

# Appendix R: Example: Personal De-escalation Plan

## Personal De-escalation Plan

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**PROBLEM BEHAVIORS:** What type of behaviours are problems for you?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Losing control    | <input type="checkbox"/> Assaultive behaviour | <input type="checkbox"/> Restraints/Seclusion  |
| <input type="checkbox"/> Feeling unsafe    | <input type="checkbox"/> Running away         | <input type="checkbox"/> Feeling suicidal      |
| <input type="checkbox"/> Injuring yourself | <input type="checkbox"/> Suicide attempts     | <input type="checkbox"/> Drug or alcohol abuse |
| <input type="checkbox"/> Other: _____      |   |  |

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Not being listened to                | <input type="checkbox"/> Feeling pressured          | <input type="checkbox"/> Being touched      |
| <input type="checkbox"/> Lack of privacy                      | <input type="checkbox"/> People yelling             | <input type="checkbox"/> Loud noises        |
| <input type="checkbox"/> Feeling lonely                       | <input type="checkbox"/> Arguments                  | <input type="checkbox"/> Not having control |
| <input type="checkbox"/> Darkness                             | <input type="checkbox"/> Being isolated             | <input type="checkbox"/> Being stared at    |
| <input type="checkbox"/> Being teased or picked on            | <input type="checkbox"/> Contact with family: _____ |   |
| <input type="checkbox"/> Particular time of day/ night: _____ |   |   |
| <input type="checkbox"/> Particular time of year: _____       |   |   |
| <input type="checkbox"/> Other: _____                         |   |   |

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

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

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Time out in your room    | <input type="checkbox"/> Time out in the Quiet room  | <input type="checkbox"/> Listening to music      |
| <input type="checkbox"/> Reading a book           | <input type="checkbox"/> Sitting with staff          | <input type="checkbox"/> Watching TV             |
| <input type="checkbox"/> Pacing                   | <input type="checkbox"/> Talking with peers          | <input type="checkbox"/> Talking with staff      |
| <input type="checkbox"/> Coloring                 | <input type="checkbox"/> Exercising                  | <input type="checkbox"/> Calling a friend (who?) |
| <input type="checkbox"/> Hugging a stuffed animal | <input type="checkbox"/> Writing in a journal        | <input type="checkbox"/> Calling family (who?)   |
| <input type="checkbox"/> Taking a hot shower      | <input type="checkbox"/> Taking a cold shower        | <input type="checkbox"/> Molding clay            |
| <input type="checkbox"/> Blanket wraps            | <input type="checkbox"/> Running cold water on hands | <input type="checkbox"/> Humor                   |
| <input type="checkbox"/> Lying down               | <input type="checkbox"/> Ripping paper               | <input type="checkbox"/> Screaming into pillow   |
| <input type="checkbox"/> Using cold face cloth    | <input type="checkbox"/> Using ice                   | <input type="checkbox"/> Punching a pillow       |
| <input type="checkbox"/> Deep breathing exercises | <input type="checkbox"/> Having your hand held       | <input type="checkbox"/> Crying                  |
| <input type="checkbox"/> Getting a hug            | <input type="checkbox"/> Going for a walk            | <input type="checkbox"/> Speaking with therapist |

**INTERVENTIONS (continue):**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Drawing          | <input type="checkbox"/> Snapping bubble wrap | <input type="checkbox"/> Being read a story         |
| <input type="checkbox"/> Making a collage | <input type="checkbox"/> Bouncing ball in QR  | <input type="checkbox"/> Being around other people  |
| <input type="checkbox"/> Playing cards    | <input type="checkbox"/> Male staff support   | <input type="checkbox"/> Female staff support       |
| <input type="checkbox"/> Video games      | <input type="checkbox"/> Using the gym        | <input type="checkbox"/> Doing chores/ special jobs |
| <input type="checkbox"/> Other: _____     |   |   |

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Being alone           | <input type="checkbox"/> Loud tone of voice           | <input type="checkbox"/> Humor         |
| <input type="checkbox"/> Not being listened to | <input type="checkbox"/> Having many people around me |  |
| <input type="checkbox"/> Being disrespected    | <input type="checkbox"/> Peers teasing                | <input type="checkbox"/> Being ignored |
| <input type="checkbox"/> Other: _____          |   |  |

**STRENGTHS:** What are your strengths when feeling out of control?

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**SKILLS:** What skills do you have/ what are you good at?

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**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??

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What kinds of incentives work for you?

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**SPECIAL PLANS:** List any special plans that help you (things you have used in the past or would like to try).

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Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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