Trauma-Informed Individualized Safety Plan

Facility: _____ Name of youth: _____

Date: _____ Name of staff: _____

We would like to make you as safe as possible while you are here with us. Please complete the following safety plan with your social worker, psychologist, or trusted staff member. Read the following questions and answer all that apply to you.

Have you ever been in a detention facility before? ☐ Yes ☐ No

Have you ever experienced or witnessed? (Please check all that apply)

- ☐ Physical abuse
- ☐ Sexual abuse
- ☐ Emotional abuse
- ☐ Death of a friend due to violence
- ☐ Death of a friend due to accident/illness
- ☐ Abandonment
- ☐ Seclusion
- ☐ Restraint
- ☐ Injuring your self
- ☐ Other: (Please describe)

- ☐ Neglect
- ☐ Domestic violence
- ☐ Death of a loved one due to violence
  - ☐ Parent
  - ☐ Sibling
  - ☐ Family member
- ☐ Observed a fight
- ☐ Room confinement
- ☐ Homelessness

- ☐ Prostitution
- ☐ Forced labor
- ☐ Death of a loved one due to accident/illness
  - ☐ Parent
  - ☐ Sibling
  - ☐ Family member
- ☐ Been in a fight
- ☐ Strip searched
- ☐ Fear of being attacked

- ☐ Natural disaster
- ☐ Serious injury
  - ☐ Been stabbed
  - ☐ Been shot or shot at
- ☐ Serious Illness
- ☐ Serious accident
- ☐ Bullying
- ☐ Suicidal thoughts
- ☐ Suicide attempts
- ☐ Running away

_____

_____

_____

If you feel unsafe are you able to communicate about your safety level? For example, could you tell staff when you are struggling or upset? ☐ Yes ☐ No ☐ Sometimes

In what situations would this be difficult for you?

_____

_____

What are your trauma reminders or triggers? (Please check all that apply)

- ☐ Being touched
- ☐ Time of year *(When)*
- ☐ Particular time of day *(When)*
- ☐ Seeing others out of control
- ☐ Room checks
- ☐ Other:

- ☐ Not having input
- ☐ Bedroom door open
- ☐ Being isolated
- ☐ Specific person *(Who)*
- ☐ People being to close

- ☐ People in uniform
- ☐ Yelling
- ☐ Fighting
- ☐ Anniversaries *(What)*

- ☐ Loud noise
- ☐ Being forced to talk
- ☐ Being around men
- ☐ Being around women

_____

_____

Please describe your warning signs, for example, what your body feels when you are losing control and what other people can see changing? (Please check all that apply)

- ☐ 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
- ☐ Nauseous
- ☐ Shortness of breath
- ☐ Sleeping Less
- ☐ Eating less
- ☐ Eating more
- ☐ Being rude or agitated
- ☐ Singing inappropriate song
- ☐ Other:

_____

_____

What helps you feel or stay safe? (Please check all that apply)

- ☐ Yelling
- ☐ Having male staff support
- ☐ Reading
- ☐ Getting exercise/sports
- ☐ Writing
- ☐ Having female staff support
- ☐ Ice
- ☐ Drawing/coloring
- ☐ Watching TV/Movie
- ☐ Having support from peers
- ☐ Playing video games
- ☐ Taking a shower
- ☐ Listening to music
- ☐ Walking
- ☐ Talking
- ☐ Weighted blankets/vests
- ☐ Other:

_____

_____

What helps you stay in control? _____

_____

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

_____

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

☐ Quiet Area ☐ Your room ☐ Safety room ☐ In bed ☐ Other: _____

Is there a safe place here you can use? ☐ Yes ☐ No ☐ Describe: _____

What positive alternative behaviors can you use when you begin feel unsafe?

_____

What incentives work for you?

_____

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

_____

Thank you for completing this form. We will update it with you in three months. Please sign below

Youth: _____ Staff: _____