Appendix R: Example: Personal De-escalation Plan

Personal De-escalation Plan

Patient Name: ____________________________________________
Date: ____________________________________________________

**PROBLEM BEHAVIORS:** What type of behaviours are problems for you?
- [ ] Losing control
- [ ] Feeling unsafe
- [ ] Injuring yourself
- [ ] Other: _________________________________________________________________________________________
- [ ] Assaultive behaviour
- [ ] Running away
- [ ] Suicide attempts
- [ ] Restraints/Seclusion
- [ ] Feeling suicidal
- [ ] Drug or alcohol abuse

**TRIGGERS:** What type of things (triggers) make you feel unsafe or upset?
- [ ] Not being listened to
- [ ] Lack of privacy
- [ ] Feeling lonely
- [ ] Darkness
- [ ] Being teased or picked on
- [ ] Other: _________________________________________________________________________________________
- [ ] Feeling pressured
- [ ] People yelling
- [ ] Arguments
- [ ] Being isolated
- [ ] Contact with family
- [ ] Being touched
- [ ] Loud noises
- [ ] Not having control
- [ ] Being stared at
- [ ] Particular time of day/night: ____________________________
- [ ] Particular time of year: _________________________________
- [ ] Other: _________________________________________________________________________________________

**WARNING SIGNS:** Please describe your warning signs, for example what other people may notice when you begin to lose control?
- [ ] Sweating
- [ ] Clenching teeth
- [ ] Wringing hands
- [ ] Bouncing legs
- [ ] Squatting
- [ ] Crying
- [ ] Not taking care of self
- [ ] Singing inappropriately
- [ ] Eating more
- [ ] Other: _____________________________________________________
- [ ] Breathing hard
- [ ] Clenching fists
- [ ] Loud voice
- [ ] Rocking
- [ ] Cant sit still
- [ ] Isolating/avoiding people
- [ ] Hurting myself
- [ ] Sleeping less
- [ ] Being rude
- [ ] Racing heart
- [ ] Red faced
- [ ] Sleeping a lot
- [ ] Pacing
- [ ] Swearing
- [ ] Hyper
- [ ] Hurting others or things
- [ ] Eating less
- [ ] Laughing loudly/giddy

**INTERVENTIONS:** What are some things that help to calm you down or keep you safe?
- [ ] Time out in your room
- [ ] Reading a book
- [ ] Pacing
- [ ] Coloring
- [ ] Hugging a stuffed animal
- [ ] Taking a hot shower
- [ ] Blanket wraps
- [ ] Lying down
- [ ] Using cold face cloth
- [ ] Deep breathing exercises
- [ ] Getting a hug
- [ ] Time out in the Quiet room
- [ ] Sitting with staff
- [ ] Talking with peers
- [ ] Exercising
- [ ] Writing in a journal
- [ ] Taking a cold shower
- [ ] Running cold water on hands
- [ ] Ripping paper
- [ ] Using ice
- [ ] Having your hand held
- [ ] Going for a walk
- [ ] Listening to music
- [ ] Watching TV
- [ ] Talking with staff
- [ ] Calling a friend (who?)
- [ ] Calling family (who?)
- [ ] Molding clay
- [ ] Humor
- [ ] Screaming into pillow
- [ ] Punching a pillow
- [ ] Crying
- [ ] Speaking with therapist
INTERVENTIONS (continue):

- Drawing
- Making a collage
- Playing cards
- Video games
- Other: __________________________

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

- Being alone
- Not being listened to
- Being disrespected
- Other: __________________________

- Loud tone of voice
- Having many people around me
- Peers teasing
- Being ignored

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 to staff when you are having a hard time? If not, what can staff do at these moments to help?

_________________________________________________________________________________________________
_________________________________________________________________________________________________

What kinds 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: __________ ___

Boston Medical Center
Intensive Residential Treatment Program
85 E. Newton St.
Boston, Ma. 02118

Reprinted with Permission from The Massachusetts Department of Mental Health.