Personal De-escalation Plan

Patient Name:_____
Date:_____

PROBLEM BEHAVIORS: What type of behaviors are problems for you?

q Losing control	**q** Assualtive 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

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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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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**:_____ ____

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