Youth Villages- Safety & Treatment Planning

Today's Date: _____ Child's Name: _____ Age: _____
Caregiver: _____ Relationship to Child: _____
Location being secured with safety planning: _____

Child's Behaviors That You Want to Change or Prevent (What has your child done today or in the past that may be unsafe?)**:**_

_____

Possible Reasons Child Might Display Unsafe Behaviors (Include key specific reasons in the child, peer, family, school or community that may cause the behavior)**:**

1. _____
2. _____
3. _____

Ideas For Preventing Another Crisis From Occurring: (Things that would be practiced on a daily basis, when a crisis is not happening, to prevent a crisis from starting? Ex. Regular practice of coping skills, check in by parent, weekly family meetings, etc.)**:**

1. _____
2. _____
3. _____
4. _____
5. _____

Signs Of Crisis For This Child (describe child's behaviors & appearance before/leading up to a crisis)**:**

1. _____
2. _____
3. _____

Managing A Crisis When It Is Occurring: (Specific steps to take when you see the signs and symptoms worsening. Ex. Call supports, remove other children/pets, time out, etc.)**:**

1._____
2._____
3._____
4. _____
5. _____

Avoid: _____

Key People in Child or Family's Life and Ways They Can Help:

Name (Neighbors, family, friends, pastor, positive staff at facility, PO, CM)	**Support they can provide** (Help supervise, phone support, respite, help setting rules, help reinforce positive behavior of child, etc.)
1.	
2.	
3.	
4.	

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Special Supervision Plans and Responsible Parties (i.e. - specific supervision needs (before, during, after school), instructions for using sharp items, med. administration, etc.)**:**

_____

_____

Safety Sweep And Removal Of Means To Target Present Risky Behavior: (What is available in home/facility that may be unsafe for child having a crisis?)**:**

- ☐ Guns and bullets
- ☐ Prescribed medications
- ☐ Household items (cleaning products)
- ☐ Illegal drugs
- ☐ Over the counter medications
- ☐ Alcohol
- ☐ Knives or sharps
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

How/Where Will Items Be Secured; Who Is Responsible For Securing The Items; When the Items will be secured:

_____

_____

Plans For Long-Term Stability Of Child (What needs to be done by the child, family and crisis counselor within the next 24 hours to get the safety plan going?)**:**

Plan #1: _____

Plan #2: _____

Plan #3: _____

Potential Barriers to the safety plan being successful:

_____

Steps to Address the Barriers:

_____

Contact the Crisis Team: (Phone #_____) if above interventions are unsuccessful or additional referrals are needed.

Contact Police or EMS if youth has a weapon or medical attention is needed.

Clinical Follow-Up (Describe follow up to be provided by Crisis Team Staff):

_____

_____

My signature below indicates I have reviewed and agree to this safety plan. (The safety plan is created to be followed for 24-72 hours after the crisis assessment or until an appointment with mental health provider)

_____	_____
Client	Caregiver/Custodian
_____	_____
Crisis Counselor	Caregiver/Custodian
_____	_____
Facility Staff Member	Other Involved Adult