less
☐ Eating more	☐ Being rude	☐ Singing inappropriate songs		

☐ Other:_____

What are your triggers?

☐ Being touched	☐ Being isolated	☐ Bedroom door open	☐ People in uniform
☐ Yelling	☐ Particular time of day	☐ Loud noise	☐ Not having input
☐ Being forced to talk	☐ Being around men	☐ Being around women	☐ Anniversaries

☐ Seeing others out of control ☐ Specific people (Who):_____

☐ Time of year? (When):_____

☐ 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 work 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:_____

APPENDIX C: School Safety Tool

We are committed to providing a safe and comfortable environment for your child. It is very helpful to us to understand the types of things that make your child upset and what helps him/her calm down or de-escalate when he/she is agitated or upset. Please answer the following questions so that we can keep this in your child's school health record and use it to help problem solve when your child feels upset.

Child's name _____

Grade _____ Date of Birth _____

What particular "triggers" will cause your child to escalate/have a hard time?
Number the top triggers **1-4** below.

Being touched		Being isolated	
Particular time of day (when?)		People in uniform	
Loud environment		Time of year (when?)	
Not having control/input. Explain		Yelling or angry/agitated people	
Arguments with friends or family		Having to wait for things	
Other (please explain):		Other (please explain)	

What types of warning signs might we see that can help us understand that your child is getting upset?
Number the top warning signs **1-4** that apply to your child below.

Sweating		Breathing hard		Racing heart	
Clenching teeth		Clenching fists		Red faced	
Wringing hands		Loud voice		Sleeping in class	
Bouncing legs		Rocking		Pacing	
Squatting		Can't sit still		Swearing	
Crying		Isolating/ avoiding people		Hyperactive	
Not taking care of self		Hurting myself		Hurting others or things	
Singing inappropriately		Sleeping less		Eating less	
Eating more		Being rude		Laughing loudly/ giddy	
Other:					

We may not be able to do all of these, but think about the top **4** specific things that might help your child feel better.

Number the top **4** of the ones that apply to your child below **or** add your own for a total of **4** items.

Quiet time in room away from others		Drinking warm milk	
Seek help with school nurse		Exercise	
Talking with teacher or aide		Using ice as a grounding technique	
Talking with parent		Lying down with cold face cloth	
Writing in a diary/journal		Using a scent box (perfume in a small container) as grounding technique	
Deep breathing exercises		Working on a puzzle	
Wrapping up in a blanket		Meditation or using pleasant images	
Listening to music		Drawing	
Reading (specify what you like to read)		Other (please list)	
Time in activity room			
Pacing the halls			

Do you have any cultural, religious or spiritual practices that help (_____) when he/she is upset?

Do you use any Sensory Techniques to help your child calm down?

Does your child have any medical issues that we should be aware of?

Do you have any other comments?

_____

_____

_____

Thank you for taking the time to complete this form. We are committed to assist your child to have a wonderful and successful year at school.

_____	_____	_____
Parent/Caregiver Signature	Parent/Caregiver Printed Name	Date
_____	_____	_____
School Nurse Signature / title	School Nurse Printed Name	Date

Safety Tools

Carmen, E., Crane, W., Dunnicliff, M., Holochuck, S., Prescott, L., Reiker, P., Stefan, S., & Stromberg, N. (1996). *Task force on the restraint and seclusion of persons who have been physically or sexually abused: Report and Recommendations*. Boston, MA: Massachusetts Department of Mental Health.

Champagne, T., Stromberg, N. (2004). Sensory approaches in inpatient psychiatric settings: Innovative alternatives to seclusion & restraint. *Journal of Psychosocial Nursing*, 42(9), 34-44.

Gapinski, M. A. (2013) Protocol for school Nurses in the Prevention and Reduction in the Use of Restraint and Seclusion in the School Setting. Massachusetts Department of Public Health, Massachusetts, USA.

Jonikas, JA., Laris, A., & Cook, J.A. (2002). *Increasing self-determination through advance crisis management in inpatient and community settings: How to design, implement, and evaluate your own program.* Chicago: University of Illinois at Chicago/National Research and Training Center on Psychiatric Disability.

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper, G., LaFlair, L., & Sudders, M. (2004). Child and adolescent inpatient restraint reduction: A state initiative to promote strength-based care. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(1), 37-45.

Massachusetts Department of Mental Health (MA DMH). (2003, January). Unpublished survey on kids' perspective on restraint and seclusion. Conducted by Spofford, R., Goldstein, R., Weeks, M., LeBel, J. & Stromberg, N.

References

Massachusetts Department of Mental Health (MA DMH). (2006, April 3). Code of Massachusetts Regulations for the Department of Mental Health (104 CMR 27.00).

Mazelis, R. (2003, October). Understanding and responding to women living with self-inflicted violence. *Women, Co-occurring Disorders, and Violence Study (WCDVS).* https://healingselfinjury.files.wordpress.com/2017/11/siv-fact-sheet-responding-to-those-who-self-injure.pdf

National Executive Training Institute. (2005). *Training curriculum for the reduction of seclusion and restraint.* Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD), National Technical Assistance Center for State Mental Health Planning (NTAC).

Prescott, L. (2000). Veterans of abuse and daughters of the dark: The politics of naming and risk of transformation in building partnerships for change. *Perspectives in Psychiatric Care, 36*, 95-100.