Personal De-escalation Plan

Patient Name: ____________________________________________________________
Date: __________________________________________________________________

PROBLEM BEHAVIORS: What type of behaviors are problems for you?
q Losing control         q Assaulative behavior         q Restraints/Seclusion
q Feeling unsafe         q Running away             q Feeling suicidal
q Injuring yourself      q Suicide attempts         q Drug or alcohol abuse
q Other:____________________

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

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

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

**INTERVENTIONS (continue):**

| q Drawing                       | q Snapping bubble wrap                     | q Being read a story            |
| q Making a collage             | q Bouncing ball in QR                      | q Being around other people     |
| q Playing cards                | q Male staff support                       | q Female staff support          |
| q Video games                  | q Using the gym                            | q Doing chores/ special jobs    |
| q Other:                       |                                           |                                |

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

| q Being alone                  | q Loud tone of voice                       | q Humor                         |
| q Not being listened to        | q Having many people around me            |                                |
| q Being disrespected           | q Peers teasing                            | q Being ignored                 |
| q Other:                       |                                           |                                |

**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?

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

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**Boston Medical Center**

**Intensive Residential Treatment Program**

85 E. Newton St.

**Boston, Ma. 02118**
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:__________ ____