



Personal Safety Plan

Name: _____ Date: _____ Facility: _____

You can document on this form suggested calming strategies IN ADVANCE of a crisis. You can list things that are helpful when you are under stress or are upset. You can also identify things that make you angry. Staff and individuals receiving services can enter into a “*partnership of safety*” using this form as a guide to assist in your treatment plan. The information is intended only to be helpful; it will not be used for any purpose other than to help staff understand how to best work with you to maintain your safety or to collect data to establish trends. This is a tool that you can add to at any time. Information should always be available from staff members for updates or discussion. Please feel free to ask questions.

1. Calming Strategies: It is helpful for us to be aware of things that help you feel better when you’re having a hard time. Please indicate (5) activities that have worked for you, or that you believe would be the most helpful. If there are other things that work well for you that we didn’t list, please add them in the box marked “Other”. We may not be able to offer all of these alternatives, but we would like to work together with you to determine how we can best help you while you’re here.

<input type="checkbox"/>	Listen to music	<input type="checkbox"/>	Exercise
<input type="checkbox"/>	Read a book	<input type="checkbox"/>	Pace in the halls
<input type="checkbox"/>	Wrapping in a blanket	<input type="checkbox"/>	Have a hug with my consent
<input type="checkbox"/>	Write in a journal	<input type="checkbox"/>	Drink a beverage
<input type="checkbox"/>	Watch TV	<input type="checkbox"/>	Dark room (dimmed lights)
<input type="checkbox"/>	Talk to staff	<input type="checkbox"/>	Medication
<input type="checkbox"/>	Talk with peers on the unit	<input type="checkbox"/>	Read religious or spiritual material
<input type="checkbox"/>	Call a friend or family member	<input type="checkbox"/>	Write a letter
<input type="checkbox"/>	Voluntary time in the quiet room/comfort room	<input type="checkbox"/>	Hug a stuffed animal
<input type="checkbox"/>	Take a shower	<input type="checkbox"/>	Do artwork (painting, drawing)
<input type="checkbox"/>	Go for a walk with staff	<input type="checkbox"/>	Other? (Please list below)

2. What are some of the things that make you angry, very upset or cause you to go into crisis? What are your “triggers”?

<input type="checkbox"/>	Being touched	<input type="checkbox"/>	Called names or made fun of
<input type="checkbox"/>	Security in uniform	<input type="checkbox"/>	Being forced to do something
<input type="checkbox"/>	Yelling	<input type="checkbox"/>	Physical force
<input type="checkbox"/>	Loud Noise	<input type="checkbox"/>	Being isolated
<input type="checkbox"/>	Contact with person who is upsetting	<input type="checkbox"/>	Someone else lying about my behavior
<input type="checkbox"/>	Being restrained	<input type="checkbox"/>	Being threatened

3. Signals of Distress: Please describe your warning signals, for example, what you know about yourself, and what other people may notice when you begin to lose control. Check those things that most describe you when you’re getting upset. This information will be helpful so that together we can create new ways of coping with anger and stress:

<input type="checkbox"/>	Sweating	<input type="checkbox"/>	Clenching teeth
<input type="checkbox"/>	Crying	<input type="checkbox"/>	Not taking care of self
<input type="checkbox"/>	Breathing hard	<input type="checkbox"/>	Running
<input type="checkbox"/>	Yelling	<input type="checkbox"/>	Clenching fists
<input type="checkbox"/>	Hurting others:	<input type="checkbox"/>	Swearing
<input type="checkbox"/>	Throwing Objects	<input type="checkbox"/>	Not eating
<input type="checkbox"/>	Pacing	<input type="checkbox"/>	Being rude
<input type="checkbox"/>	Injuring self: (Please be specific)	<input type="checkbox"/>	Other? (Please list below)

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4. Preferences Regarding Gender and Others: Do you have any preferences or concerns regarding who serves you when you are upset or angry?

Women staff Men staff No preference

Language (specify): _____ Ethnicity (specify): _____

Culture (specify): _____ Particular religion(specify): _____

5. Preferences Regarding Physical Contact: We would like to know about your preferences regarding physical contact. For example, you may not like to be touched at all or you may find it helpful to have a hug or be touched *appropriately* when you are upset.

Do you find it helpful to be hugged or touched appropriately when you are upset? Yes No

Comments: _____

6. Seclusion and Restraint: This facility is trying to eliminate the use of seclusion and restraints, therefore, it would be helpful to know if you have ever been placed in a seclusion room or been restrained. This information will be used only for collecting data and for training purposes, not to predict any future behaviors.

Have you ever been placed in a seclusion room? Yes No

Have you ever been restrained? Yes No

7. In Extreme Emergencies: In **extreme** emergencies seclusion and restraint may be used as a last resort. Is there anything you find helpful in emergency situations that could prevent them from being used?

Alternative physical spaces such as: Comfort Room Quiet Room

Other alternatives such as: Exercise Medication by mouth Emergency injection

Other: _____

8. Medical Conditions: Do you have any physical conditions, disabilities, or medical problems such as asthma, high blood pressure, back problems, etc., that we should be aware of when caring for you during an emergency situation?

9. Helpful Medications: We may be required to give medications if other measures do not help you to calm down. In this case, we would like to know what medications have been especially helpful to you? Please describe.

10. Not Helpful Medications: Are there any medications that are not helpful? What and why?

11. Room Checks: Room checks are done at night to make sure you are okay. In order to make room checks as non-intrusive as possible is there anything that would make room checks more comfortable for you?

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12. Trauma History:

Do you have any issues regarding abuse such as sexual or physical abuse that you would like to talk about with staff, or with a counselor? Yes No
Would you like more information on these issues in classes or support groups? Yes No

13. Anything Else? Is there anything else that would make your stay easier and more comfortable? For example, do you have any special issues like cultural, diet, sexual preference, appearance, etc. that you think could contribute to misunderstandings or cause problems for you? Please describe:

The Personal Safety Form Information should be presented to the treatment team and incorporated into the treatment plan for this individual. Each individual shall receive a copy. This form has been adapted from an original form created by the Massachusetts Department of Mental Health.