

# Increasing Self-Determination through Advance Crisis Management in Inpatient and Community Settings: How to Design, Implement, and Evaluate Your Own Program




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# **Increasing Self-Determination through Advance Crisis Management in Inpatient and Community Settings**

## **Introduction**

This manual was designed to guide the efforts of hospital- and facility-based programs in developing procedures for advance crisis management with their patients/clients who have a psychiatric disability (suggestions also are given throughout the manual about how to adapt these techniques for community-based settings). The type of crisis management described in this manual involves working directly with people to determine their self-identified crisis triggers and calming techniques. These triggers and de-escalation strategies are recorded on a simple form that can easily be consulted when crises occur. Simply stated, this process allows staff and clients to talk openly about what might cause a crisis **before** it happens.

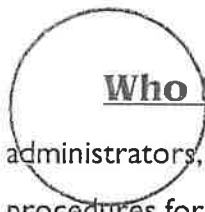
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**This manual primarily focuses on advance crisis management in inpatient and residential facilities, although suggestions are given for adaptation to community-based treatment settings.**

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Some staff naturally worry that to **discuss** crises will **cause** crises. On the contrary, when handled sensitively and systematically, such discussions can go a long way towards letting people know that safety is a priority in your program and that you want to work with them in maintaining calm and safety. This process also empowers people in your program to understand that they, too, are expected to take responsibility for maintaining their own safety and well-being. These discussions will emphasize that staff and patients are entering into a

**partnership of safety**, in which both are taking responsibility for creating and maintaining a safe therapeutic environment. Discussing in advance what might help calm an escalating individual also allows staff to have a series of **personalized** de-escalation strategies in mind to avoid scrambling around, trying to decide what can or should be done during those often difficult moments when a crisis is erupting. Additionally, when promptly and correctly used, advance crisis management can assist inpatient units and residential facilities in their efforts to reduce the utilization of physical or chemical restraint, seclusion, and other involuntary or coercive procedures. Of course, this Program does not take the place of formal crisis prevention and de-escalation training that is offered regularly (at least annually) for all staff.

 **Who Should Use this Manual?** This manual was written for administrators, supervisors, managers, service providers, and clients interested in developing procedures for advance crisis management in psychiatric treatment settings. It addresses designing, implementing, and evaluating advance crisis management procedures from the viewpoints of all those involved. It is intended for use in inpatient programs, partial hospitalization programs, and residential facilities, but also can be adapted for psychosocial rehabilitation programs, community mental health centers, clubhouses, and any other acute or long-term mental health treatment settings in which people with psychiatric disabilities are served.

 **Organization of the Manual.** This manual was developed primarily for programs in the beginning stages of designing and implementing client-determined, crisis management procedures. Those wishing to learn evaluation methods or ways to help staff who are struggling with advance crisis management also will find useful information. This manual focuses on what is commonly believed to be the first step in introducing programmatic change: **preparing the organizational environment to support an innovative approach** (in this case, crisis and risk management). When instituting major programmatic



changes, a lack of advance preparation can leave many staff and patients/clients with the feeling that they are lost in the confusion and uncertainty that often accompanies organizational change (Solomon et al., 1998). Even staff members who are dedicated to working directly with patients to increase their self-determination via crisis planning can become overburdened and resentful when left with the impression that their organizations did not adequately prepare for the procedural changes involved.

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**This manual addresses four major topics:**

- ▶ **designing and implementing an Advance Crisis Management Program;**
  - ▶ **creating and using Advance Crisis Plans each day;**
  - ▶ **evaluating Advance Crisis Plans and procedures; and**
  - ▶ **common concerns about advance crisis management.**
- 

The first chapter of the manual addresses **the foundations of an effective Advance Crisis Management Program**. It begins with a discussion of the underlying values and purposes of an Advance Crisis Management Program and how it can increase self-determination. Next is a detailed overview of the person-centered Crisis De-Escalation Interview, which is the basis for each patient/client's Advance Crisis Plan, as well as for related programmatic policies and procedures. Also discussed are ways in which the information gathered in the Interview can be translated into a Crisis Plan for each person served.

The second chapter deals with **the implementation of an Advance Crisis Management Program in one's treatment setting**. The chapter begins with a


discussion of the need to identify key organizational players to form an Implementation Team to introduce and evaluate this process. Next, the chapter outlines why it is crucial to garner support from administrators and managers of the organization, and offers several strategies for doing so. After that, guidelines for analyzing existing policies and procedures to assess how well and where advance crisis management will fit within the current organizational structure are outlined. Methods for adopting/adapting crisis management procedures are addressed, as is the need to translate the interview and evaluation forms into the primary languages spoken by agency/facility clients. The chapter concludes with how to train administrators, managers/supervisors, nurses, counselors/technicians, social workers, and patients/clients about the importance and techniques of the Advance Crisis Management Program.

The third chapter turns to **how Advance Crisis Plans are created and utilized on a daily basis**. The value of skills training and support groups for clients emphasizing self-soothing and calming techniques also is discussed. The next chapter tackles the **common concerns among supervisors, direct service staff, and patients/clients** regarding the development, utilization, and evaluation of person-centered advance crisis management. In the fifth chapter, **the importance of ongoing evaluation of the effectiveness of advance crisis management procedures and policies** is discussed, as well as simple strategies for conducting this type of evaluation. The manual concludes with a reminder of the need for perseverance, since all meaningful change is slow and sometimes difficult. The Appendix contains sample de-escalation tools, including a Spanish-language version, as well as sample Evaluation Logs and resources that programs may draw upon in their efforts to develop effective safety and crisis prevention procedures.

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**A training video is available for use in conjunction with this manual. It highlights: the history of advance crisis management; strategies to implement an Advance Crisis Management Program; and common concerns that arise when instituting the Program. Check the title page for ordering information.**

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 **A Word of Acknowledgment.** This manual grew out of a pilot-project funded by the U.S. Department of Education's National Institute on Disability and Rehabilitation Research in 1997 to design and implement person-centered, advance crisis management procedures on a local university's adult psychiatric inpatient unit. The idea for the project was sparked by the pioneering work of the Massachusetts Department of Mental Health's Task Force on the Restraint and Seclusion of Persons Who Have Been Physically or Sexually Abused, co-chaired by **Elaine Carmen, MD and Bill Crane, JD** (Carmen, Crane, Dunncliff, et al., 1996). The de-escalation interview and procedures described in this manual were adapted from those produced by this Task Force. Dr. Carmen provided expert consultation on our project in its early stages of development, and connected us with three invaluable and supportive colleagues: **Nan Stromberg, RN, CS, Laura Prescott, and Evelyn Carey, RN.** These women spent many hours helping our team to design and deliver the all-staff training on person-centered crisis de-escalation procedures. They generously shared their time, professional experience, personal lives, and materials/resources with us and the staff, helping to take the project to a higher level. For this, we sincerely thank them.

### What About Language?

Because this manual focuses primarily on inpatient and residential facilities, we use the terms “patient” and “client” to describe individuals who are receiving mental health services. When confronted with the best way to use inclusive gender pronouns throughout this manual, we decided to use the pronouns, “she” and “he,” as well as “her” and “his,” alternately to reduce awkward phrasing and to minimize sexist biases in our language. We ask any readers who find our use of language jarring or offensive to try to look beyond the terms to the messages being conveyed.

### This Process is Worth Doing.

We fully realize that not all individuals involved in the mental health system – personally, professionally, or both – will agree with our observations or suggestions. Such disagreement is expected and it is our contention that, however uncomfortable, conflict is often at the center of meaningful change. At the same time, it is important to remember that change is a process which will occur at different paces within different organizations. The key is to stay with the challenge and to recognize that the end goal – **increased safety and meaningful partnerships** with people with psychiatric disabilities – is essential for everyone involved. Although each organization will face different barriers to change, we maintain the belief that these barriers can be overcome with strong leadership, commitment, and patience.

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**Remember: All organizational change takes leadership, commitment, and patience. The end results of increased safety, formation of partnerships with clients, less on-the-job injuries, and greater job satisfaction will make the process worthwhile!**

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## Chapter 1:

# The Advance Crisis Management Program

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**This chapter addresses the underlying values and purposes of an Advance Crisis Management Program. Also presented is the person-centered Crisis De-Escalation Interview, which is the basis for each person's Advance Crisis Plan and the accompanying organizational policies and procedures.**

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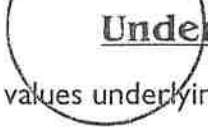
### Why Do This?

Advance crisis management, which is a form of **psychiatric advance directive**, has been growing in popularity in recent years (Carmen, Crane, Dunncliff, *et al.*, 1996; Sutherby *et al.*, 1999). Originally, this form of advance crisis management in the United States grew out of a concern that individuals with childhood abuse histories were being re-traumatized by the utilization of restraint and seclusion in inpatient settings, and that trauma-sensitive practices were needed to help reduce the need to restrain and/or seclude survivors. In the United Kingdom, the first **"crisis card"** for psychiatric inpatient settings was developed by the International Self-Advocacy Alliance and jointly launched with Survivors Speak Out in 1989 (Sutherby *et al.*, 1999). This "card" was intended as an advocacy device for use in mental health emergencies, allowing an individual to outline specific actions to be taken in the case of a personal crisis or emergency, much like an advance directive.

The fundamental value underlying these initiatives is the belief that people's crises would be addressed more humanely if they were allowed to specify **in advance** actions to be taken during times when they are too distressed to make decisions regarding treatment options. This approach builds on a long, albeit inconsistent, tradition in mental health and social work practice of fostering clients' rights to have a voice in their own treatment and lives.

Advance Crisis Plans differ from standard psychiatric advance directives in that they are not necessarily legally binding, contain much less information than the standard directive, and pertain specifically to crises or emergencies, rather than a range of psychiatric health needs/situations. In both the U.S. and the U.K., **Advance Crisis Plans are now being used in a wide variety of settings**, such as prisons, jails, residential facilities, and community-based treatment programs.

Typically, the impetus for introducing an Advance Crisis Management Program into a hospital or facility comes from the Performance or Quality Improvement (also called PI/QI) Team (which might be concerned with reducing crises, restraint, seclusion, and related injuries) or the chief psychiatrist or head nurse (who might be interested in improving safety and the therapeutic milieu). Interest in implementing the Program also may come from one of the nurses, technicians, case workers, or clients in an agency. If this is the case, the staff member or client is likely to need the support and assistance of the PI/QI Team in making the Program a reality. Introduction of this kind of Program also may come from key administrators or decision-makers who want to improve organizational practices or better meet the Joint Commission on the Accreditation of Healthcare Organizations' (JCAHO) standards regarding crisis care and the utilization of restraint and seclusion (which are discussed further below).




**Underlying Purposes and Values.** There are a number of purposes and values underlying mental health treatment and psychiatric hospitalization that dovetail with those of the Advance Crisis Management Program. These include:

- addressing emotional and/or mental health crises/difficulties;
- initiating a process of recovery through the installation of hope, by helping people to understand that they are not alone, that others have had similar experiences, and that they can learn from their peers and from staff;
- enhancing individual self-esteem by ensuring that staff and others acknowledge the validity of people's experiences and seek to involve people in their own treatment; this process enhances trust between clients and providers and is crucial to the development of client self-determination;
- restoring physical health; and
- maintaining a safe environment (Astrachan, 2001).

Like most innovations in health care practice, the Advance Crisis Management Program has a **foundation of values and beliefs** that drives its techniques, practices, and policies. The major values and beliefs are as follows.

- Most people, no matter what their diagnoses or situations, can identify their personal stressors and triggers to crises. Those who have never been asked to do so can be educated to recognize these triggers in a relatively short amount of time.
- People with psychiatric disabilities also can identify or be taught to use simple calming strategies when they begin to feel upset. Many of these calming techniques do not take a lot of external resources, although they may require support from staff and others.
- Discussing possible triggers and calming techniques in advance of a crisis allows the staff and client to enter into a **partnership of safety**, in which both parties take responsibility for maintaining safety on the unit or in the program.
- Working with people to help them identify de-escalation strategies in advance of an emergency sends the message that safety is a priority on the unit or in the program, and that staff believe they can offer tools to help patients/clients to maintain their own safety.
- Client self-determination is increased when people with psychiatric disabilities direct their own care whenever possible.

As discussed further in a later section, everyone who will be involved in the Advance Crisis Management Program will need to be educated about or familiar with these values because their widespread acceptance increases the likelihood of success of the Program. Involving people with psychiatric disabilities who hold these beliefs and, even better, who have used or are aware of advance crisis management techniques can be a very powerful way to convey these values.

 **Purposes of the Program.** The fundamental purpose of advance crisis management is to reduce people's crises. It also enhances the safety and well-being of everyone involved in the treatment setting. Helping people identify triggers and useful calming strategies will increase their self-determination and help them to take personal responsibility for their own recovery, while learning to take charge of their lives (Schmook, 2001). A reduction of crises also can **reduce the utilization of:**

- **physical restraint** (i.e., physically securing people to a bed/gurney),
- **seclusion** (i.e., putting people in an isolated room for extended periods of time),
- **chemical restraint or PRNs** (i.e., medication used to control behavior or to restrict the person's freedom of movement **that is not standard treatment** for the person's medical or psychiatric condition),
- and **other involuntary procedures.**

Reducing these types of involuntary practices will help hospitals and facilities to meet the standards of the Joint Commission on the Accreditation of Healthcare Organizations.



Specifically, in a report on their revised standards for 2001, JCAHO notes that,

. . . Because restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of an individual's rights, and even death, organizations [must] continually explore ways to **prevent, reduce, and strive to eliminate the use of restraint and seclusion** through effective performance improvement initiatives (Joint Commission on Accreditation of Healthcare Organizations, 2001).

This report goes on to say that,

. . .the use of restraint and seclusion poses an inherent risk to the physical safety and psychological well-being of the individual patient and staff member. Therefore, restraint and seclusion are used only in an **emergency**, when there is **imminent risk** of an individual harming self or others, including staff. Non-physical interventions are the first choice as an intervention, unless safety issues demand an immediate physical response.

Another reason to engage in advance crisis management procedures is to help **reduce the traumatizing or re-traumatizing aspects of care** often found in inpatient and residential facilities. For individuals who have been physically or sexually abused or neglected as children, the loss of power and control often experienced when hospitalized, in addition to physical/chemical restraint or seclusion, can be severely re-traumatizing (Carmen & Rieker, 1998; Jennings, 1994). This loss of self-determination through the use of involuntary treatments can trigger increased emotional distress or crises because they mimic the traumatizing abuse of the person's past. Thus, the very techniques used to "calm" a person with a history of abuse often will provoke crisis and increase emotional duress. For others, the utilization of physical/chemical restraint or seclusion in the hospital may be the first time they have felt traumatized, leading them to avoid all contact with the mental health system, even when in


extreme need. Furthermore, many **staff also report being emotionally traumatized and physically injured by having to restrain or seclude people**, and would prefer to use less invasive/harmful ways to help people reduce threats towards self or others (Marangos-Frost & Wells, 2000; DiFabio, 1981).

For community-based programs, advance crisis management procedures may be used in several major ways.

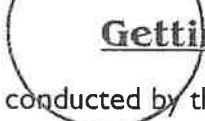
- The first is to help clients identify their personal triggers and how they would like staff to respond should they go into crisis. Since restraint and seclusion are not utilized in these settings, these obviously would not be emphasized, although clients may wish to share their preferences regarding restraint and seclusion should they be hospitalized.
- Service providers also may utilize the Crisis De-Escalation Interview to help their clients outline a plan for dealing with crisis triggers when they are alone (i.e., without family, peer, or staff support) in their homes or apartments. These calming strategies may be helpful in decreasing pre-crisis feelings and behaviors, and may help to avert a full-blown crisis (Schmook, 2001).
- Community-based staff may use information from the Crisis De-Escalation Interview to help clients manage crises and thereby avoid hospitalization.

Some organizations which hire people with psychiatric disabilities, such as our own, use what are known as voluntary Employment Support Plans, working with employees in advance of crises to determine how they would like supervisors and coworkers to respond should an emergency occur (Solomon *et al.*, 1998). In other words, advance crisis management procedures are readily adaptable to a variety of settings, even those that do not utilize restraint or seclusion.

Each of these values and purposes serves as the foundation of a successful Advance Crisis Management Program. Keeping them in mind will help to clarify the actual practices and procedures used in the Program, including the Crisis De-Escalation Interview, to which we now turn.



**The Crisis De-Escalation Interview.** The basis of the Advance Crisis Management Program is the Crisis De-Escalation Interview conducted with people when they enter the treatment setting (adapted from Carmen, Crane, Dunncliff, et al., 1996). A copy is found in the Appendix, in both English and Spanish languages. Recommended procedures for conducting and continually updating this Interview are described in the third chapter of this manual. At this point, however, it is important to have a thorough understanding of each aspect of the Interview and its purpose. Understanding the questions and why they are asked will help all involved in designing and implementing your Program to understand where it might fit into existing procedures and how it may be adapted to meet the needs of your particular organization.



**Getting Started.** In most settings, the Crisis De-Escalation Interview will be conducted by the person who handles the intake process. The Interview would be **integrated into the assessments typically conducted when a person enters a program**, or shortly thereafter (this is discussed further in the next two chapters). Because it does not require any special clinical training or certification, any provider in the setting should be able to conduct the Interview. That said, because effective administration of the Interview requires that providers use active and empathic listening skills, it may be necessary to have senior or supervisory staff observe its administration on a periodic basis to provide guidance and feedback.

In most hospitals and facilities, it will be the psychiatric nurses who handle the Interview, as well as ensure that the strategies are discussed/practiced daily and used in times of:

- **pre-crisis**

(i.e., according to JCAHO, these are incidents that appear to be leading to a crisis, such as screaming or yelling, threats of harm to others, property damage, extreme withdrawal, crying, and refusing to follow directions); or

- **crisis**

(i.e., a full-blown crisis or emergency, defined as *imminent* risk of an individual harming self or others, including staff).

The Interview starts with an explanation of how it is to be completed and explained to the patient/client. At this point, the staff person describes the Advance Crisis Management Program, and then, lets the client know the purpose of the Interview, how the resulting Crisis Plan will be used, and that the information will be kept confidential. If it appears that the person is not able to focus on or complete the Interview upon intake, this is noted at the end of the form, as described on pages 25-26.

Patient/Client Name \_\_\_\_\_ (PRINT)


Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

STAFF: At intake, complete Items 1-7. **Note:** For the first two questions, Plan 1 should be completed and dated at intake. Any changes to the Plan should be recorded in the Plan 2 column for the first two questions **only**, dating each (use Plan 3 if more changes are needed). **After each change, initial it above the column.**

STAFF, READ TO PERSON: To provide you with the best care we can, we want to know what helps you to feel better and safer when you are having a hard time and think you might lose control. These questions will help us to understand you better, and help you to feel safer while you're here. The information will be shared with your treatment team and put in your treatment plan.

The Interview consists of 7 questions, most of which involve simple checklists. Before beginning, the staff person records the patient/client's name and the date the Interview was first **attempted** (date of completion is found at the end of the Interview). Next, there are instructions to attempt to complete the Interview at intake or shortly thereafter if the person is not ready or able to do so when first entering the program. The design of the Interview allows for changes/updates to be made whenever necessary. The "Plan 1" column is the first to be completed, typically upon intake or shortly after. The "Plan 2" column is completed if the staff or client identifies additional triggers and calming strategies at any point after the initial Interview. The second Plan **does not** negate the first Plan, but rather, adds supplemental strategies to be considered for use. The "Plan 3" column allows for additional changes that might be necessary (again, it does **not** negate the first or second Plans). The importance of dating and initialing **each** change is emphasized. Examples of how the different Plans might be used are given below, in the section describing the first question.

Next, the staff member explains the reason for the Interview in simple terms. If the person has a question about the Interview or how it is used, these questions are answered before proceeding.



**The First Question: Stress or Crisis Triggers.** The introduction having been completed and individual concerns addressed, the first question asks people to identify what triggers them or leads them to feel that they will lose control.

This question is **not** meant to identify what makes people feel blue, or down, or even angry, but in particular what leads them to become extremely agitated or to lose control. This is a very important distinction because there are many things that can upset any of us as human beings that will not cause us to go into crisis.

If a person is starting to say, "yes," to every trigger during the Interview, the staff member should stop and make sure that the client understands that he should only identify those things that lead him to become **extremely agitated** or to go into a crisis, rather than those things that make him feel unhappy or sad or angry, but not really **agitated**. If this distinction does not seem clear after explaining it, the staff member may decide that it would be better to complete the Interview when the person is in a more stable condition or able to concentrate. This would be noted at the end of the Interview form, as explained in more detail below. Having said that, there may be individuals who have been so severely abused that they are triggered by most everything in a treatment setting. In these cases, staff will need to be sensitive to the person's personal history and needs, with an eye towards keeping the Plan feasible and manageable by limiting the number of identified triggers, if possible.

1. Stress/Crisis Triggers. Certain things make people become very angry, very upset, or to go into a crisis when in the hospital. To help you feel safe, we want to know what things might agitate you while you're here. I'll read a list and you tell me which ones might agitate you, or cause you to feel like you'll lose control of yourself. (STAFF: Check all that apply.)

| PLAN #  | 1 | 2 | 3 | PLAN #   | 1 | 2 | 3 |
|---|---|---|---|--|---|---|---|
| DATE  |   |   |   | DATE   |   |   |   |
| being touched                                     |   |   |   | being isolated   |   |   |   |
| bedroom door open                                 |   |   |   | people in uniform  |   |   |   |
| particular time of day (when?)                    |   |   |   | time of the year (when?)   |   |   |   |
| noises  |   |   |   | someone else yelling   |   |   |   |
| not having control/input                          |   |   |   | being around men or women (circle)                                     |   |   |   |
| feeling a lack of respect                         |   |   |   | people not paying attention to me                                      |   |   |   |
| shift change                                      |   |   |   | feeling threatened or unprotected                                      |   |   |   |
| not having personal space                         |   |   |   | nightly room checks  |   |   |   |
| too many people crowding around me when I'm upset |   |   |   | seeing other people escalate and/or seeing them restrained or secluded |   |   |   |
| other (please list)                               |   |   |   | other (please list)  |   |   |   |

---

**Through this Interview, staff and clients are seeking to identify what makes someone go into a crisis or potential crisis.**

---

An example of how the first question might be addressed over the course of several days will help to clarify how the process works. Let's say that staff member, Joanna, is working with patient, Robert.

*After writing his name on the form and explaining the purpose of the Interview, Joanna reads the instructions for the first question to Robert. He understands, so Joanna begins to read each trigger on the list to him, asking if it causes him to become extremely agitated or upset. He says that the first seven things can make him frustrated, but do not cause crises, so Joanna does **not** put checks in these columns. When she gets to, "not having personal space," however, Robert says that he has lost control in the hospital before when he couldn't find a way to be alone to "get some peace and quiet." Therefore, Joanna marks a check in Question 1, Plan 1, Item 8. She reads through the rest until Robert identifies that "nightly room checks" also can cause him to become very upset. She marks a check in Question 1, Plan 1, Item 18. She asks him if he has any other triggers to share, to which he says no. She then puts the current date and her initials over Plan 1 for the First Question. (How to complete the rest of the Interview is described in the next section.)*

*The next day, during a community meeting, Joanna notices that Robert becomes very agitated when two of the patients start yelling at one another. Robert begins to pace the room, saying that he is going to "lose it" if people don't respect others' need for "peace and quiet." After taking Robert from the room, Joanna discusses Robert's reaction to the situation with him, and they both agree that it should be added to his list of triggers. Thus, Joanna gets out his Plan and marks a check in Question 1, Plan 2, Item 14, "someone else yelling." She then dates and initials Plan 2 for the First Question.*

**The Second Question: Calming Strategies.** During the **initial** Interview, once the person's triggers are identified, the staff member next turns to the second question, what helps to calm the person. This question helps an individual to identify calming strategies that are feasible in most inpatient, residential, and community-based settings. Few of these strategies require extensive resources and most can be done alone, without the support of staff or others, although such support might be necessary when someone is escalating and needs help in focusing on the use of the calming strategy. Note that the last four options are possible calming strategies for someone who has a history of self-injury or is threatening to harm herself: **lying down with cold face cloth; snapping rubber band on wrist; drawing on arm with red marker; putting hands under cold water.** These strategies offer a less harmful but important physical alternative to people who engage in bodily self-injury.

There will be times when people suggest alternatives under "other" that are not feasible or appropriate for the setting. For example, it is not unusual for a person to say, half-jokingly, that she would like a glass of wine to help calm her down. Obviously, this is not possible in any service setting, but the staff conducting the Interview might inquire whether there is something else like wine that might calm the person, such as a cup of decaffeinated tea or warm milk. **Rather than dismissing an individual's suggestions, it is more helpful to try to build on them in ways that might produce the same calming effect.** Of course, if someone suggests something that is very inappropriate or disturbing, that would need to be addressed as an issue for further clinical work (rather than built upon or re-directed).



2. Calming Strategies. It's helpful for us to know the things that make you feel **better** when you're agitated and fear losing control of yourself. Which of the following have helped you to gain control in these situations? (STAFF: Only check 3-5 items.)

| PLAN #                                    | 1 | 2 | 3 | PLAN #                                 | 1 | 2 | 3 |
|---|---|---|---|--|---|---|---|
| DATE                                      |   |   |   | DATE                                   |   |   |   |
| voluntary time out in your room           |   |   |   | calling therapist (w/ privs & permis.) |   |   |   |
| writing in a diary/journal                |   |   |   | reading a newspaper/book               |   |   |   |
| being near staff                          |   |   |   | watching TV                            |   |   |   |
| talking with staff about my needs         |   |   |   | pacing the halls or in the quiet room  |   |   |   |
| artwork (drawing or coloring)             |   |   |   | calling a friend (w/ privs & permis.)  |   |   |   |
| music via personal stereo                 |   |   |   | pounding clay                          |   |   |   |
| punching a pillow                         |   |   |   | exercise                               |   |   |   |
| deep breathing exercises                  |   |   |   | hot packs at night to help me sleep    |   |   |   |
| going for a walk in halls with staff      |   |   |   | lying down with cold face cloth        |   |   |   |
| cup of hot tea, especially at night       |   |   |   | snapping rubber band on wrist          |   |   |   |
| taking a shower or sitting in shower area |   |   |   | drawing on arm with red marker         |   |   |   |
| wrapping up in a blanket                  |   |   |   | putting hands under cold water         |   |   |   |
| using a "weighted" blanket                |   |   |   | other, describe                        |   |   |   |

It is important to understand that the point of identifying these de-escalation strategies is not so that people can make repeated demands on the staff to do activities with them. Rather, these strategies are used to avert crises or to serve as least-restrictive alternatives to restraint and seclusion. For example, it would not necessarily be appropriate for someone who is not in crisis to demand that a staff member immediately engage in artwork with him because it is one of his de-escalation strategies. When not in crisis, therapeutic art would be used as it always is on the unit, and it would be acceptable to set that limit, if necessary and appropriate. Having said that, however, the impression should not be given that people need to "act out" or

escalate, in order to get attention or support from the staff. A balance will need to be struck between setting limits when necessary and providing vulnerable individuals with support, caring treatment, and structured activities throughout the day. Of course, **calming strategies must be tried in times of pre-crisis or crisis, even if time and effort on the part of staff are required.**

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**Preventative measures such as these can reduce staff burden and paperwork over time, particularly if restraint and/or seclusion are avoided through the de-escalation techniques.**

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The second question concludes with the staff member letting the person know that the calming strategies that he identified will be discussed/practiced each day and will be used if he starts to go into a crisis (as described in more detail in Chapter 3).

STAFF, READ TO PERSON: When you start to get agitated or go into crisis, we'll ask you to try these things to help you calm down. We hope that you'll work on these strategies to keep yourself and others safe. While we won't always be able to offer every alternative you've identified, we'd like to work together to help you. So, each day, we'll talk about the calming strategies you've identified and what you can do, and what we can do, to help you feel safe while you're here.

Returning to the example of staff person, Joanna, and patient, Robert, will illustrate how this question might be completed during the initial Interview and in the days that follow.

Once Joanna and Robert have completed the first question of the Interview, they turn to the second one, regarding Robert's possible calming strategies. Joanna reads the instructions to Robert and he indicates that he understands. Thus, she begins reading each item on the list, asking him if he uses it to calm himself when agitated. Robert stops her after the sixth strategy, "music via personal stereo." Robert tells Joanna that sometimes when he's agitated about too much noise, listening to music, especially via a personal stereo, helps to calm him. Thus, Joanna marks a check in Question 2, Plan 1, Item 6. Joanna continues to read the list until Robert lets her know that "watching TV" can sometimes help him deal with his agitation, as long as it's early enough in the process. Joanna places a check in Question 2, Plan 1, Item 16. Robert tells her that these are the only things he can think of right now that might help him when he's starting to get very upset. She then puts the current date and her initials over Plan 1 for the Second Question. (How to complete the rest of the Interview is described in the next section.)

The next day, during the community meeting when Robert becomes agitated because the other patients are yelling at each other, Joanna realizes that the best thing to do is to take Robert to his room to give him some space. As she is talking to him in his room, he begins to calm down and is able to share how much he dislikes hearing people yell. Joanna takes note of how this time alone helped Robert to cope, and suggests that he might like to include it in his Crisis De-Escalation Interview. He agrees, so Joanna gets the Interview, and with Robert there, marks a check in Question 2, Plan 2, Item 1, "voluntary time out in your room." Robert tells her that he is pleased by this insight. Joanna dates and initials Plan 2 for the Second Question.



**The Third and Fourth Questions: History of Restraint.** The next two questions are designed to allow a discussion about whether the person has ever been physically restrained in a treatment setting. Clearly, if this Interview is being used in a community-based setting, then these questions may be omitted (unless the client would like the community staff person to know of her preferences upon hospitalization).

The first of these two questions about physical restraint establishes whether or not the person remembers being restrained in a treatment setting in the past. This item serves as a "screen" for the rest of the questions on the Interview, so that individuals who have never been restrained are not asked to address items that are not relevant to them. This screen also helps staff avoid giving the impression that people can expect to be restrained and/or secluded

while in the current hospital or facility. For persons who have not been hospitalized frequently (or ever), avoiding detailed discussions of the types of physical and chemical restraint that patients may experience in facilities may help them to feel less frightened. Having said that, however, some people believe that these involuntary procedures should be discussed with **all patients**, especially after they have seen someone “taken down,” restrained, or secluded. An air of mystery around these techniques can be just as frightening as too much information. Perhaps the best compromise is to avoid detailed discussions about these procedures upon intake, but to be sure to answer all questions and allay fears whenever anyone on the unit or in the program is restrained or secluded. This is a delicate balance that will need to be struck by the staff and clients together.

3. History of Restraint. In thinking about your well-being while here, it is helpful for us to know whether or not you have ever been restrained or held down against your will in a treatment setting. Has this ever happened to you?    Yes ☐            No ☐

**STAFF: ONLY ask the next four questions if the person answers “yes” to item 3. Otherwise, skip to the end, ask the person to sign the form, and find out if he/she has any questions about what you’ve discussed.**

4. Were you restrained:

☐ in a hospital    ☐ in a crisis unit    ☐ in a group home or residential facility    ☐ in another setting

Please think about the last time you were restrained and tell me why you were restrained.

Was it because you (staff read whole list):

- ☐ Threatened someone with serious physical assault
- ☐ Physically assaulted someone else
- ☐ Threatened to seriously hurt yourself
- ☐ Attempted to or did hurt yourself

How were you restrained?

Were you:

- ☐ Sedated (or chemically restrained)
- ☐ Put in walking or hand restraints
- ☐ Put in four-point or full leather restraints

If the person answers, “yes,” to the third question, then question four asks her to identify in what type of setting the past restraint occurred, as well as the major reason why and

the type of physical or chemical restraint used. This history allows staff and patients to gain an understanding of the person's past experiences of restraint and what has led to the need for this procedure.

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**Note that this discussion is likely to be difficult for some people. As such, they may need a break or some extra support. Staff should demonstrate increased empathy for clients at this point in the Interview to ensure that it is completed in the most empowering manner.**

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**The Fifth Question: Preferences Regarding Restraint.** The next question allows the individual to indicate what type of restraint or seclusion she prefers, should this become necessary. While few people prefer any type of restraint or seclusion, many will have opinions about which is the least frightening or damaging to them.

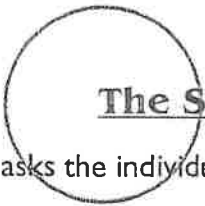
5. Preferences Regarding Restraint. If you're becoming a danger to yourself or someone else, we may need to restrain or seclude you. If it becomes necessary to do this, we'd like to know what you would prefer, if it's appropriate. Would you prefer:

(Staff, read all and ask the person to choose one, or two at most.)

|   |  |                                     |  |
|---|--|-------------------------------------|--|
| to be in the locked quiet room  |  | to be given an open door seclusion  |  |
| to be sedated (chemical restraint)  |  | to be put in full leather restraint |  |
| to be placed in walking restraints<br>(hand/wrist restraints, posey vest) |  |                                     |  |

As a matter of respect and trust, it is important for staff to let people know that they may not be able to honor these wishes under certain circumstances. For example, if a person is too threatening to self or others, he may require a more restrictive option than walking restraints. However, every attempt should be made to respect the individual's preferences when using these potentially psychologically and/or physically damaging procedures.

Be aware that people who are trauma survivors may have had abusive experiences in childhood similar to restraint and seclusion. These experiences could include being locked in a closet, being forced to take illegal or prescription drugs, or being tied down and abused or neglected. If this type of history is reported, then locked door seclusion, forced medications, and four-point restraint would be especially harmful to these individuals. Therefore, it is crucial that a trauma assessment be conducted with all people upon intake to ensure that the most sensitive practices are being recommended and utilized.



**The Sixth Question: Contracting for Safety.** The next question asks the individual what might be done to help her to “contract for safety” as soon as possible in the event of restraint. Contracting for safety refers to a **person’s ability to verbally agree that she will no longer pose a threat to self or others once released from restraints.** This item on the Interview allows the person to define what would help her to de-escalate and no longer be an imminent threat to self or others once restrained. Here, staff might ask, “How can we help you become calm enough to get out of restraints as quickly as possible?” or “What do you need to get out of restraints as fast as possible?” Be aware that the ability to verbally “contract for safety” is only one of a number of indicators that someone is ready to be released from restraints (or seclusion) (Stromberg, 2001). For example, some people (e.g., adolescents, the elderly, those who are cognitively impaired, those who are currently psychotic) may be unable or unwilling to enter into a verbal agreement that they no longer pose a threat, even after they have sufficiently calmed down. Thus, release

assessment should be based more on mental status and behavioral indicators than on the ability to “contract for safety” once restrained (Stromberg, 2001).

6. Contracting for Safety. If we need to restrain you at some point, is there anything that we can do to help you “contract for safety” to get out more quickly? Please describe.

The Seventh Question: Preferred Medications. The seventh item allows the person to request the chance to discuss preferred medications with a physician in the event that physical restraints are not effective. Of course, medications also may be administered to calm certain people prior to the utilization of physical restraints. Either way, people should be given the chance to discuss with a physician their past experiences (both positive and negative) and preferences for certain medications in advance of the need to use them for chemical restraint.

7. Preferred Medications. We may be required to administer medication if physical restraints aren’t calming you down. Would you like to discuss what medication you would prefer with your doctor? Yes ☐ No ☐

Person Unable to Complete Interview at Intake. There certainly will be times when a person is unable to complete this Interview upon intake (or ever). She may:

- be too sedated or symptomatic,
- be cognitively impaired and unable to understand the questions,
- have come from the emergency room in restraints,
- not be ready to discuss her triggers and calming strategies at that time,  
or
- simply not be interested in completing the Interview.

If any of these is the case, staff would put a check in the box next to, “person unable to complete Interview at intake,” and record the reason why. The Interview must be attempted at every shift unless the person has made it clear that she does not want to discuss safety in this way with staff or is cognitively unable to understand the questions.

☐ Person unable to complete Interview at intake.

Reason why:

☐ too sedated  
☐ too symptomatic  
☐ cognitively impaired

☐ in restraints  
☐ not ready to discuss  
☐ refused entirely

**(If yes, Interview must be re-attempted at every shift, unless patient demands no further attempts.)**

**Concluding the Interview.** Once the Interview is complete, both the staff person and the client/patient sign the form, indicating their agreement to try to use the information found in the Interview in the event of a pre-crisis or crisis. As discussed further in the third chapter, both the staff person and the client are to receive copies of the Interview.



|  |              |
|--|--------------|
| <b>**<u>UPON COMPLETION OF INTERVIEW</u>**</b> |              |
| _____ (staff signature)                        | _____ (date) |
| _____ (patient signature)                      | _____ (date) |

Translating the Interview into a Crisis Plan. Upon completion of the Interview, there are two major ways that the information gathered can be translated into the individual's **Advance Crisis Plan**. The method used will depend upon the policies and procedures already in place in the treatment setting, and what is easiest for all involved. Additionally, a program or unit may decide to adopt a different procedure after a trial practice period, depending upon feedback from the staff and clients.

### **Method One: Using the actual Interview as the Advance Crisis Plan**

Rather than translating the information to another form, staff and clients simply would consult the Interview itself when needing to discuss/practice the strategies or use them during a pre-crisis or crisis. If this method is chosen, then each person's Interview would be stored in an easily accessible Log Book that would not leave the nurses' station or other centralized location (rather than filing it with the rest of the forms in the medical or case record). The person's name would be flagged in the standard kardex (or whatever centralized place information about current patients is held) to let staff know that a Crisis Plan is on file for that person in the Log Book.

- ❑ The **advantages** to this method are that it requires the least amount of additional paperwork, the information is very easy to read, changes to the Plan are straightforward and do not require extra paperwork, and the Interview forms are easily accessible at all times.
- ❑ The **disadvantage** to this method is that the planning information is not contained in the treatment plan, disconnecting it from the rest of the information about the client and making it easier to forget to review the Plan every day.

### **Method Two:**

#### **Incorporating the information gathered in the Interview directly into the patient/client's treatment plan**

The nurse or technician/counselor would incorporate the information gathered from each of the 7 questions into the treatment plan as strategies to be used in the event of a pre-crisis or crisis. An existing section (such as one regarding crisis information or current stressors for the patient/client) could be utilized to record the information, or a new section, labeled Client's Crisis Plan, could be developed. If this procedure is used, then the person's name would be flagged in the kardex when the Interview has been completed and the information translated into the treatment plan.

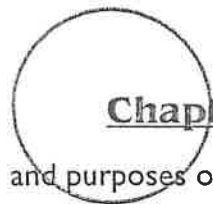
- ❑ The **advantages** of this method are that the Interview information is contained with the rest of the client's history and can be more easily reviewed each day during team/nurses meetings, and the act of writing out the information may increase the staff person's recall of it during a pre-crisis or crisis (assuming he/she is present).

- ❑ The **disadvantages** of this procedure are that it increases staff's paperwork burden, that changes made to the Crisis Plan require additional paperwork, and that the treatment plan may not easily be accessible when a pre-crisis or crisis is occurring if another staff person is making use of the client's record at that time.

### **Method Three:**

**Using a combination of these two methods,  
by filing the Interview in a Log Book and incorporating the  
information into the treatment plan**

While this may be the most burdensome procedure, depending upon the size and resources of the program or unit, it is the most thorough and would help to overcome some of the disadvantages of either method used alone.



**Chapter Summary.** This chapter has provided a detailed overview of the values and purposes of an Advance Crisis Management Program. Also described was the Crisis De-Escalation Interview, including the reason and approaches for each question. Methods for translating the Interview information into an Advance Crisis Plan also were provided. With a thorough understanding of the Program and its centerpiece (the Interview/Plan), the next step is to determine the best way to integrate it into a unit's existing policies and procedures. This is the topic of the next chapter.

## Chapter 2:

# Implementing the Advance Crisis Management Program

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This chapter addresses major strategies for implementing an Advance Crisis Management Program. It begins with a discussion of the formation of an Implementation Team, and turns to how to fit the Program into existing organizational policies and procedures. Also addressed is the importance of garnering administrative support for the Program. The chapter concludes with an outline of strategies for successfully training the entire staff in advance crisis management and de-escalation.

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### The Major Phases of Program Implementation

Keeping in mind that the purpose of this Program is to work with people in advance of crises to outline preferred de-escalation approaches, it is time to turn to the steps involved in adapting and implementing these procedures. There are **5 major phases** of this work, which can be as thorough or simplified as the setting's resources and time will allow. These phases include:

- ✓ Garnering administrative support for the Advance Crisis Program;
- ✓ Analyzing precipitating events to crises in the unit/program;
- ✓ Reviewing existing organizational policies and procedures;

- ✓ Adapting the Interview and procedures to fit one's own setting; and
- ✓ Training all staff on the values, purposes, procedures, and evaluation of the Advance Crisis Management Program.



**The Implementation Team.** A group of people from the hospital, unit, or facility will need to take the lead on implementing and evaluating the Advance Crisis Management Program. Most likely, this either will be the Performance or Quality Improvement (also called PI/QI) Team or members of it. Depending upon its size and current workload, the PI/QI Team may decide to form a Subcommittee on Safety and Crisis Management to be the **Implementation Team**. If the organization does not have a PI/QI Team, then it will need to form a special Implementation Team to guide this work. However the group is comprised, it is crucial that one or two people from it be assigned ultimate responsibility, to ensure that the Program is fully adopted and evaluated.

To increase “buy in” across the organization, it is advisable that nurses, counselors, technicians, and other front-line providers are well-represented in this group, as well as key administrators, managers, clients/patients, and family members. Because the success of the Program requires everyone’s cooperation, they **all must feel that their needs, concerns, and viewpoints are being heard and addressed.**

The frequency of meetings of the Team will depend upon the size of the organization and its resources. As mentioned previously, the implementation phases can be as thorough or simplified as the setting will allow, driving the nature of the group’s work. Whatever is decided, it is advisable for the Team to meet at least monthly for the first year of the implementation and evaluation phases of the Advance Crisis Management Program.

## **PHASE 1: Garnering Administrative Support for the Advance Crisis Management Program**

A critical part of designing and implementing an Advance Crisis Management Program is to gain the support of people in the administrative hierarchy of the organization where the Program will be located. This is a "necessary but not sufficient" step, given that the Team will need administrators' approval and sign-off, but will not be able to achieve meaningful success without the support and cooperation of the front-line staff and their supervisors. That being said, it is important to view the administrative hierarchy not only as gatekeepers with the decision-making power to endorse or reject the Program, but also as a valuable source of information about how best to proceed with other supervisory and line staff.

The Team should **begin by identifying the key decision-maker or decision-makers** who have the power to authorize the Program. Often, this will be an individual with the title of "chairperson," "manager," "chief," or "director" of the larger unit within which the Team is working. In identifying whom to approach, some questions to consider include:

- ▶ "Who has the final say over what policies and procedures are followed on the unit?"
- ▶ "Who has to approve or sign-off on any policy or procedural changes that are made in the ways patients or clients are treated?"
- ▶ "Who is ultimately held responsible for how well the unit functions?"

Once this person or persons are identified, the Team will want to meet with them to propose the Program and ask for their support and cooperation. The Team should prepare for this meeting in several ways.

- ▶ First, they should come to the meeting fully knowledgeable about the organization's or unit's current policies for handling crises and critical incidents. This is important because the Team will want to be able to discuss where and how the new Program will fit into existing procedures and guidelines.
- ▶ The Team also should have available for discussion relevant statistics from reports about the organization's current rates of critical incidents, staff/patient injuries, or instances of restraint and seclusion.
- ▶ The Team should prepare a concise, well-reasoned presentation regarding the purposes of the proposed Program, its underlying values, and expected outcomes, as outlined in Chapter I. Accompanying this presentation should be a one-page summary of the Program that addresses issues of why it is needed, who will be involved, and what will occur and how, as well as where and when the Program will be implemented.
- ▶ Also, the Team should be ready to offer brief verbal or written summaries of similar programs occurring around the country or, if possible, in the local area or state.
- ▶ Finally, the Team should be prepared to discuss and allay any concerns that are raised about risks and burdens that the Program may create for staff and for patients/clients.

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### **What to Bring to the Initial Meeting with Key Decision-Makers**

- 1. Current policies and procedures for handling clinical crises and emergencies;**
  - 2. Statistics regarding the current rates of critical incidents, staff/patient injuries, or seclusion/restraint;**
  - 3. A one-page description of the Program's who, what, where, when, how, and why factors;**
  - 4. Summaries of similar programs in the local or national area; and**
  - 5. Answers to anticipated questions, objections, or concerns regarding the Program.**
- 

Once the Team has been successful in gaining the support of the key decision-maker(s), they most likely will **proceed to convene a series of meetings** with these senior staff and any additional employees they wish to invite. The purpose of these sessions will be to introduce the idea of implementing the Program to ever-widening levels of the organization's management. This allows both the Team and the key decision-maker(s) to gauge other managers' reactions to the Program, to surface obstacles and possible resolutions, and to identify which managers (or members of their staff) might best serve on the Implementation Team. These meetings also may increase in size as the group begins to address issues arising from needed changes in organizational procedures, requiring cooperation and feedback from quality assurance staff, union representatives, hospital ombudspersons, patient advocates, and others.

### **PHASE 2: Analyzing Precipitating Events to Crises in the Unit/Program**

The second phase of implementation involves determining the unique precipitants to



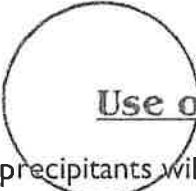
crises in one's own treatment setting. This will help to ensure that the crisis triggers listed on the Crisis De-Escalation Interview (from question one) represent the common needs of one's patients/clients. Certainly, this review of crisis precipitants may serve to confirm that the current list is adequate, but it is important to be sure, since staff and clients will be more likely to accept the Program if it rings true to their own experiences. Depending on the methods used, this review also can help the Implementation Team to understand what is happening in the work environment and culture that may lead to crises, as well as how crises typically are handled. This would provide very valuable information for the All-Staff Training described in a later section of this chapter.

In what follows, several methods for conducting an analysis of crisis precipitants are presented, starting with the least time-consuming and leading up to the most complex.

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**There are three major types of analysis that can be conducted to determine crisis precipitants:**

- **Use of existing crisis reports**
  - **Client case record reviews**
  - **Proactive observation and recording**
- 

 **Use of Existing Crisis Reports.** In some settings, a review of crisis precipitants will be quite simple if the Performance or Quality Improvement Team already is keeping such records or creating similar reports, particularly regarding the occurrence of restraint and seclusion. Some units and facilities routinely collect and report information about client crises and how they were handled, and will be in a good position for this phase of implementation. Analyzing existing data from a new perspective (e.g., what can we learn about how advance crisis management may function in our setting) may be necessary, but the leg work involved in collecting the information would not be required.

- ❑ The **advantage** to this method is that it requires little additional work on the part of the Implementation Team or other staff members. This would allow the Team more time to spend on reviewing the current policies and procedures, as well as adapting the Interview to fit their own setting.
- ❑ In terms of **disadvantages**, a note of caution is necessary. If the Team relies solely on restraint and seclusion paperwork for this information (typically collected for JCAHO accreditation purposes), it may not always provide rich or useful insights into crisis precipitants and resolution. Sometimes, staff simply will record that the person was “a danger to self or others,” in the section in which they are asked to describe the reasons for the restraint or seclusion. This phrase makes it impossible to know if the person was trying to self-harm or hurt others, and whether the term “others” refers to staff, patients, or visitors.

Similarly, sometimes staff record information about how the episode started that is difficult to interpret or not easy to categorize, such as “was threatening” (to self or to others not clarified), “was acting strangely and was frightening” (focusing on intrapsychic state instead of concrete behaviors), or “became very agitated” (not clarifying the reasons why or what provoked the person). If this sounds familiar, then the Implementation Team might want to consider collecting supplemental information for at least one to six months, as described below.

- ❑ Another **disadvantage** may arise if the crisis information being routinely collected by the program is limited to “critical incidents” of violence that ended in self or staff injuries (reports typical in residential facilities or community-based programs). These reports may not be representative of all crisis precipitants in the setting. Many crises do not end in violence/injuries, and it is important to analyze these as well to understand the program’s organizational culture and experiences. Thus, if the only information in this area on which the program has to rely is “incident reports,” then we would advise the Implementation Team to collect supplemental information for at least one to six months.



### Client Case Record Review.

Another method for collecting information regarding crisis precipitants is to conduct an analysis of clients' case records over a specified time period (often six months to one year). Typically, this review would start with the creation of an "abstraction form," containing key questions or information needed from client files. Such items would include:

- ☐ demographic information (e.g., gender, age, ethnicity, etc.),
- ☐ information regarding challenging behaviors,
- ☐ history of violence,
- ☐ recent crises (particularly in that setting) and how they were resolved,
- ☐ on what shift the crises occurred (or time of day, if the program is not operational 24 hours/day, 7 days/week), and
- ☐ incidents of restraint and seclusion. If restraint and seclusion are utilized in the setting, then information about the reasons why, what was tried prior to restraint/seclusion to divert the crisis, and duration of each restraint or seclusion episode would be relevant.

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**Before the review is conducted, the Team must make sure that they have clients' consent on file for their records to be used in this way. Of course, no individual or personal information about any one client would be reported (i.e., data would be aggregated). Nonetheless, client safeguards must be in place.**

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This type of information may be similar to what the PI/QI Team already is collecting; on the other hand, it may be more detailed. Thus, if the Implementation Team feels it necessary to supplement existing reports, it may consider conducting a more thorough case record review. If the treatment setting does not have a PI/QI Team or it is not collecting any such information, then this method would allow the retroactive collection of information regarding clients and their crises.


- ❑ The **advantages** to this method are that it can be done at any time (i.e., it does not need to involve current patients/clients or be done while a crisis actually is occurring), it can provide more detailed information than that routinely collected by the PI/QI Team, and it can allow for data analysis to establish some basic patterns of behaviors among clients and staff (with appropriate statistical controls).
- ❑ The **disadvantages** are that it requires a large amount of staff time to review records, that training will be necessary if more than one reviewer is used to ensure “interrater reliability” (i.e., that each person interprets recorded information in the same ways), and that case records can be incomplete or unclear, leading to missing or difficult to interpret information.



**Proactive Observation and Recording.** The final method that can be used to collect information about crisis precipitants is through clinical observation of staff and clients in their daily interactions for a specified time period (typically one to three months, although longer would be desirable). To facilitate this process, the Implementation Team might design a Clinical Observations Recording Form, with checklists and close-ended items to facilitate ease of use. This form would include the following types of information.

- ✓ Close-ended demographic items to allow the observer to easily note background information of the staff and clients involved in pre-crises or crises (which then could be verified/supplemented via case records).
- ✓ Structured items including what triggered the pre-crisis or crisis, how staff or other patients reacted or were involved, and how the situation was resolved.
- ✓ A checklist regarding what alternatives were tried prior to use of restraint or seclusion, whether the incident ended in restraint or seclusion regardless, and whether both the patient and staff involved were provided with post-restraint/seclusion de-briefing.
- ✓ Also included on the Form would be the duration of the restraint or seclusion episode.

The greater the number of structured items this form contains, the less errors there will be if more than one person serves as observer, and the easier the resulting data will be to manage. Having said that, however, it is important to include some **open-ended items** in which the observers can make note of important details surrounding the crises and incidents that are not elicited by the structured items.

 **Who Should Conduct the Observations?** Depending upon the length of the clinical observation period, as well as the length of the daily observations, it may be preferable for at least two Implementation Team members to perform observations. It also is advisable to assign staff from other units or programs as observers as they may be more objective. Staff who are involved in the program/unit daily may be inadvertently biased positively or negatively towards other staff members. Similarly, when noting the behaviors of a patient who is well-known to the staff observer, the observer may record what is known to have been true in the past, rather than what is happening at the moment. If this is not possible, then the training will need to include greater emphasis on accurately and objectively recording observations.



## When Should Observations Occur?


It is important to choose the right time of year to conduct the clinical observation. For example, some programs may historically have “slow” months, in which the census is low, and others “heavy” months, in which the census is full to bursting. Of course, each of these time periods may have different precipitants to crises, which would need to be considered when interpreting the results. For instance, many hospitals experience a surge in intake during the winter holidays, when more people are likely to feel alone, depressed, and desperate. This seasonal effect may artificially inflate the rate of crises, which would not be representative of other months. Thus, if possible, it is best to choose an **observational time period in which there is an average or typical census** (perhaps including a time of increased intake, if understanding what happens during these months is important to the organization). The program may not have documentation to substantiate when this would be, but many long-time staff or administrators will have a good sense of the “slow,” “typical,” and “heavy” months.

Similarly, the Implementation Team needs to consider the best times of day to conduct the clinical observations. It would be **ideal to stagger the times**, so that all shifts are represented in the observation, including the night shift. Relying only on one shift for observations could easily bias the results. For example, it has been shown that crises are more likely to occur during day and evening shifts, when there typically are more staff available than on night shifts, disputing the notion that crises are always a direct result of under-staffing. If a program is not operational 24 hours/day, 7 days/week, it still would be important to ensure that observations occur in the morning and in the afternoon, to represent all of the hours of operation in which crises may occur.

- ❑ The **advantages** to using this method to collect crisis precipitant information are that it provides the most complete picture of how crises develop and erupt and how they are handled. This method also provides the best sense of the

organizational culture and how it may contribute to good or poor crisis management. It supplies excellent information to be covered in the All-Staff Training, and it allows the clinical observers to identify who might be most in support of program changes and who might have the hardest time.

- ❑ The **disadvantages** of this method are that it is very time intensive, that training will need to occur to increase the impartiality of clinical observations, that many people change their behavior when they are observed (thus biasing results), and that it may make patients feel nervous to be under observation.

 **Combining the Three Methods.** Certainly, the most complete information about crisis precipitants and the organizational environment would be gained by conducting an analysis that combines all three of these methods. Drawing from existing reports, a case record review, and clinical observation would provide much excellent information to make the case for why an Advance Crisis Management Program may augment or improve the existing treatment setting's procedures. Of course, a combination strategy would require the most time and resources, and thus, may not be feasible.

### **PHASE 3: Reviewing the Existing Organizational Policies and Procedures**

Armed with information about the purposes/values of an Advance Crisis Management Program, as well as the setting's unique crisis precipitants, the Implementation Team is now ready to review its organization's policies and procedures.



### **Reviewing Existing Policies.**

A good place to start in considering program implementation is with a review of the unit's or program's existing **policies** to assess which of them already support advance crisis management procedures and which may need to be altered or enhanced. The Implementation Team could decide to keep it simple by relying solely upon JCAHO regulations, and whether they feel the unit/program is in full compliance, particularly in the areas related to crisis care. **A more thorough review would include policies related to:**

- ▶ workplace violence,
- ▶ client and staff safety,
- ▶ workplace conflicts or grievances, and
- ▶ protection and advocacy for patients/clients.

Here, the Implementation Team would determine whether the current policies support efforts to identify and manage crises and to include patients/clients as partners in their own care. The Team also may wish to consider the organization's mission statement or values about self-determination and empowerment of people with psychiatric disabilities, since these are core aspects of successful advance crisis management as described in this manual.



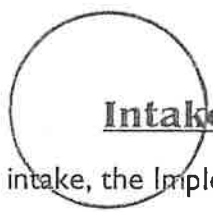
### **Reviewing Existing Procedures.**

Determining the best ways to integrate the Advance Crisis Management Program into the **current** organizational environment also is of primary importance to its success. Creating a new layer of job responsibility or undue paperwork will undermine staff acceptance of and ability to accomplish the Program objectives. At the same time, of course, some new expectations will be required (e.g., to conduct the Interview itself and to use the information before, during, and after crises) and are inherent in Program success as well.



**As with most programmatic changes, this will involve a careful balancing act between requiring new work and trying to make it feasible and palatable.**

To get started, the Implementation Team will need to answer a series of questions about organizational procedures from intake to discharge in order to determine where to incorporate the new techniques. These questions can be broadly divided into five major categories: **Intake, Staffing, Accessibility of Information, Information Sharing, and Clinical and Crisis Procedures.** The Implementation Team will find information collected during Phase 2 of this process (Analyzing Precipitating Events to Crises) helpful when answering some of these questions, particularly if they were able to conduct the clinical observation.

 **Intake.** Because the Crisis De-Escalation Interview typically is first attempted upon intake, the Implementation Team should have a good understanding of how intake usually works, the types of forms/assessments currently used, and where the new Interview might best fit. Some major questions for the team to consider include:

- ▶ How many assessments or other forms currently are completed at intake? If there are a significant number, would there be a better time to conduct the De-Escalation Interview? (In some cases, programs have found that they have a number of assessments and forms that no longer are being conducted at intake and could be eliminated to make room for new procedures.)
- ▶ Are there other safety or risk assessments in place? Can these be integrated with the De-Escalation Interview in order to avoid duplication and improve efficiency?


- ▶ What is the level of privacy afforded to clients during intake? Would they feel comfortable sharing private information about their crisis histories during intake?
- ▶ What is the psychiatric and medical condition of the typical client upon intake? What sorts of exceptions have been seen, and how do these affect intake (e.g., clients who have significant cognitive impairment, those unable to speak English, etc.)?
- ▶ What is the process for completing assessments or other forms that were not finished upon intake (for whatever the reason)? What is the best procedure for ensuring that all assessments, including the new De-Escalation Interview, are completed in a timely fashion if they are not done at intake?



**Staffing.** Taking into consideration staffing patterns from intake to discharge also is important when determining program modifications to support the Advance Crisis Management Program. Some major questions in this area include:

- ▶ On what shift does intake typically occur? Are there enough staff during this shift to take the time necessary to conduct the Crisis De-Escalation Interview?
- ▶ Who typically conducts intake interviews? Are there staff more likely to take on this responsibility than others? If so, why?
- ▶ How are staff assigned to various patients? Are there room for staff changes, if the patient/client would feel more comfortable discussing and practicing crisis management techniques with a particular staff member (i.e., someone of the same gender and/or ethnicity)? If not, what will be the process for explaining to clients why changes can not occur and for helping them to feel safe enough to have these discussions with the assigned staff?
- ▶ Does the facility use “floating, per diem, or agency” staff? If so, what procedures will be developed to ensure that they receive training on the Advance Crisis Management Program as part of their orientation to working on the unit or in the program?

- ▶ Do staff complete their paperwork in a timely manner? This may be a larger issue that will affect the completion of the De-Escalation Interview, development of the Advance Crisis Plan, and other important clinical records.
- ▶ How regularly do staff receive clinical supervision? Do they consider the amount/type of supervision adequate? If not, what can be done to improve this process, so that staff can continually hone their crisis management skills?
- ▶ Have the staff received comprehensive, competency-based crisis prevention training? How often do they receive refreshers? Do they consider this level of training adequate? How does the current training support the efforts of the Advance Crisis Management Program?
- ▶ In inpatient settings, how will physicians and residents be educated about the Advance Crisis Management Program? What role will they play in the Program? Which staff or external trainers will be most effective in training physicians and residents?

 **Accessibility of Information.** Because the information gathered during the De-Escalation Interview must be accessible at all times, thought also must be given to the logistics of how client information is managed on the unit or in the program. Here, major questions to consider are:

- ▶ Is client information centrally located?
- ▶ Is all client information computerized? If so, is it easy to locate or access needed information from the computer, especially before or during a crisis? If not, how will this be addressed?
- ▶ Where is the best place to keep the Crisis Log Book (or other centralized mechanism)? Can it be held in a confidential place, so that individuals who are not privy to client information will not have access to it?



### **Information Sharing.** An area related to information management concerns

how staff communicate information to one another about clients when on the same shift and across shifts. Since all staff must be informed of the current clients' crisis triggers and calming techniques, as well as any changes made to Advance Crisis Plans, an understanding of how information is shared among providers and administrators is essential. Also of importance is how staff share clinical and treatment information with patients/clients, and vice versa. Key questions to consider in this domain include:

- ▶ How and when does the whole staff communicate about current patients/clients? Are there all-staff meetings, team/nurses meetings, or clinical meetings in which patient information is shared? How often do these occur? Are the meetings frequent enough to convey daily updates made to Crisis Plans, if necessary?
- ▶ How easy is it to access client information across all shifts, especially before or during crises? If the information is not readily accessible, what new procedure will be developed to ensure that the Crisis Plans are available at all times? Log Books, kardexes, blackboards, flags on the front of clients' charts, or the voluntary posting of Crisis Plans in people's rooms all are ways of highlighting relevant information to staff that would be easily accessible during crises.
- ▶ How is information about patients communicated across shifts (or one day to the next in community settings)? How are changes to treatment plans or critical incidents reported across shifts? How quickly and adequately does this occur?
- ▶ How are supervisors and administrators apprized of client clinical information, particularly changes to treatment plans and crises that may have occurred?
- ▶ How are clients told about program information that may be relevant to their treatment? How do they communicate with staff and administrators about their histories and preferences in treatment/services? Are clients/patients considered equal partners in their own care? Does the process of developing treatment plans support client choice in treatment and services? If not, why not, and how will this reflect upon the Advance Crisis Management Program?



## Clinical and Crisis Procedures. Since the Crisis De-Escalation Interview

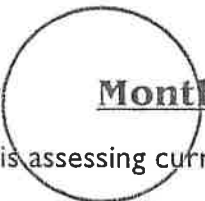
is more than a one-time assessment (i.e., it is the basis for the Advance Crisis Plan), it is important to have a handle on standard clinical and crisis procedures on the unit or in the program. Major questions in these areas include:

- ▶ Are there meetings in which treatment planning occurs that include a variety of providers (e.g., the attending psychiatrist, the nurse/case worker assigned to the client) and the client himself/herself? How can discussion of Advance Crisis Plans be incorporated into these existing meetings? If this type of collaborative meeting does not occur, how will patients/clients be involved in developing and implementing their own Crisis Plans?
- ▶ What are natural times that staff and clients can discuss and practice the Crisis Plans each day? (In inpatient settings, staff have found that **discussions** best occur when they are taking clients' vital signs or dispensing medications. As detailed in the next chapter, some programs find that daily or regular groups emphasizing calming strategies is an efficient and effective way to encourage **practice**.)
- ▶ What are the primary languages spoken by the patients/clients? What process will be used to ensure that the new Interview is translated into those languages, if necessary? (A Spanish-language version of the Interview is included in the Appendix of this manual.) Are there culturally sensitive methods for handling crises that should be considered? How can these be communicated across the staff to ensure their use?
- ▶ Who typically handles crisis situations? Are there certain staff who end up handling "take downs," restraint, and seclusion? Why? How can other staff be more involved in de-escalation, based on the new crisis management procedures, so that these responsibilities don't always fall on the same individual(s)?
- ▶ Who generally handles de-briefing after a crisis incident, both for staff and patients/clients? Do the patients and staff consider the de-briefing adequate? If not, why not? What can be done to make this crucial activity work better?

- ▶ How familiar are staff with the standards and regulations of the Joint Commission on the Accreditation of Healthcare Organizations and the ways the new Program will support their efforts in this area?

#### **PHASE 4: Adapting the Interview and Procedures to Fit One's Setting**

As mentioned previously, the success of any new program is partially dependent upon efforts made to include in the planning and implementation those individuals who will be affected by it. Although it is certainly not feasible to include every staff person and client in every decision and phase of implementation (which is why a Team is assigned to accomplish this work), there are key places along the way that staff and patients can give expert advice and consultation.

 **Monthly Meetings with Staff.** Starting in Phase 3, during which the Team is assessing current policies and procedures, monthly meetings with key players from the organization (including front-line providers and opinion leaders) should be held to discuss the new Program and their thoughts on needed modifications. Direct service staff are in an excellent position to identify the strengths and weaknesses of their work environment and the planned Program. These meetings should continue throughout the implementation and evaluation phases, in order to ensure that problems are being quickly identified and addressed by the Implementation Team.



### **Focus Groups with Staff.**

Focus groups with staff members not involved in these monthly meetings also are advisable, to review the findings from the crisis precipitants analysis, the Interview form itself, and the planned procedures. This will help to ensure that a wide variety of views and experience levels are represented as modifications/adaptations occur. These (or separate) focus groups also can be used to determine the ways in which the new Program may have personal meaning for the staff as a whole, such as enhancing their own safety at work, being involved in a larger quality improvement project, or improving their clinical skills and experience. Common concerns about the Program and working with clients in this way also should be identified during the focus groups, so that the Team can address them either in the All-Staff Training described below or through another mechanism.



### **Focus Groups with Patients/Clients.**

Similarly, patients/clients should be consulted about their experiences on the unit or in the program, especially as related to safety and crisis management. Here, too, focus groups are an efficient way to gather opinions and information from people in a relatively short amount of time. In these groups (or separate ones), clients also can review the Crisis De-Escalation Interview to ensure its relevance, as well as the planned procedures to determine whether plans are comfortable and effective for them and their peers.

## **PHASE 5: All-Staff Training**

Once decided upon, **all staff** will need to be trained on the policies and procedures of the Advance Crisis Management Program. Ideally, depending upon the organization's

resources, this training should be a highly consistent, coordinated effort to ensure that everyone involved understands what is to be done and why in the same way. Relying on administrators, program directors, managers, or supervisors to conduct this type of training for their staff can introduce a good deal of variability in how things get done. On the other hand, educating these individuals to train their staff may promote hospital and/or unit ownership of the Program, as well as greater mastery among people who supervise front-line staff (Chassman, 2001).

The best training strategy, if feasible, is to conduct an all-staff training. To cover the scope of material necessary to ensure successful implementation of the Program, a full-day of training is recommended. However, it may be possible to offer the educational program in a half-day, if necessary. This training would focus on topics such as:

- ▶ the history of advance crisis management,
- ▶ the values underlying this type of Program,
- ▶ the purposes of the Program (which would include information regarding crisis precipitants specific to that environment),
- ▶ organizational and national policies that support the implementation of the Program (reviewing JCAHO's standards, if necessary),
- ▶ the Crisis De-Escalation Interview (modified for the particular setting) and procedures for conducting and utilizing it each day,
- ▶ common concerns that staff and patients/clients have about this type of Program (discussed in more detail in Chapter 4 of this manual), and
- ▶ time to practice conducting the Interview and for asking questions about how it is to be used and managed.



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**For use in conjunction with this manual, specifically for the all-staff training, The UIC National Research and Training Center on Psychiatric Disability also has created a training video focusing on the above topics. See the title page of this manual for ordering information.**

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Utilizing trainers from outside of the organization for certain parts of the training can be beneficial, as long as they are people who have worked in similar settings and will hold credibility with the staff. Experts committed to advance crisis management practices, who also understand the realities of daily inpatient pressures, would be especially useful. Sometimes, hearing certain information from individuals outside of the politics of an organization can help people to be more receptive to it. Of course, staff from within the organization will need to review the new policies and procedures during the training, since outsiders will not have enough perspective on the unique responsibilities, habits, and concerns of the staff.

It is crucial to involve people with personal experience in the mental health system as trainers (recruiting those who have had experience in public speaking, training, advocacy, and sharing their personal stories in non-threatening ways). Although it can be uncomfortable, staff need to hear from people who have had personal experience with restraint, seclusion, or being mistreated during a crisis. In their discomfort, some staff may dismiss these perspectives as invaluable or overly-personalized. The trainer should be prepared for the possibility that this attitude may be expressed during the training itself, and discuss with the organizers possible responses. If staff make such comments to their supervisors or managers, the opportunity should be taken immediately to explore why such views are held (e.g., bad experiences in the past, burnout or exhaustion, lack of experience with advocates, etc. ), the purpose these views may be serving, and why clients' opinions are to be respected and valued.



### **Chapter Summary.**

Taking into consideration the expert advice of various individuals from the organization, as well as all the information collected by the Implementation Team, it is time to introduce the Advance Crisis Management Program into the work environment. As mentioned previously, this should be considered “a work in progress,” in that adaptations and modifications will continue as the Program is used and evaluated. The next chapter outlines how the crisis management procedures are to be used daily on the unit or in the program in broad terms.

# Chapter 3:

## Creating and Using Advance Crisis Plans on a Daily Basis

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**This chapter addresses how Crisis De-Escalation Interviews are conducted and how the resulting information is utilized on a daily basis. The value of skills training and support groups for clients emphasizing self-soothing and calming techniques also is discussed.**

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The process for conducting the Crisis De-Escalation Interview and using the information to better manage emergencies is quite straightforward. The Interview itself was designed to be brief and simple to complete, in order to reduce staff and client burden. Because JCAHO standards require that staff attempt to use least restrictive alternatives prior to involuntary procedures, for most units and programs this process simply will formalize what they already are doing. For others, it will help concretize crisis management procedures to meet JCAHO accreditation standards. In all cases, **this process will help staff to work more directly with clients to determine their preferences in treatment**, thereby increasing self-determination in treatment and services settings. (The purposes and values underlying this type of Program are outlined more fully in Chapter 1).

### Conducting the Interview and Creating the Plan

**Getting Started.** As detailed in the previous chapter, the best time to conduct the Crisis De-Escalation Interview is during intake or shortly thereafter. Regardless of the

person's diagnosis, level of functioning, and symptoms at intake, staff should attempt to conduct the Interview as soon after admission as possible, once the person is willing and able to respond to the questions. It is important to note that individuals with severe thought disorders and/or serious emotional distress can provide information about what upsets and calms them, if given enough time and with patience on the part of staff (this is addressed in Chapter 4).

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**When asked, people with a large range of psychiatric diagnoses are capable of identifying their personal stressors and calming techniques.**

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As explained previously, the staff responsible for intake are the most appropriate and competent candidates for conducting the Crisis De-Escalation Interview in inpatient and residential facilities (community-based programs may decide to use intake staff or assigned line staff). As part of the Interview, it is important for staff to emphasize that they are concerned about the **safety of all people on the unit**, and that this Interview is a way to increase everyone's feelings of safety, especially the clients'. Being admitted into a hospital or joining a new program is an extremely vulnerable and frightening time for many people. Therefore, emphasizing staff commitment to safety and crisis de-escalation from the beginning may help to calm people's fears and to build their trust in the staff and the unit (which also may help to avoid crises triggered by fear and distrust).

It is crucial for staff who are conducting the Interview to **thoroughly engage and listen closely** to clients, in order to get the most complete and accurate information. Simply reading the questions without expressing empathy and concern is likely to offend many individuals, calling into question the unit's commitment to safety. Some staff have found it


useful to conduct the Interview in a more “conversational” style, to put people at ease. Rather than reading the form word-for-word, they let clients know that, because safety is a priority on the unit, they would like to talk about what makes them upset and what calms them. Other staff have realized that certain people would prefer to complete the Interview by themselves, in their own rooms. Many times, people need time to consider the questions and how they would like to respond, especially if they never have been asked about their personal safety in this way. As long as staff take steps to ensure that people clearly understand the questions and follow-up to make sure that the Interview has been completed, allowing individuals to work on the Interview privately is perfectly acceptable and should not compromise the process.

While not necessarily a reason to dismiss the possibility of conducting the Interview, staff should be mindful of people’s levels of functioning at various times, and **respect that each person has different timelines and abilities**. Repeated, but sensitive, attempts to complete the Crisis De-Escalation Interview will reinforce the perception of staff dedication to safety, as well as to client well-being and autonomy. Some people will need quite a bit of time to complete the Interview, and may wish to work on it over several days. Staff should try their best to honor this preference and be flexible in the process. It may help them to remember that these Interviews will be kept on file, so they may not need to be fully repeated for individuals who come to the unit or program regularly (thus reducing some paperwork burden). If not completed upon intake, staff should continue to engage clients in this discussion on a daily basis so that a Crisis Plan may be developed prior to a crisis situation. As always, the client’s needs should be respected and staff should proceed according to a pace which is comfortable for the individuals with whom they are working.

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**Some people will be unable to attend to the Crisis De-Escalation Interview at intake, or even during their first day or two. Therefore, staff flexibility and diligence are assets in successful advance crisis management.**


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 **Creating the Advance Crisis Plan.** After the Interview is completed, staff should immediately process the information. As discussed fully in the previous chapter, this means either promptly filing the Interview in the Crisis Log Book or integrating the information directly into the person's treatment plan (or some combination thereof). Because pre-crises or crises often happen within the first days on the unit, it is extremely important that this paperwork be handled as soon as possible.

Additionally, **clients always should be given a copy of their completed Interview**, so that they may review them or share them with others, whenever they like. By having their own copies, clients will begin to understand that they are in partnership with staff in the crisis management process, that their Interviews are theirs to keep and refer to, and that it is a work in progress that they may change at any time. Some people have even posted their Interviews in their rooms to remind themselves and staff of what upsets and calms them. This level of involvement in one's own treatment enhances self-esteem, hope, and self-determination – all important values that should be the basis for mental health treatment (as discussed more fully in Chapter 1).

People also must be involved in ongoing discussions about how this information will be integrated into the plans developed for their services, treatment, and goals. If a program does

not include service recipients in treatment planning, then immediate procedures will need to be developed by the Implementation Team for this to be accomplished. The crisis management process will be virtually meaningless if staff never discuss de-escalation strategies with patients again after the initial Interview. Specifically, there need to be **ongoing discussions** about what might have changed since the initial Interview, patients' feelings about how the information is being used or not used (by them and the staff), or how they might use the calming strategies each day. These discussions also are a good time for staff and clients to review any calming strategies identified by patients that are not feasible within the organization. For example, some units do not provide clay as an art supply because of problems with mis-use of it (being thrown at others or eaten) and subsequent need for clean-up. Ideally, most of these organizational-level problems will be identified and remedied during the Interview modification process detailed in Chapter 2, so the need to rule out reasonable patient-identified strategies during these joint meetings should be relatively rare at this point in the process.

 **Daily Use of the Advance Crisis Plans.** At each shift change (or daily in community programs), staff are required to check the Log Book or treatment plans for new Advance Crisis Plans and to review all existing ones (to note any changes). It is their responsibility to ask their supervisors or colleagues if the new or existing Plans contain information that is confusing or unclear, or to request clarification in relevant meetings. If the unit has a shift change meeting, this is an ideal place to discuss each Plan, and to address any questions that arise. This also will provide an efficient way for staff to become acquainted with new clients and their Plans. Other places where staff and patients/clients can discuss Advance Crisis Plans are during treatment planning meetings and discharge planning meetings.

In most settings, one staff person will be assigned primary responsibility for a certain number of people (in community programs, this will be the staff's case load). This staff person will take on responsibility for reviewing and discussing the Advance Crisis Plans, as well as working on calming strategies, with patients each day. This entails:

- ▶ having a private or semi-private place to meet each day,
- ▶ reminding the person about the purposes of his Plan,
- ▶ reviewing with him the particular triggers and discussing anything that might have changed, and
- ▶ practicing some of the identified calming techniques.

In inpatient settings, **daily discussions** might best be had when staff are **taking patients' vitals or when administering medications**. To get the conversation started, staff might state such things as:

"The last time we met, we talked about your Advance Crisis Plan. You told me that your calming strategies when you get upset are 'deep breathing exercises,' 'being near staff,' and a 'hot cup of tea.' Let's practice deep breathing right now." [This allows the person to practice a calming strategy with support from a staff person.]

"Yesterday you told me that 'loud noises' trigger stress and possible crises for you. Have you found that to be a problem here? What can you do when that happens to feel better?" [This can reinforce information already found in the person's Advance Crisis Plan.]

"I notice from your Advance Crisis Plan that 'listening to music' helps to calm you when you are upset or stressed out. What music in particular helps you to feel better?" [This can help the person to think in advance of what music to play when he or she is upset.]



**These daily discussions need not be lengthy,  
but their importance cannot be over-emphasized.**

If staff continue to talk about and teach clients to use these de-escalation strategies frequently, a foundation will be built for their use when a pre-crisis or crisis actually occurs. This way, the strategies are familiar to both the clients and staff, and are not used “out of the blue” the first time someone starts to go into crisis, which can lead to failure and frustration. Instead, daily discussions allow staff to make reference to their ongoing crisis management work once someone begins to become agitated. For example, a staff member will be able to say,

*“Yolanda, it looks like you’re starting to become withdrawn and nervous. Do you remember how all week we’ve been working on art as a way to calm you? Let’s go get the paints and focus on keeping you calm and safe right now.”*

**Daily check-ins also allow discussion of any changes** that clients would like to make to their Plans, such as adding new calming techniques that they have found helpful, or new triggers that they have only recently identified. Staff also could mention anything they may have noticed about particular calming techniques or triggers relevant to each client. After this new information is shared, understood, and agreed upon, the staff and client would make the adjustments to the existing Crisis De-Escalation Interview (as outlined in Chapter 1, by using the column for Plan #2). A new copy would be given to the patient. The Interview then would be re-filed in the Crisis Log Book or, if the information is being integrated into the treatment plans, this would be handled as soon as possible. The revisions also would be discussed at the next shift change meeting, team meeting, and treatment meeting that involves the client.

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**The more often Plans are discussed and reinforced, the more likely they are to be used successfully.**

**Discussion of the Advance Crisis Management Program should be had during all appropriate group meetings held on your unit or in your program (e.g., community meetings, case reviews, treatment planning, client meetings, staff meetings, etc.).**

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### **During a Pre-Crisis or Crisis**

**Perhaps the most crucial time in the use of the Advance Crisis Plan is the first few minutes that a person starts to become upset or agitated, or during a pre-crisis.**

Keen perception of this, and subsequent swift action, often will avert a full-blown crisis. Too much delay or inaction on the part of the staff will jeopardize the effectiveness of crisis prevention strategies contained in the Plans. Staff are to immediately approach and remind an escalating person that he seems to be getting upset or agitated, and that they will work together to try a series of safety alternatives to help calm him down.

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**Staff must make a genuine, gentle, concerted effort to help clients use their calming strategies effectively, and to stay with them during this turbulent period (as long as their own safety is not being compromised).**

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At this point, **staff make a commitment to trying at least three of the alternatives outlined in the Plan** in a substantive way, before resorting to any involuntary procedures, including restraint or seclusion (or calling the police in a community setting). In many facilities, the use of least-restrictive alternatives is reinforced by adopting and communicating a treatment philosophy that involuntary procedures indicate a failure in treatment and are to be done **only** as a last resort. There will be times when restraint or seclusion must be used, but this should not be considered as the first (or even second or third) option during a crisis situation, unless there is immediate danger to the client or others.



### After a Pre-Crisis or Crisis

Whatever the result of the pre-crisis or crisis (i.e., whether or not restraint or seclusion becomes necessary), it is important for both clients and staff to have separate post-incident **debriefings to discuss what happened and why**, as well as what might be done differently in the future for de-escalation, if necessary. This process must avoid “finger pointing” and blame, even if staff did make mistakes. Of course, errors **must** be corrected, but staff who are treated as failures every time an incident occurs likely will become demoralized and less effective in their clinical work. Instead, supervisors should comment on all actions that staff took which were correct, as well as on the difficulty of the situation.

Support should be offered to staff by acknowledging the challenge of changing to new procedures. The staff person also should be given the chance to share her self-assessment of what she could have done better. Finally, the supervisor may offer constructive and nonjudgmental suggestions for better handling a similar event in the future. Whenever restraint or seclusion is utilized, debriefing also must occur with the entire staff and the clients in the program at that time. The use of these procedures typically is very upsetting for everyone in the setting and some processing of feelings can help reduce agitation and burnout.

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**If a staff person still feels stressed or confused after the debriefing, she should meet with a trusted manager or colleague to discuss these difficult and potentially damaging feelings.**

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For clients, the staff person assigned to their care should conduct the debriefing (unless the client wishes otherwise due to feeling mistreated by or distrustful of that person). This debriefing should include a discussion about what happened, why, and how the process could have been handled differently. If any changes to the Crisis De-Escalation Interview/Plan are made during this discussion, then the usual procedures for dealing with such changes would be followed. Having this discussion with clients reinforces the importance of the clients' safety and opinions, and helps to streamline the de-escalation process so that it will continue to improve.

### **Reinforcing the Use of Advance Crisis Plans – Self-Soothing Groups**

In some settings, staff have found that direct practice of the calming strategies identified during the Interviews is facilitated by starting a **Self-Soothing Group** for clients. These groups are **not** meant to take the place of daily discussions between staff and patients about

their Plans. Additionally, each staff person should be involved in the group (perhaps taking turns as facilitators) to gain an understanding of what people find distressing or helpful in the treatment environment and their current skills in self-soothing. Even the most seasoned staff person can benefit from hearing clients describe how they experience the setting and how it may be contributing either to crises or to de-escalation.

The frequency of these group meetings would be determined by what is most realistic for the setting. For example, acute care settings could hold 30-minute groups each day, focusing solely on people's self-identified calming techniques. Longer-term or community settings could hold weekly or bi-weekly sessions, for 60 minutes, in which clients discuss their individual Plans, as well as work on de-escalation, problem-solving, conflict resolution, and self-soothing techniques. Still another facility may prefer to have clients complete their Crisis De-Escalation Interviews in a group setting and could hold a daily session for this purpose alone.

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**Groups often provide a comfortable, yet structured, format for clients to ask questions of staff and to make connections with their peers. Getting to know the people around them better will help some people to feel less anxious and less likely to go into crisis.**

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A note of caution is in order when considering the discussion of individuals' unique triggers in group settings. Some people have reported that their peers may use this information to manipulate more vulnerable group members. Others have found that issues arise when trauma survivors participate in groups with people who have perpetrated violence. Thus, it is crucial to consider the needs of the individuals being served, and whether a more sensitive or protective approach is indicated. To this end, some have suggested that self-soothing groups

focus solely on calming techniques, leaving triggers for personal, private discussions with staff. Others have found that holding separate self-soothing groups for men and women is preferable, especially for trauma survivors who were abused by members of the opposite sex.

Included in the Appendix to this manual is a sample eight-session group that presents a format for conducting either a short or a long session on the topic. Of course, this information can be modified to fit different treatment facilities' needs.



**Chapter Summary.** This chapter has provided a broad overview of how the Crisis De-Escalation Interview should be conducted and managed in a treatment setting. Special attention was paid to the process before, during, and after a pre-crisis or crisis occurs. Also described were the benefits and drawbacks of holding regular group meetings for clients to discuss and practice their self-identified calming techniques. The following chapter addresses typical concerns about Advance Crisis Management Programs that are held by managers, direct service staff, and service recipients, as well as how to address those concerns.

## Chapter 4:

# Common Concerns when Implementing an Advance Crisis Management Program

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**This chapter addresses the common concerns held by supervisors, direct service staff, and clients about Advance Crisis Management Programs.**

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As with all programmatic change, staff and clients are likely to have questions and concerns about how the Advance Crisis Management Program will work in real life. This is to be expected and should be encouraged. Trying to **air everyone's concerns before the Program is initiated** will help to reduce problems down the line (keeping in mind, of course, that not all problems can be anticipated). Each setting will have its unique concerns and barriers, but this chapter outlines those that have arisen in several facilities instituting advance crisis management procedures. The Implementation Team can use this information to help allay concerns about the Program at all levels, and also should devote a portion of the all staff training (discussed in Chapter 2) to it. Generally, the common concerns that arise about this process can be categorized into three major areas: supervisory-level concerns; direct staff-level concerns; and patient-level concerns.<sup>1</sup>

## Concerns at the Supervisory Level

Typically, the types of concerns held at this level pertain to struggles supervisors might have in implementing and enforcing a new program, even one that makes sense and furthers

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<sup>1</sup>Special thanks to Nan Stromberg, RN, CS, for her administrative and clinical expertise in this area. A number of the ideas reflected in this chapter were formulated with her expert assistance.

the mission of the organization. Also, supervisors have concerns about whether this particular Program will be effective or whether it will fail and reflect poorly on them. Some of the major issues likely to be encountered are as follows.

**Staff shortages on our unit (or in our program) make it impossible to discuss and practice the Advance Crisis Plans every day.**

Under-staffing is a real problem in many facilities that cannot be ignored. Clearly, addressing this issue requires commitment from the highest administrative and funding levels. If it appears that staff shortages will continue, then the Implementation Team will need to determine whether there are tasks that have been conducted historically which now could be phased out for efficiency purposes (this is discussed further below). Furthermore, part of the training involved with the Program will need to address the fact that crisis prevention efforts, while somewhat time consuming, will take less time in the long-run than restraining and secluding people. The amount of monitoring and paperwork required when someone is restrained or secluded is far greater than what is expected as part of the Advance Crisis Management Program.

**The unit (or program) rules prohibit the use of some of the calming strategies listed on the Crisis De-Escalation Interview.**

Of course, a unit does not want to offer options that it cannot “make good on.” This only will serve to disappoint and frustrate the people whom they are trying to help. Therefore, the modification phase of the implementation process is very important, to ensure that all options listed on the Interview are feasible. Having said that, it can be healthy for a unit or program to objectively evaluate **why** something is not currently offered to patients, particularly if it is mentioned by many of them as helpful. Is it just habit or history that dictates the unit rule? Whom does it really serve? If it were to help calm people, would that outweigh some of the difficulties that may be involved? These are tough questions and can make some staff naturally defensive. However, part of healthy growth is to periodically assess whether what you do serves a clinical, ethical,



or administrative function. If not, it may be time to change that rule or to try a new approach.

**My staff already has more paperwork than it can handle. Even one more piece of paper might cause a rebellion!**

Probably every person involved with the mental health system can relate to this complaint. Here, too, perhaps the only meaningful option is to review whether there is paperwork being done that no longer serves a specific purpose or forms that could be combined or otherwise streamlined. Upon examination, some units have conducted an overhaul of all forms/assessments completed by staff, eliminating things that were related to dated funding mechanisms, collapsing some related forms into one, more convenient format (i.e., using more check-lists and closed-ended items), and training ancillary support staff to conduct some assessments to ease the requirements placed on the main clinical staff. Also, it may be useful to point out to staff that new JCAHO and HCFA standards regarding restraint and seclusion require additional documentation, and the Advance Crisis Management Program offers a way to streamline some of this paperwork. Although there is no “quick fix” for the large amounts of documentation expected in health care settings, if staff see that genuine efforts are being made to limit the amount of paperwork they must complete, this may ease some of their complaints about new expectations.

**Pressure is being placed on our unit to reduce restraint and seclusion from people who have never been on the unit and do not have any idea about the conditions we face here. Also, we are told to reduce these rates without anyone teaching us realistic alternatives.**

Few people like to be told they are doing the wrong thing from outsiders who do not have a good understanding of what they go through each day, no matter what the job. Even if you know that the outsider is correct, it is difficult not to feel resentment from being told you need to improve without being given options for how to do so. In this

case, an argument can be made that the Advance Crisis Management Program is just such an alternative. It is designed to formalize and concretize least restrictive alternatives to restraint and seclusion, giving staff some immediate options.

Additionally, it may very well reduce staff injuries that often occur during a “take down” or while restraining or secluding someone. It also cannot be over-emphasized that staff from all levels of the organization must be involved in implementing and evaluating this programmatic change. They must feel that they not only had input into how things were decided, but have ownership over its success.

**Too often, due to new regulations, people who should be restrained or secluded are not, which is dangerous for everyone on the unit.**

This is a touchy issue that must be handled with care, since it likely needs to be challenged. According to JCAHO and other regulatory bodies, people who are posing immediate danger should indeed be restrained or secluded. Nobody is suggesting that dangerous people should not be isolated until the threat passes. Thus, the challenging questions here are whether proper crisis prevention techniques actually are being utilized and whether these people truly are dangerous or just a “nuisance.” Basic crisis prevention training emphasizes that many emergencies can be headed off if the “warning signs” are quickly read and properly addressed. Inaction or indecision when warning signs are occurring can allow a situation to get to the danger point fairly quickly. Also, expressions of fear, anger, or frustration towards the escalating individual (raising one’s voice, crowding around the person, yelling “just calm down”) are common but improper responses that can further escalate the person. The concern that restraint and seclusion now are being under-utilized is fairly typical among supervisors and staff, and it will require sensitive clinical supervision to try to get at the root of what is happening, while clarifying that staff should indeed never be placed in personal danger.

## **My staff are so “burned out” that they won’t endorse anything new, even if they think it is a good idea and could work.**

This very real problem will require a much more concerted effort than can be addressed in this manual. However, most units will find that taking burnout seriously and openly addressing it in various phases of the implementation will help to re-energize and motivate many providers. Also, it is reasonable to expect that this Program may improve morale and prevent burnout by reducing staff injuries, making staff more effective, increasing the quality of staff and patient interactions, and improving job satisfaction. Some units have found that staff who were ready to move on, but were having difficulty leaving, were helped to do so by honest discussions regarding the expectations of long-term inpatient work and the nature of the organizational environment. Sometimes, staff who no longer are invested in or energized by their work (whatever it may be) should be helped to consider other options for the good of the whole unit.

Certainly, burnout and its effect on starting a new program could be added as a topic for discussion in the staff focus groups and the all-staff training detailed in Chapter 2 of this manual. In conducting its various analyses of the unit, the Implementation Team may uncover certain sources of burnout (e.g., under-funding, unit over-reliance on untrained “floating” staff, not enough clinical supervision) that would need to be addressed at the highest levels, no matter what decisions are made about implementing the new Program. This is another reason why garnering administrative support and involving key decision-makers throughout the process is so crucial.

## **What do I do if one of my staff refuse to complete the Interview or follow-through with patients to help better manage their crises?**

Almost all workplaces struggle with that certain person (or persons) who just won’t “get on board” when something new is instituted. Sometimes, the person may have a good reason for resisting the new procedures. Other times, it will be related to high

levels of personal burnout or lack of investment in the job. Whatever the case, the Implementation Team will need to outline what supervisors have the power to do if certain staff members refuse to participate in the new Program. Here again, key administrators will need to be involved to ensure that the supervisor has authority and backing for whatever procedures will be followed when someone will not complete this new job requirement.



### Concerns at the Direct Staff Level

Major concerns at this level tend to focus on clinical procedures and issues that are thought to have an impact on the effectiveness of working with people in advance of their crises. Also of concern to many direct service staff is their own personal safety, which they may feel is in jeopardy while at work. Typical issues that will be raised at this level include the following.

#### **Some people seem to want to be restrained or secluded (even requesting these measures sometimes). How does this Program work for them?**

Perhaps the first thing to point out when addressing this concern is that it is the rare person who desires to be restrained or secluded in an inpatient or residential facility. However, there are times when someone will tell a staff person that she would feel safer being restrained (especially “walking restraints”) or secluded because she is worried about hurting herself or others. Other times, staff may feel that someone is purposely “acting out,” in order to be restrained or secluded.

In terms of the first concern, good clinical procedure would suggest that staff use the new Crisis De-Escalation Interview to talk with the person about why she wants to be restrained, and what alternatives they may develop together to give her the same feeling of safety. Just because someone requests restraint or seclusion, does not mean that it is

justifiable under JCAHO regulations. Therefore, efforts need to be made to help the individual understand that the staff would rather help her find less intrusive or damaging ways to protect herself and others. In this way, the Interview/Plan can be used therapeutically, to encourage discussions between staff and the patient about what has happened to her in life and how she might develop more positive coping mechanisms.

In terms of the second concern, it is more likely that the person is “acting out” to get attention than to get restrained or secluded. Some inpatient settings, especially those that are under-staffed and under-funded, may offer little for patients to do and limited opportunities for interacting with staff. Thus, people may become agitated because of under-stimulation, and “start something” just to get attention or to have something interesting happen on the unit. In this case, staff need to be helped to understand that the person does not necessarily want to be restrained or secluded, and that offering him something he can do instead from his Plan (e.g., reading, listening to music, calling a friend, watching a movie in the day room, playing a board game with someone else, etc.) might prevent a crisis from developing.

**Many people don't have insight about what triggers or calms them, and won't be able to complete the Interview. Others will be too distressed or disorganized the whole time they're with us to do this. This seems like something for people who are functioning well at the time of their treatment.**

As stated earlier in the manual, it very well may be true that some people will not have a good understanding of what triggers and calms them the first time they are asked. However, it is important to understand that this may be because they have never been given an opportunity to consider this in an inpatient or treatment setting, rather than because of something inherent in their psychiatric disability. Therefore, for some people, the Interview may need to be completed over a series of days, with the staff and patient working together to identify what is naturally triggering or calming the person during the course of her stay on the unit. In our experience, the Self-Soothing Group (described in Chapter 3) can become an enlightening experience, as people with less

insight into this issue hear from their peers about what triggers and calms them, and begin to make connections in their own lives. Of course, if need be, it is always possible to use the Interview in a more “behavioral” way, helping these individuals to focus on simple behaviors in their environment which trigger or calm them (e.g., when someone yells), versus people with more insight who may understand that it is the lack of personal control or distrust of authority figures that causes them to escalate. Finally, if a person simply cannot identify what triggers him, the staff person can ask him why he thinks he is in the hospital. Perhaps the staff can gain some insight into what causes the person to lose control from antecedents to the hospitalization.

In terms of people who are actively psychotic for their entire stay on the unit, the Interview clearly will need to be handled differently, but should not be ruled out as impossible. In our experience, holding a series of conversations with these individuals can eventually elicit some basic stressors and calming techniques, even if the information is delivered in a somewhat convoluted way. If these conversations fail to yield useful information, then staff should observe the person on the unit to see what is naturally triggering and/or calming her. Staff would then bring this information to the patient to determine if she agrees and would like to include it in an Advance Crisis Plan. Again, in this case, the Interview would be used in a therapeutic way, with some degree of patience, but the end result of identifying what may escalate someone who otherwise wouldn't be included in the Program is worth the effort.

Ultimately, the challenging aspect of this area of concern is to avoid using someone's psychiatric diagnosis as the sole reason not to conduct the Interview. While this may be tempting, given the extra time that might be involved in helping more vulnerable people direct their own care, it must be resisted because it could result in underserving a large number of people on the unit.

**I am worried about identifying all these calming techniques for people. What if I can't do what they ask on their Plan at some point and they become angry or more agitated?**

As covered in the first chapter, the point of the Advance Crisis Plan is not to create unmanageable demands upon the staff (or patients). It is perfectly appropriate to set reasonable limits, as long as it is done safely and judiciously. When someone who is **not** in crisis requests staff's time to do something identified in the Crisis De-Escalation Interview (e.g., artwork, have a talk, play a game, etc.) and the staff doesn't have time, then that person should explain why she is busy and when she can meet with the patient to talk or engage in the activity. This acknowledges the patient's wishes and lets him know that an effort will be made to meet his needs. It goes without saying that the staff person would need to follow-through on this promise. Providers should never tell patients that the unit is under-staffed, leaving no time to meet or engage in activities. This makes the setting seem unsafe and poorly managed. Rather, the staff person could say something like, "I am concerned about you. I can see you have some important needs, but I don't have the time right now to meet with you. Why don't we meet in about an hour?" Or, if there truly is no way to meet with the person that day, the staff person may inquire as to whether there is someone else – another patient, a volunteer, a friend who might be called to visit – with whom he might conduct the activity. Additionally, to prepare in advance for times when staff will be too busy, it's important to try to ensure that people identify at least two things they can do on their own as part of their Advance Crisis Plans. Of course, if someone is escalating, no matter how busy the staff are, they must respond by trying **at least three of the least restrictive alternatives from the Advance Crisis Plan** to try to prevent a crisis from occurring.

### **I find the men less able to identify their triggers and calming strategies than the women on the unit.**

At the risk of perpetuating gender stereotypes, some staff will find that women have an easier time than men identifying what triggers their crises and what helps to calm them. There are many reasons for this, including that in many cultures it is more acceptable for women to openly admit their struggles or limitations than for men to do so. One way to help men feel able to identify triggers and calming strategies is to talk about

them in a more behavioral way, outside of the context of their feelings, being upset, and so forth. In other words, with men, staff might find it beneficial to focus more on what they **do** when they get very angry and what they **do** to deal with these situations. It also may help to refer to a past crisis, asking them what happened and how they dealt with it.

**There already is a lot of attention being paid to the safety of patients around here. Nobody seems to care about the staff's safety and well-being, which can be jeopardized at work. We need some attention and understanding, too!**

Absolutely! Research shows that workplace violence is prevalent in health care environments in the United States (National Institute for Occupational Safety and Health, 1996; U.S. Department of Labor, 1996). Most injuries to inpatient staff occur during restraint and seclusion procedures. To dismiss this fact during the implementation and evaluation phases will call into question the legitimacy of the new Program and the management team. Regular crisis prevention training for the entire staff is absolutely critical to maintaining a safe environment. Special treatment planning for individuals with a documented history of violence, in order to protect both patients and staff, also is essential. Additionally, when someone overhears another person making seriously threatening remarks about a staff member or patient, these comments must be taken very seriously, with the entire staff alerted to the potential problem. That person should never be alone with the threatening person and, in some cases, may even be excused from interacting with the person at all. While this seems fundamental, in the busy milieu of most units/programs, it can be neglected or over-looked, to the possible detriment of the entire facility.

Moreover, staff most certainly need understanding and support during and after a crisis occurs. An atmosphere of blame, criticism, and judgement not only can affect staff well-being, but can reduce their clinical effectiveness as well. The staff de-briefing that occurs post-crisis is designed to provide a safe environment for staff to identify their



feelings, fears, and perceptions of what happened. Those involved with the crisis must be allowed some time to vent and express their anxiety before discussions of what could have been done differently or better occur. Of course, staff need ongoing training and support to improve their clinical skills, but this is better accomplished in a learning versus punitive environment. Staff not involved in the crisis, as well as the other patients, also should be allowed some time to discuss how it made them feel and any of their concerns. This will increase the broader perception that safety is a priority on the unit. In general, providers who are made to feel that their safety and well-being matter are more likely to be able to transfer this respect to their clients.



### Concerns at the Patient/Client Level

Major concerns at this level will revolve around the development of the Advance Crisis Plans and how the information is being shared or used during the person's stay. Some of these issues are as follows.

**I am not comfortable with information about what triggers my crises being openly shared with other patients. This is something private between me and my service providers.**

This concern may be shared quite often, but is relatively easy to resolve. Indeed, information about what triggers a person need not be openly shared in a group or any other setting. When this issue arises on a unit that also has decided to offer Self-Soothing Groups (described in Chapter 3), then two options are available. One is to conduct the group such that only self-soothing strategies are discussed (rather than specific triggers). In other words, nobody in the group would share specific information about what causes them to go into crisis. The other approach is to allow the person who does not want information about her triggers shared with others to participate in the group in a more limited way (i.e., she would not have to contribute to the group when discussions of triggers are being had). This would need to be handled with care,

however, since some group members may become uncomfortable with a member who does not fully participate.

Requests for confidentiality also would require that staff be careful about where they are and who else is around when they are discussing that person's triggers or Crisis Plan. The information should be treated as would any other confidential facts. Of course, when someone's triggers and crisis behaviors are clearly evident on the unit, then it is difficult to keep such information private, but staff should still use their clinical discretion to try to protect the person's privacy and dignity as much as possible.

**I don't feel like staff are really helping me to use my calming strategies when I'm upset. What's the point of these Plans any way?**

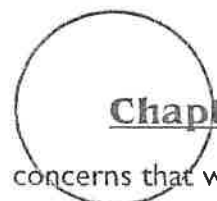
This concern is most likely to arise during the early stages of Program implementation, when staff are just getting used to developing and using the Plans regularly. As discussed in earlier chapters, there is nothing less empowering to people than asking them to identify triggers and calming techniques, and then, not using the information as promised. While there certainly will be bumps along the way, the negative effects of suggesting options to clients that never are used cannot be over-emphasized. If this occurs, strong and energetic leadership on the part of the administrators and managers will be necessary to ensure that all staff and patients are participating fully in the Advance Crisis Management Program. On some units, during the early implementation stage, peers have decided to help each other to do the activities identified in their Plans to help avoid crises. While this natural support should not be discouraged, it also should not be used to replace professional responsibility for using the Plans as designed.

**I don't feel like staff take me seriously when I identify my triggers and calming strategies.**

The Crisis De-Escalation Interview is special compared to some types of assessments, in that it must be conducted with a good deal of empathy and sensitivity. While tough to

resist during a busy day, simply reading the questions without also demonstrating interest and concern is not clinically appropriate, given the sensitive nature of this information. A caring approach is particularly important for trauma survivors, for whom feelings of safety can be quite tenuous. For this reason, the Implementation Team and staff may decide that the Interview is best conducted outside of the context of intake, when so many other forms and assessments must be completed, compromising the ability to take the time and care necessary to conduct the Crisis De-Escalation Interview.

Certainly, there are concerns that will arise among supervisors, providers, patients, and others when implementing the Advance Crisis Management Program. However, administrators and staff who have initiated new programs in the past will recognize that many of these same issues arise whenever change is introduced on the unit, and will have experience in working through the rough spots. It often helps to ask staff to identify another major programmatic change that they never thought would work that actually succeeded, in order to give them hope and encouragement that change is possible, even if challenging.



**Chapter Summary.** This chapter raised and sought to address a number of concerns that will manifest at all levels when instituting the Advance Crisis Management Program. Special emphasis was given to the fact that many of these issues are not unusual and can be overcome with understanding, commitment, and leadership. An important aspect of the implementation of this new Program is to ensure that it is effective and is improving clinical care. How to design a simple, but effective, evaluation is the topic of the next chapter.

## Chapter 5:

# Evaluation of the Advance Crisis Management Program

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**This chapter addresses the importance of ongoing evaluation of the effectiveness of advance crisis management procedures and policies. Simple strategies for conducting this type of evaluation are discussed and tools are provided.**

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### Why Evaluate Advance Crisis Management Procedures?

It is very difficult to implement and sustain an Advance Crisis Management Program without having some evidence of its effectiveness. Without such evidence, some managers and staff may argue that the Program is not worth the time and effort involved in setting it up and running it. Others may feel that the Program does nothing more than create unnecessary paperwork without any tangible positive outcomes for patients/clients or for staff. The evidence needed to counter these arguments can only be gained by conducting an evaluation of how well the Program works. Basically, the justification for evaluating advance crisis management procedures is the same as for conducting any quality assurance assessment – **to make sure that the policies and procedures in place are working well in your setting, and to continually find ways to improve the Program.**

### Designing an Evaluation.

An evaluation of the Program should assess whether pre-crises and crises are reduced, whether restraint and/or seclusion are reduced, and whether the coping and well-being of patients/clients and staff improve over time as a result of the Program. In the Appendix, we have included copies of sample instruments that can be used for this type of evaluation. These instruments are described in what follows.

### Patient/Client Participants.

Within 24 hours of admission to the unit or program, members of the Implementation Team (or staff they designate) would meet with patients/clients to invite them to participate in the evaluation by explaining its purpose, discussing what is involved, and asking them to consider participating. After obtaining human subjects informed consent, a Team member would administer the **Client Pretest**, measuring personal characteristics that are expected to be positively influenced by the Program:

- ▶ increases in feelings of self-esteem and coping mastery (Pearlin & Schooler, 1978; Rosenberg, 1965),
- ▶ decreases in levels of hostility towards self and others (Buss & Durkee, 1957),
- ▶ decreases in levels of depression (Kohout et al., 1993), and
- ▶ enhanced feelings of personal empowerment and control (RRIHS, 1994).


To evaluate the Advance Crisis Management Program, a Team member also would administer the **Client Feedback Tool** each time a pre-crisis or crisis occurs on the unit. Once the situation is resolved, a Team member would administer this Tool to the patient/client involved, reading each item aloud and recording the individual's responses. This would be done whether or not the situation ended in the utilization of restraint and/or seclusion. Then, at the end of each person's hospital stay, shortly after discharge papers are signed by the psychiatrist, the previously described pretest instruments would be re-administered to the person, as a posttest. Also administered along with the posttest would be the **Discharge Feedback**

**Tool.** This instrument is used for all people, regardless of whether or not they have experienced a crisis while on the unit, **to assess whether the process of developing the Advance Crisis Plans helped them:**

- ▶ to feel more involved in their own treatment,
- ▶ to develop a sense of personal power,
- ▶ to feel safer while on the unit, and
- ▶ to gain insights into their crisis triggers and how best to manage them.

This Tool, along with the Client Feedback Tool, is described later in this chapter.

As part of an evaluation, Implementation Team members also would abstract information from people's medical files, such as gender, age, ethnicity, and diagnosis, as well as information from their Advance Crisis Plans.

 **Staff Participants.** Prior to implementing the Advance Crisis Management Program, members of the Implementation Team would approach those staff responsible for creating Advance Crisis Plans with patients/clients to obtain their consent to participate in the evaluation. Team members would then administer the **Staff Pretest** evaluation instrument, which includes items assessing staff morale, feelings of personal effectiveness at work, provider "burnout," and tendencies to "depersonalize" their patients (Maslach & Jackson, 1981). The survey would be administered again at the end of the evaluation period (as determined by the Implementation Team) in the form of a **Staff Posttest**. The purpose of the Staff Pretest-Posttest is to assess changes in levels of line and supervisory staff morale and burnout during the time of the evaluation. Additionally, each time that a pre-crisis or crisis occurs, staff would complete the **Staff Feedback Tool**, to provide their own views about the use and effectiveness of the crisis management procedures. This Tool also is described in greater detail later in the chapter.

## EVALUATION DESIGN

| INSTRUMENT                                       | TIME ADMINISTERED                        |
|--|--|
| <input type="checkbox"/> Staff Pretest           | ⇒ Before the Advance Crisis Program      |
| <input type="checkbox"/> Client Pretest          | ⇒ Within 24 hours of admission           |
| <input type="checkbox"/> Client Feedback Tool    | ⇒ After pre-crisis or crisis or Plan use |
| <input type="checkbox"/> Staff Feedback Tool     | ⇒ After pre-crisis or crisis or Plan use |
| <input type="checkbox"/> Client Posttest         | ⇒ Immediately prior to discharge         |
| <input type="checkbox"/> Discharge Feedback Tool | ⇒ Immediately prior to discharge         |
| <input type="checkbox"/> Staff Posttest          | ⇒ At end of evaluation period            |
| <input type="checkbox"/> Case File Abstraction   | ⇒ Following discharge                    |

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**Keep in mind that these tools and procedures were designed to be used in an inpatient setting, but can easily be reworked for use in a residential or community setting.**


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### The Client Feedback Tool

The purpose of the Client Feedback Tool is to access a person's unique reaction each time a pre-crisis or crisis occurs. Since the point of the evaluation is to assess how well advance crisis management procedures are working, it is critical to gain patients' or clients' perspectives on their usefulness.

The Client Feedback Tool is comprised of 10 questions, one of which is in a checklist format, eight are answered "yes" or "no," and one is fill-in-the-blank. The Tool is designed to be **administered each time a person experiences a crisis or an incident that appears to be leading to a crisis.** Incidents that appear to be leading to a crisis (called pre-crises) include things such as extreme withdrawal, property damage, suicidal threats, crying, screaming or yelling, and threats of bodily harm to others. A full-blown crisis (referred to as an emergency by JCAHO) is defined as imminent risk of an individual harming self or others, including staff. Once the critical incident has passed, an Implementation Team member (or someone they designate) would approach the patient and ask whether he is willing to answer a few questions about the crisis management procedures. Individuals would be assured that their feedback is to be used to further refine their Advance Crisis Plans and the Program. If the person agrees, then the Client Feedback Tool would be administered, taking no more than five minutes.

 **Questions 1 and 2: Reasons for Using their Plans.** After the person agrees to complete the Tool, the first questions ask her to identify the reasons she believes her Crisis Plan was used.

1. Did you use your Advance Crisis Plan to help you deal with what happened when ...(fill in a description of the pre-crisis or crisis that precipitated the need for the Crisis Plan)?

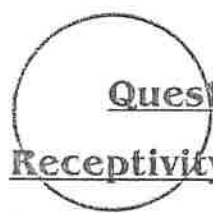
\_\_\_Y \_\_\_N Interviewer: If no, ask why not and record on back of this sheet.

2. Why did you need to use your Advance Crisis Plan? (check all that apply)



|                                     |  |                                    |  |
|-------------------------------------|--|------------------------------------|--|
| PRE-CRISES:                         |  | CRISES:                            |  |
| totally withdrawn                   |  | self-harming behavior              |  |
| overly nervous or anxious           |  | suicidal behavior/attempt          |  |
| uncontrollable crying               |  | physical attack on staff           |  |
| self-harming threats                |  | physical attack on another patient |  |
| suicidal threats                    |  | other? (list)                      |  |
| uncontrollable screaming or yelling |  |                                    |  |
| threats to staff/another patient    |  |                                    |  |
| property damage                     |  |                                    |  |
| refusal to follow directions        |  |                                    |  |
| other? (list)                       |  |                                    |  |
|                                     |  |                                    |  |

The purpose of this question is to obtain the individual's view of the situation, regardless of whether or not this view coincides with that of staff. This holds true for all evaluation instruments administered to patients.



**Questions 3, 4 and 5: Ease of Implementation & Receptivity.** The next three questions assess the individual's view of the ease with which his Advance Crisis Plan was implemented; whether he thought staff were receptive to its use, and how receptive he himself was to its use.

3. Did you find your Crisis Plan easy to use? \_\_\_Y \_\_\_N
4. Did you find that staff were willing to use your Crisis Plan? \_\_\_Y \_\_\_N
5. Did you find that you wanted to do the things described in your Crisis Plan? \_\_\_Y \_\_\_N

**Question 6: Time of Implementation.**

The next question asks the patient/client how long she believes it took for procedures outlined in her Crisis Plan to begin. This question is important to assess the timeliness with which the procedures were put into place and whether, in the patient's opinion, the process could have occurred more rapidly and efficiently.

6. How long did it take before you were able to do the things described in your Crisis Plan?  
\_\_\_\_\_ minutes/hours

**Question 7: Feelings of Control.**

The next question deals with how much the person felt in control of the crisis situation as a result of using the Plan. For evaluation purposes, this provides important information about whether the person views use of her Crisis Plan as a means of increasing her sense of control over a pre-crisis or crisis situation.

7. Did using the Crisis Plan help you feel more in control of the situation? \_\_\_\_Y \_\_\_\_N


**Questions 8, 9, and 10: Crisis Diffusion.**


The last three questions elicit opinions about the effectiveness of the Crisis Plan by specifically asking if the person feels that it helped him to manage his difficult behaviors, if it worked to de-escalate the crisis, and if he had to be restrained or secluded anyway. These questions are obviously crucial to the evaluation of how well the Crisis Plan worked, since they directly target the purpose of these Plans.

8. Do you think that your Crisis Plan helped you to better manage your behavior?  
\_\_\_\_Y \_\_\_\_N Why or why not? Interviewer note why or why not on the back of this sheet.

9. Do you think your Crisis Plan helped you to avoid getting more upset? \_\_\_\_Y\_\_\_\_N  
Why or why not? Interviewer note why or why not on the back of this sheet.

10. Did you have to be restrained or secluded? \_\_\_\_Y\_\_\_\_N  
If yes, why was this? If yes, interviewer note why on the back of this sheet.

 **The Discharge Feedback Tool.** The Discharge Feedback Tool is used at the end of the person's stay in the hospital, in order to assess her opinion of how the advance crisis management procedures worked for her in general, as opposed to regarding each pre-crisis or crisis in particular. This tool is administered to **everyone** who was served on the unit or in the program, in order to give people who did not have a pre-crisis or crisis the chance to share their opinions. After the discharge papers are signed, or once staff are aware that the person will be leaving, the individual is approached and asked to answer a few questions about whether and how the crisis management procedures affected his time in the hospital. Once again, individuals are reminded of the value of their opinions to the staff and their peers, and how their feedback will be used to improve the Program in the future. This Tool consists of 11 "yes" or "no" questions, one of which includes an open-ended item, taking no more than five minutes to administer.

 **Questions 1 and 2: Use of the Crisis Plan.** The first question asks the person whether he used his Crisis Plan at any time during his stay in the hospital, reminding him of his admission and discharge dates to orient him to the time period being asked about. The second question asks if there were any times during his hospitalization when he would have liked to have used Crisis Plan, but found himself unable to do so. Individuals who reply in the affirmative are asked to relate the reason they were unable to use their Crisis Plans. While the first question elicits the individual's own view of whether or not his Crisis Plan was activated, the second question is particularly helpful because it gives staff insight into whether clients feel that their Crisis Plans were not fully utilized during their stay in the hospital.

1. During this hospitalization, which lasted from \_\_\_\_\_(date) to \_\_\_\_\_(date), did you use your Crisis Plan? \_\_\_Y \_\_\_N

2. Were there times when you wanted to use your Crisis Plan, but didn't? \_\_\_Y \_\_\_N  
If yes, why?

**Question 3: Use of Restraint and Seclusion.** The third question asks the person whether or not she was restrained and/or secluded during her hospitalization, again using hospital admission and discharge dates to orient the individual. This question is used to verify any instances of restraint and/or seclusion that appear in the person's medical/case file, and elicits information that, when combined with information from the first two questions, offers valuable insights about potential underutilization of the crisis management process. For example, if the person reports instances in which she was not able to use her Plan during the hospitalization, but wanted to, and in addition was restrained or secluded, one might speculate (after obtaining further information) that enhanced Crisis Plan utilization might have resulted in avoidance of coercive treatment.

3. Were you restrained and/or secluded during this hospitalization? \_\_\_Y \_\_\_N

**Questions 4, 5, 6, 7, and 8: Feelings Related to Developing Crisis Plans.** The following five questions explore whether the crisis management process enhanced individuals' feelings of personal safety, control, empowerment, treatment choice, and insight into what upsets them. Ideally, the development and existence of Advance Crisis Plans should contribute to patients' sense of well-being in each of these areas. If individual responses indicate otherwise, it may be unique to this person or it may signal that Crisis Plans are being developed incorrectly on the unit, implemented inadequately, or used too infrequently. In addition, the targeted nature of these items allows the evaluation to identify specific ways in which Crisis Plans may not be achieving their intended results. For example,

people may report that they feel more in control and safer, but not that they have greater understanding of what upsets them. This may indicate that, while crisis management procedures are being used in emergencies, there is not enough debriefing occurring with patients afterwards that could increase their level of insight into their triggers and how to use the Crisis Plan to avoid escalating into full-blown crises.

4. Did you feel safer knowing that you had a Crisis Plan? ☐Y ☐N

5. Did you feel more in control of yourself knowing that you had a Crisis Plan? ☐Y ☐N

6. Did you feel like you had more personal power because you had a Crisis Plan? ☐Y ☐N

7. Did having a Crisis Plan make you feel more involved in your own treatment? ☐Y ☐N

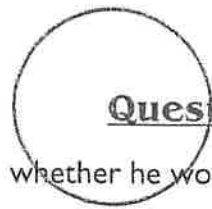
8. Do you think that developing a Crisis Plan helped you better understand what upsets you?  
☐Y ☐N



**Questions 9 and 10: Management of Behaviors.** The next two questions ask the person whether she thought that her Plan worked on the behaviors it was supposed to target, and also, whether she believed that the staff gained better insight into her behaviors due to the development of her Plan.

9. Do you think that having a Crisis Plan helped you to better manage your behavior?  
☐Y ☐N

10. Do you think that the staff were able to help you more because they knew what kinds of things upset you? ☐Y ☐N



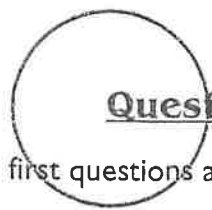
**Question 11: Use in the Future.** This final question asks the person whether he would want to use his Crisis Plan during any potential future hospitalizations. This is an important evaluation question because it allows one to gauge how much the patient values his Crisis Plan, and whether he feels it would be helpful enough to use in the future.

11. Would you want to use your Crisis Plan if you were hospitalized in the future?

\_\_\_Y \_\_\_N



**The Staff Feedback Tool.** Similar to the Client Feedback Tool, the Staff Feedback Tool is **completed every time a patient/client appears to be heading toward a crisis, experiences a crisis, or when the Crisis Plan is used.** The tool is designed to assess staff's opinions and feelings about the use of crisis management procedures. An Implementation Team member (or their designee) would approach all staff who were involved in a pre-crisis or crisis – after the situation has been resolved (whether or not restraint or seclusion have been employed) – and ask them to answer a few questions about the use of the particular Crisis Plan. They also would be told that their opinions are important and valuable to the success of these procedures on the unit, and that their feedback will be used to refine the crisis management process. The Staff Feedback Tool consists of 11 questions: one checklist, one fill-in-the-blank, and nine "yes" or "no" questions.



**Questions 1 and 2: Reasons for Using the Crisis Plan.** The first questions ask staff to identify all of the reasons the person's Crisis Plan was used, choosing from a pre-designated checklist including a space for writing in any reasons not specified.

1. In handling the pre-crisis or crisis incident that occurred with (patient's name), was his/her Crisis Plan used? \_\_\_Y\_\_\_N If no, please explain why not on the back of this page.

2. Which of the following behaviors resulted in use of the person's Crisis Plan? (check all that apply)

| PRE-CRISES:                         |  | CRISES:                            |  |
|-------------------------------------|--|------------------------------------|--|
| totally withdrawn                   |  | self-harming behavior              |  |
| overly nervous or anxious           |  | suicidal behavior/attempt          |  |
| uncontrollable crying               |  | physical attack on staff           |  |
| self-harming threats                |  | physical attack on another patient |  |
| suicidal threats                    |  | other? (list)                      |  |
| uncontrollable screaming or yelling |  |                                    |  |
| threats to staff/another patient    |  |                                    |  |
| property damage                     |  |                                    |  |
| refusal to follow directions        |  |                                    |  |
| other? (list)                       |  |                                    |  |
|                                     |  |                                    |  |

While it is not essential that the staff's reasons match those given by the patient to this same question, it is instructive for staff to compare their answers not only with each other but also with the patient's perception of why the Plan was activated. That said, the major purpose of this question is to elicit the staff's view of the situation. This holds true with all evaluation instruments administered to staff.

**Questions 3, 4, and 5: Ease and Receptivity to Implementation.** The following three questions are used to assess how easily the staff

member believes the Crisis Plan was implemented, and whether he thought the patient and other staff were receptive to its use.

3. Did you find the patient's Crisis Plan easy to use? \_\_\_\_Y \_\_\_\_N

4. Did you find the patient receptive to using the Crisis Plan? \_\_\_\_Y \_\_\_\_N

5. Did you find other staff receptive to using the patient's Crisis Plan? \_\_\_\_Y \_\_\_\_N

**Question 6: Time of Implementation.** The next question asks the staff member how long it took for the patient to begin doing the things outlined in her Crisis Plan. This question is important to gain staff's perspective on the efficiency of the procedures and the speed with which the Plan's provisions are implemented.

6. How long did it take before you were able to help the patient follow the instructions on the Crisis Plan? \_\_\_\_\_minutes/hours

**Questions 7 and 8: Control of Situation.** The next two questions elicit the staff member's perception of how much both staff and the patient felt in control of the crisis situation due to use of the Plan. For evaluation purposes, this provides important information about whether hospital staff view Crisis Plans as a means of increasing their sense of control over a pre-crisis or crisis, and increasing patients' sense of control as well.

7. Did using the Crisis Plan help you feel more in control of the situation? \_\_\_\_Y \_\_\_\_N

8. Do you think that the Crisis Plan made the patient feel more in control of the situation?  
\_\_\_\_Y \_\_\_\_N



### Questions 9,10, and 11: Crisis Diffusion.

The last three questions elicit staffs' opinions about the effectiveness of the Crisis Plan by specifically asking if it helped them to better manage the person's difficult behaviors, if it worked to de-escalate the crisis, and whether the patient had to be restrained or secluded despite use of the Plan. These questions are obviously crucial to the evaluation of how well the Crisis Plan worked, since they directly target the purpose of these Plans.

9. Do you think that the Crisis Plan helped you to better manage the patient's disruptive behaviors? \_\_\_Y\_\_\_N Why or why not? Interviewer note why or why not on the back of this sheet.

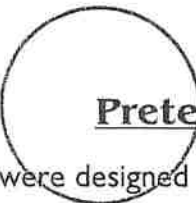
10. Do you think it worked to de-escalate the crisis? \_\_\_Y\_\_\_N Why or why not? Interviewer note why or why not on the back of this sheet.


11. Did the patient have to be restrained or secluded anyway? \_\_\_Y\_\_\_N Why or why not? Interviewer note why or why not on the back of this sheet.

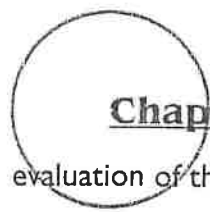
### Using Information from the Pretest-Posttest and Evaluation Tools.

There are many ways to utilize information collected by the Pretest-Posttest and the Feedback Tools. In some cases, this will require the skills of a professional researcher to conduct statistical analyses that test for significant differences in patients' and staffs' scores between Pretest and Posttest. In other cases, simple comparisons between staff and patient/client responses, as well as summing responses and computing averages with a calculator is enough to gain useful information to improve the Program. Keep in mind, however, that if you wish to use any of this information for purposes beyond Quality Assurance, such as for research presentations or publications, you will need to have your project plans and instruments reviewed by your organization's Human Subjects Protection Committee (sometimes referred to as the Institutional Review Board or IRB). This needs to be

done before gathering data, conducting interviews, and administering instruments or assessments.

 **Pretest-Posttest.** The scales that comprise the Client and Staff Pretest-Posttest were designed by their creators to be scored in a certain way which will require the knowledge and skills of a researcher working with a computer program. Once total and subscale scores have been computed, statistical analyses can be conducted to look for significant changes over time in people's feelings of mastery and self-efficacy, as well as their levels of self-esteem, hostility, and depression. In the same way, statistical analyses can be conducted to determine whether the implementation of an Advance Crisis Management Program raises the unit staff's feelings of morale and reduces provider burnout and the tendency to depersonalize patients.

 **Client and Staff Tools.** The Client and Staff Feedback Tools can be examined descriptively following each use of a person's Crisis Plan, to determine whether crisis management procedures were followed successfully and how the individual Plan might be improved to better meet the patient's or staff's needs. In addition, the patient's and staffs' responses about the same critical incident can be compared, not with the assumption that they should be identical, but to look for ways in which agreement or disagreement points to successes or failures of the crisis management process. Similarly, the Discharge Feedback Tool can be examined to assess patients' feelings upon discharge, especially regarding whether, in retrospect, they feel that creating (and using) an Advance Crisis Plan fostered a greater sense of personal safety, control, empowerment, treatment choice, and increased insight into their difficult-to-manage behaviors. By examining and discussing people's responses to the Discharge Tool, staff can gain valuable information about improving the Program for those still remaining on the unit, since people might be more honest at the point of discharge than they would be if they were continuing to receive services in a given setting.



**Chapter Summary.** This chapter described the importance of ongoing evaluation of the effectiveness of advance crisis management procedures and policies. Simple strategies for conducting this type of evaluation were discussed. Evaluation instruments and tools were presented and described, along with methods for analyzing the information collected in order to gain valuable feedback about improving Program performance.

## Chapter 6: In Conclusion

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**This chapter concludes the Advance Crisis Management Program manual.**

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This manual was developed primarily to assist hospitals and other mental health treatment facilities in the development, implementation, evaluation, and refinement of a person-centered Advance Crisis Management Program. Its focus is on the provision of practical, real-life advice about how to make a Program like this work in inpatient, residential, and community settings. Of course, when it comes to change, nothing is “written in stone,” and each organization will find that certain suggestions work well, while others do not succeed or resonate for them. This is to be expected and is why the Implementation Team must bring not only a wide variety of perspectives, but flexibility, patience, and strong leadership to the change process. It always is important to remember that change is difficult for most people and agencies, but that many of us have survived a myriad of changes in the mental health system. Thus, **conveying encouragement and hope along the way will be necessary** to keep staff believing in what they are doing and moving forward.

No matter where your organization finds itself along the change continuum in regard to advance crisis management, we applaud your interest in and efforts to create safer treatment environments with a foundation of patient self-determination and client-directed care. Having helped to introduce many new programs in a variety of settings through the years, we are well-aware of how easy it can be to shift one’s focus to everything that is not being accomplished, instead of to all that has been done. Try to resist this human tendency, as it can drain everyone’s enthusiasm for the Program. Of course, you don’t want to shut your eyes to real problems that need solutions, but you also don’t want to lose sight of what has been

accomplished or the importance of the end goal. **Take time each month to celebrate among the Implementation Team and the entire staff any and all changes that have been made, even the smallest of steps.** We know that this constitutes good clinical practice, but it also is a part of good organizational practice.

The Appendix of this manual contains copies of various de-escalation tools, as well as Web-based resources that may help inform your efforts to better manage crisis and risk within your organization. We hope these will be helpful for educating yourselves and those involved in the Program.

**Trust your power to make change happen!** We wish you the best of luck as you realize the possibilities that such change can bring.

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# APPENDIX

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**The Crisis De-Escalation  
Interview  
(English-language version)**

**Crisis De-Escalation Interview** (developed by the UIC National Research & Training Center, 1999; funded by NIDRR & CMHS)

Patient/Client Name \_\_\_\_\_ (PRINT) Date \_\_\_\_/\_\_\_\_/\_\_\_\_

STAFF: At intake, complete Items 1-7. **Note:** For the first two questions, Plan 1 should be completed and dated at intake. Any changes to the Plan should be recorded in the Plan 2 column for the first two questions **only**, dating each (use Plan 3 if more changes are needed). **After each change, initial it above the column.** STAFF, READ TO PERSON: To provide you with the best care we can, we want to know what helps you to feel better and safer when you are having a hard time and think you might go into crisis. The information will be shared with your treatment team and put in your treatment plan.

1. **Stress/Crisis Triggers.** Certain things make people become very angry, very upset, or to go into a crisis when in the hospital. To help you feel safe, we want to know what things might upset or agitate **you** while you're here. I'll read a list and you tell me which ones might make you feel this way. (STAFF: Check all that apply.)

| PLAN #  | 1 | 2 | 3 | PLAN #   | 1 | 2 | 3 |
|---|---|---|---|--|---|---|---|
| DATE  |   |   |   | DATE   |   |   |   |
| being touched                                     |   |   |   | being isolated   |   |   |   |
| bedroom door open                                 |   |   |   | people in uniform  |   |   |   |
| particular time of day (when?)                    |   |   |   | time of the year (when?)   |   |   |   |
| noises  |   |   |   | someone else yelling   |   |   |   |
| not having control/input                          |   |   |   | being around men or women (circle)                                     |   |   |   |
| feeling a lack of respect                         |   |   |   | people not paying attention to me                                      |   |   |   |
| shift change                                      |   |   |   | feeling threatened or unprotected                                      |   |   |   |
| not having personal space                         |   |   |   | nightly room checks  |   |   |   |
| too many people crowding around me when I'm upset |   |   |   | seeing other people escalate and/or seeing them restrained or secluded |   |   |   |
| other (please list)                               |   |   |   | other (please list)  |   |   |   |

2. **Calming Strategies.** It's helpful for us to know the things that make you feel **better** when you're upset or agitated and fear losing control. Which of the following have helped you to gain control in these situations? (STAFF: Only check 3-5 items.)

| PLAN #                                 | 1 | 2 | 3 | PLAN #                                 | 1 | 2 | 3 |
|--|---|---|---|--|---|---|---|
| DATE                                   |   |   |   | DATE                                   |   |   |   |
| voluntary time out in your room        |   |   |   | calling therapist (w/ privs & permis.) |   |   |   |
| writing in a diary/journal             |   |   |   | reading a newspaper/book               |   |   |   |
| being near staff                       |   |   |   | watching TV                            |   |   |   |
| talking with staff about my needs      |   |   |   | pacing the halls or in the quiet room  |   |   |   |
| artwork (drawing or coloring)          |   |   |   | calling a friend (w/ privs & permis.)  |   |   |   |
| music via personal device              |   |   |   | pounding clay                          |   |   |   |
| punching a pillow                      |   |   |   | exercise                               |   |   |   |
| deep breathing exercises               |   |   |   | hot packs at night to help me sleep    |   |   |   |
| going for a walk in halls with staff   |   |   |   | lying down with cold face cloth        |   |   |   |
| cup of hot tea, especially at night    |   |   |   | snapping rubber band on wrist          |   |   |   |
| taking a shower/sitting in shower area |   |   |   | drawing on arm with red marker         |   |   |   |
| wrapping up in a blanket               |   |   |   | putting hands under cold water         |   |   |   |
| using a "weighted" blanket             |   |   |   | other (describe)                       |   |   |   |

STAFF, READ TO PERSON: When you start to get agitated or go into crisis, we'll ask you to try these things to help you calm down. We hope that you'll work on these strategies to keep yourself and others safe. While we won't always be able to offer every alternative you've identified, we'd like to work together to help you. So, each day, we'll talk about the calming strategies you've identified and what you can do, and what we can do, to help you feel safe while you're here.

3. History of Restraint. In thinking about your well-being while here, it is helpful for us to know whether or not you have ever been restrained or held down against your will in a treatment setting. Has this ever happened to you? Yes ☐ No ☐

STAFF: ONLY ask the next four questions if the person answers "yes" to item 3. Otherwise, skip to the end, ask the person to sign the form, and find out if he/she has any questions about what you've discussed.

4. Were you restrained:

☐ in a hospital ☐ in a crisis unit ☐ in a group home or residential facility ☐ in another setting

Please think about the last time you were restrained and tell me why you were restrained?

Was it because you (staff read whole list): ☐ Threatened someone with serious physical assault

☐ Physically assaulted someone else

☐ Threatened to seriously hurt yourself

☐ Attempted to or did hurt yourself

How were you restrained? Were you: ☐ Sedated (or chemically restrained)

☐ Put in walking or hand restraints

☐ Put in four-point or full leather restraints

5. Preferences re: Restraint. If you're becoming a danger to yourself or someone else, we may need to restrain or seclude you. If it becomes necessary to do this, we'd like to know what you would prefer, if it's appropriate. Would you prefer:

(Staff, read all and ask person to choose one, or two at most.)

|  |                          |                                     |                          |
|--|--------------------------|-------------------------------------|--------------------------|
| to be in the locked quiet room   | <input type="checkbox"/> | to be given an open door seclusion  | <input type="checkbox"/> |
| to be sedated (chemical restraint)                                     | <input type="checkbox"/> | to be put in full leather restraint | <input type="checkbox"/> |
| to be placed in walking restraints (hand/wrist restraints, posey vest) | <input type="checkbox"/> |                                     |                          |

6. Contracting for Safety. If we need to restrain you at some point, is there anything that we can do to help you "contract for safety" to get out more quickly? Please describe.

7. Preferred Medications. We may be required to administer medication if physical restraints aren't calming you down. Would you like to discuss what medication you would prefer with your doctor? Yes ☐ No ☐

\*\*\*\*\*

☐ Person unable to complete interview at intake.

Reason why:

☐ too sedated

☐ in restraints

☐ too symptomatic

☐ not ready to discuss

☐ cognitively impaired

☐ refused entirely

(If yes, interview must be re-attempted at every shift, unless patient demands no further attempts.)

**\*\*UPON COMPLETION OF INTERVIEW\*\***

\_\_\_\_ (date) \_\_\_\_\_ (staff signature) \_\_\_\_\_

\_\_\_\_ (date) \_\_\_\_\_ (patient signature) \_\_\_\_\_

Form adapted from Carmen et al. (1996).

MA DMH Task Force on Restraint & Seclusion of Abuse Survivors: Report & Recommendations

**The Crisis De-Escalation  
Interview  
(Spanish-language version)**

Nombre del Paciente \_\_\_\_\_ (Letra impresa)

Fecha: \_\_\_\_\_

PERSONAL: Hay que completar números 1 – 8 al punto de admisión del paciente. **Importante:** Para la primera y segunda pregunta, el Plan 2° se debería completar al admisión. Complete y ponga la fecha de admisión. Anote cualquier cambio que ocurra durante la hospitalización en Plan 2° para la primera y segunda pregunta solamente, incluyendo la fecha (si necesita hacer otros cambios, use el Plan 3°). **Ponga sus iniciales encima de la columna después de cada cambio.**

PERSONAL, PARA LEER A LOS PACIENTES: Para proveerle el mejor tratamiento posible, queremos saber lo que le hace sentir mejor y más seguro cuando está sufriendo o piensa que podría perder el control de sí mismo. Las siguientes preguntas nos van a ayudar entenderle mejor y ayudarlo sentir más seguro durante su hospitalización. Vamos a compartir esta información con su doctor y el personal para que ellos puedan incorporarlo en su plan de tratamiento.

1. Hay ciertas situaciones que pueden causarle una reacción fuerte o causarle una crisis personal cuando está en el hospital. Para ayudarlo a sentirse seguro, queremos saber cuáles situaciones podrían molestarle a Ud. mientras está aquí. Voy a leer una lista de situaciones y Ud. me puede decir cuáles de estas le pueden hacer sentirse agitado o que va a perder el control de sí mismo. (PERSONAL: Indique todas las que aplican.)

| PLAN #   | 1 | 2 | 3 | PLAN #   | 1 | 2 | 3 |
|--|---|---|---|--|---|---|---|
| FECHA  |   |   |   | FECHA  |   |   |   |
| Que alguien lo toque   |   |   |   | Sentirse aislado   |   |   |   |
| Puerta del cuarto abierta  |   |   |   | Gente en uniforme  |   |   |   |
| Una hora del día en particular(qual?)                                |   |   |   | La temporada del año (cuando?)                                   |   |   |   |
| Ruidos   |   |   |   | Otra persona gritando  |   |   |   |
| No tener oportunidad de contribuir o decidir a lo que le hacen a Ud. |   |   |   | Tener hombres o mujeres alrededor (cual?)                        |   |   |   |
| Sentir una falta de respeto  |   |   |   | Sentir que no me hacen caso                                      |   |   |   |
| La hora del cambio de personal                                       |   |   |   | Sentirme amenazado o sin protección                              |   |   |   |
| No tener su propio lugar/espacio                                     |   |   |   | Las inspecciones de cuarto cada noche                            |   |   |   |
| Demasiada gente alrededor cuando estoy enojado                       |   |   |   | Viendo otras personas escalar y/o verlos restringidos o aislados |   |   |   |
| Algo más (favor de notar)  |   |   |   | Algo más (favor de notar)  |   |   |   |

2. Nos ayuda bastante cuando sabemos lo que le hace sentir **mejor** cuando está agitado o tiene miedo de perder el control personal. ¿Cuáles de las siguientes situaciones le han ayudado a Ud. sentir más control personal? (PERSONAL: Solamente **escoga 3 – 5 cosas.**)

| PLAN #   | 1 | 2 | 3 | PLAN #  | 1 | 2 | 3 |
|--|---|---|---|---|---|---|---|
| FECHA  |   |   |   | FECHA   |   |   |   |
| Tomar tiempo aparte en su cuarto voluntariamente           |   |   |   | Llamar el terapeuta (si es un privilegio extendido a Ud. y con permiso) |   |   |   |
| Escribir en un diario                                      |   |   |   | Leer un periódico/libro   |   |   |   |
| Estar cerca del personal                                   |   |   |   | Mirar la television   |   |   |   |
| Hablando con el personal profesional sobre mis necesidades |   |   |   | Andar por los pasillos o en un cuarto tranquilo                         |   |   |   |
| Dibujar/Pintar   |   |   |   | Llamar un amigo (si es un privilegio extendido a Ud. y con permiso)     |   |   |   |
| Musica con audifono personal                               |   |   |   | Golpear el barro  |   |   |   |
| Pegar a una almohada                                       |   |   |   | Hacer ejercicios  |   |   |   |
| Ejercicios de respirar hondamente                          |   |   |   | Meter las manos en agua fría  |   |   |   |
| Tomar un paseo en los pasillos con el personal             |   |   |   | Acostarme con una toalla fresca sobre la cara                           |   |   |   |
| Una taza de té caliente, especialmente de noche            |   |   |   | Estirando ligas sobre la muñeca y dejandola ir                          |   |   |   |
| Tomar un baño, o estar sentada cerca del aria del bano.    |   |   |   | Marcar el brazo con una pluma roja                                      |   |   |   |

|  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|
| Envolverme en una cobija                                     |  |  | Usando una toalla tibia sobre la cara o los ojos para ayudarme a dormir |  |  |  |
| Usando una frazada gruesa con pesas para sentirse mas seguro |  |  | Algo mas, descríbala  |  |  |  |

PERSONAL, LEA AL PACIENTE: Cuando empieza a sentirse agitado o en una crisis, vamos a sugerir estas ideas para ayudarlo a sentirse más calmado. Esperamos que Ud. va a usar estas recomendaciones para mantener la seguridad de Ud. y los demás. Aunque no podemos ofrecerle **siempre** cada alternativa que Ud. sugiere, queremos trabajar juntos con Ud. para su bien. Cada día durante el Grupo de Metas (Goal Group), vamos a revisar las sugerencias calmantes que Ud. identificó y lo que Ud. puede hacer y lo que nosotros podemos hacer para ayudarlo a sentirse seguro mientras está aquí.

3. Considerando lo que Ud. necesita para sentirse seguro aquí, es importante que nos informe si Ud. haya sido restringido o mantenido contra su voluntad en un sitio de tratamiento. ¿Esto le ha ocurrido alguna vez?

Sí ☐ No ☐

**PERSONAL: SOLAMENTE siga con preguntas 4 – 7 si la respuesta es “Sí” a la pregunta #3. Si no, continúe al fin y pida que el paciente firme la forma y pregúntele si tiene alguna preguntas sobre la entrevista.**

4. ¿En dónde lo restringieron?

☐ en el hospital ☐ en una unidad de crisis ☐ en un programa residencial ☐ en otro lugar

Favor de pensar en la última vez que lo restringieron y las razones porque.

Fue porque Ud. (personal lea la lista completa):

☐ Amenazó a alguien con un asalto físico y grave

☐ Asaltó físicamente a otra persona

☐ Amenazó hacerse daño grave a si mismo

☐ Intentó o realizó hacerse daño a si mismo

¿Cómo lo restringieron?

☐ Le dieron un sedativo (restringido con medicina)

☐ Lo restringieron los brazos, pero estaba libre a caminar

☐ Le pusieron correas restrictivas en la cama

5. Si Ud. se comporta en una manera que representa un peligro a otra persona o a si mismo, pueda ser necesario restringirlo o ponerle en aislamiento. Si llegamos a este punto, queremos saber lo que Ud. prefiere, si es apropiado. ¿Cuál prefiere? (Personal, lea todo y pregunte al paciente que escoga una o dos máximo.)

|   |  |   |  |
|---|--|---|--|
| Encerrado en un cuarto calmado  |  | En aislamiento con la puerta abierta        |  |
| Tomar un sedativo (medicina)  |  | Le pusieron correas restrictivas en la cama |  |
| Lo restringieron los brazos, pero estaba libre a caminar (posey vest) |  |   |  |

6. ¿Si es necesario restringirle, hay algo que podemos hacer para llegar a un acuerdo, un contrato de seguridad, para ayudarlo salir con más rapidos? Favor de describir.

7. Es posible que sea necesario darle medicina si las restricciones físicas no le ayudan a calmarse. ¿Quiere Ud. hablar con su doctor sobre la medicina que preferiría? Sí ☐ No ☐

\*\*\*\*\*

☐ El paciente no pudo completar la entrevista al punto de admisión.

Razón porque:

☐ demasiado sedativo

☐ restringido

☐ demasiado síntomas

☐ no estaba listo para cooperar

☐ impedimento cognitivos

☐ rehusó completamente

(Si indicó algo, tiene que repetir la entrevista a cada cambio de personal hasta que este completo, a menos que el paciente insista que no siga atentando.)

**\*\*AL COMPLETAR LA ENTREVISTA\*\***

\_\_\_\_\_ (firma del personal) \_\_\_\_\_ (fecha)

\_\_\_\_\_ (firma del paciente) \_\_\_\_\_ (fecha)

# **The Client Feedback Tool**

**University of Illinois at Chicago, National Research and Training Center**  
**Client Feedback Tool**

Client research number \_\_\_\_\_ Date of completion of form \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Did you use your Advance Crisis Plan to help you deal with what happened when ...(fill in a description of the pre-crisis or crisis that precipitated the need for the Crisis Plan)? \_\_\_Y \_\_\_ N  
 Interviewer: If no, ask why not and record on back of this sheet.

2. Why did you need to use your Advance Crisis Plan? (check all that apply)

| <b>PRE-CRISES:</b>                  |  | <b>CRISES:</b>                     |  |
|-------------------------------------|--|------------------------------------|--|
| totally withdrawn                   |  | self-harming behavior              |  |
| overly nervous or anxious           |  | suicidal behavior/attempt          |  |
| uncontrollable crying               |  | physical attack on staff           |  |
| self-harming threats                |  | physical attack on another patient |  |
| suicidal threats                    |  | other? (list)                      |  |
| uncontrollable screaming or yelling |  |                                    |  |
| threats to staff/another patient    |  |                                    |  |
| property damage                     |  |                                    |  |
| refusal to follow directions        |  |                                    |  |
| other? (list)                       |  |                                    |  |
|                                     |  |                                    |  |

3. Did you find your Crisis Plan easy to use? \_\_\_Y \_\_\_N
4. Did you find that staff were willing to use your Crisis Plan? \_\_\_Y \_\_\_N
5. Did you find that you wanted to do the things described in your Crisis Plan? \_\_\_Y \_\_\_N
6. How long did it take before you were able to do the things described in your Crisis Plan?  
 \_\_\_\_\_minutes/hours
7. Did using the Crisis Plan help you feel more in control of the situation? \_\_\_Y \_\_\_N
8. Do you think that your Crisis Plan helped you to better manage your behavior?  
 \_\_\_Y \_\_\_N Why or why not? Interviewer note why or why not on the back of this sheet.
9. Do you think your Crisis Plan helped you to avoid getting more upset?  
 \_\_\_Y \_\_\_N Why or why not? Interviewer note why or why not on the back of this sheet.
10. Did you have to be restrained or secluded?  
 \_\_\_Y \_\_\_N Why or why not? If yes, interviewer note why on the back of this sheet.



# **The Discharge Feedback Tool**

**University of Illinois at Chicago, National Research and Training Center**  
**Discharge Feedback Tool**

Client research number \_\_\_\_\_ Date of completion of form \_\_\_\_/\_\_\_\_/\_\_\_\_

1. During this hospitalization, which lasted from \_\_\_\_\_ (date) to \_\_\_\_\_ (date), did you use your Crisis Plan? \_\_\_\_Y \_\_\_\_N
2. Were there times when you wanted to use your Crisis Plan, but didn't? \_\_\_\_Y \_\_\_\_N  
If yes, why?
3. Were you restrained and/or secluded during this hospitalization? \_\_\_\_Y \_\_\_\_N
4. Did you feel safer knowing that you had a Crisis Plan? \_\_\_\_Y \_\_\_\_N
5. Did you feel more in control of yourself knowing that you had a Crisis Plan? \_\_\_\_Y \_\_\_\_N
6. Did you feel like you had more personal power because you had a Crisis Plan? \_\_\_\_Y \_\_\_\_N
7. Did having a Crisis Plan make you feel more involved in your own treatment? \_\_\_\_Y \_\_\_\_N
8. Do you think that developing a Crisis Plan helped you better understand what upsets you?  
\_\_\_\_Y \_\_\_\_N
9. Do you think that having a Crisis Plan helped you to better manage your behavior?  
\_\_\_\_Y \_\_\_\_N
10. Do you think that the staff were able to help you more because they knew what kinds of things upset you?  
\_\_\_\_Y \_\_\_\_N
11. Would you want to use your Crisis Plan if you were hospitalized in the future? \_\_\_\_Y \_\_\_\_N

# **The Staff Feedback Tool**

**University of Illinois at Chicago, National Research and Training Center**  
**The Staff Feedback Tool**

Staff research number \_\_\_\_\_ Date of completion of form \_\_\_\_/\_\_\_\_/\_\_\_\_

1. In handling the pre-crisis or crisis incident that occurred with (patient's name), was his/her Crisis Plan used?   
 \_\_\_ Y \_\_\_ N If no, please explain why not on the back of this page.

2. Which of the following behaviors resulted in use of the person's Crisis Plan?  
 (check all that apply)

| <b>PRE-CRISES:</b>                  |  | <b>CRISES:</b>                     |  |
|-------------------------------------|--|------------------------------------|--|
| totally withdrawn                   |  | self-harming behavior              |  |
| overly nervous or anxious           |  | suicidal behavior/attempt          |  |
| uncontrollable crying               |  | physical attack on staff           |  |
| self-harming threats                |  | physical attack on another patient |  |
| suicidal threats                    |  | other? (list)                      |  |
| uncontrollable screaming or yelling |  |                                    |  |
| threats to staff/another patient    |  |                                    |  |
| property damage                     |  |                                    |  |
| refusal to follow directions        |  |                                    |  |
| other? (list)                       |  |                                    |  |
|                                     |  |                                    |  |

3. Did you find the patient's Crisis Plan easy to use? \_\_\_Y \_\_\_N

4. Did you find the patient receptive to using the Crisis Plan? \_\_\_Y \_\_\_N

5. Did you find other staff receptive to using the patient's Crisis Plan? \_\_\_Y \_\_\_N

6. How long did it take before you were able to help the patient follow the instructions on the Crisis Plan? \_\_\_\_\_minutes/hours

7. Did using the Crisis Plan help you feel more in control of the situation? \_\_\_Y \_\_\_N

8. Do you think that the Plan made the patient feel more in control? \_\_\_Y \_\_\_N

9. Do you think that the Plan helped you to better manage the patient's disruptive behaviors?  
 \_\_\_Y \_\_\_N Why or why not? Interviewer note why or why not on the back of this sheet.

10. Do you think it worked to de-escalate the crisis?  
 \_\_\_Y \_\_\_N Why or why not? Interviewer note why or why not on the back of this sheet.

11. Did the patient have to be restrained or secluded anyway?  
 \_\_\_Y \_\_\_N Why or why not? If yes, interviewer note why on the back of this sheet.

# **Self-Soothing Group Outline**

## Self-Soothing Group Outline

As discussed in Chapter 3, some hospitals or programs will find it useful to offer a Self-Soothing Group on a regular basis to help clients review their calming strategies and to develop new insights into what helps them to de-escalate. The following is an outline of topics, discussions, and activities that such a group might incorporate. It easily can be adapted to fit the needs of your particular facility and patients.

Before you get started, you will need to decide whether you are best able to provide a Self-Soothing Group that focuses only on reviewing patients' Advance Crisis Plans or whether you can provide a group that both reviews the Plans and helps clients to develop new skills. This largely will depend upon whether you work in an acute facility or one in which patients have an average length of stay of three weeks or longer. It also will depend on the availability of staff on your unit or in your program to facilitate a more comprehensive group experience.

### Self-Soothing Group Focused on Advance Crisis Plans

If you've chosen this option, it's likely that there will be constant change in who attends your group due to frequent admissions and discharges. Therefore, in this case, group content focuses solely on patients' Advance Crisis Plans (in particular their calming strategies). Ideally, group would be offered daily for approximately 30 minutes. These six items would be covered in **every** group, since new members will be joining all the time, and this is the core information that clients need to know to effectively manage crises while on the unit and in their lives in general.

#### **1. Facilitator introductions**

- + this need not take much time, but it is helpful to remind group members of who you are and your role on the unit or in the program

#### **2. Welcome clients to the group**

- + ask each person to introduce herself/himself and state whether s/he has worked with staff (or alone) to develop an Advance Crisis Plan

### **3. Explain/define purposes of the group**

- + to clarify purposes and uses of Advance Crisis Plans
- + to provide an open, comfortable place to become used to talking about, understanding, and using self-soothing and de-escalation techniques
- + to answer questions related to Advance Crisis Plans and general de-escalation practices

### **4. Go over ground rules of the group**

- + everyone will respect one another's feelings, opinions, and views, and will listen while others speak
- + (in some settings) each individual's crisis triggers will not be discussed to facilitate safety

As discussed in Chapter 5, it often is best to hold individual patient's crisis triggers in confidence, focusing group time on calming strategies instead

### **5. Review Crisis De-Escalation Interview and Advance Crisis Plans**

- + explain purpose and use of each section, and answer questions

### **6. Go through the second item of the Crisis De-Escalation Interview (e.g., the list of things that make people feel better when in crisis)**

- + discuss each calming strategy listed in the Crisis De-Escalation Interview, including why it is soothing, how it is used, etc.
- + ask each group member (who feels comfortable) to share what things he or she finds soothing, and why
- + practice using one or two of these techniques at each group meeting (if possible, bring "accessories" for self soothing, such as notebooks for journaling, art supplies, pillow for punching, and so forth, to help clients practice)

## **Self-Soothing Group Focused on Advance Crisis Plans & Developing New Skills**

If you've chosen this option, it's likely that patients/clients stay in your program longer than they would on an acute unit. Therefore, in this case, group content focuses on patients' Advance Crisis Plans (in particular their calming strategies) and provides time to learn and practice new skills. Ideally, group would be offered twice each week for approximately 45 to 60 minutes. In this scenario, the six topics/activities described above also would be covered in **every** group session, to remind existing members of the core information they need and to orient new members. If you do not have any new members in a given group, you do not need to spend much time on these six activities, but review of them should be offered each time.

### **Supplemental Group Topics**

#### **①Positive self-soothing**

**Purpose:** To distinguish between positive and negative things patients do to make themselves feel better

**Introduction:** "We all do things to ease the pain when we are feeling badly. Sometimes, these things can be self-enhancing or self-improving. Other times, the things that we've learned to do to soothe ourselves may be harmful or self-destructive."

**Discussion:** Ask group members to share some of the things that they have done in the past to feel better when they were stressed out, upset, or felt badly about themselves.

**Facilitator:** Offer two of your own ideas to get them started, using one positive and one negative strategy that you've used in the past. Write your examples and their responses on a flip chart or board, if possible. Remind the group of the ground rules, including respecting others' feelings or needs. Encourage exploration of both positive and negative answers, and make sure you mention that unhealthy ways of dealing with stress are not at all uncommon.



After a sizeable list is generated, ask the group to point out the negative ways to deal with stress, and write a minus sign next to them. Ask the group to come up with possible consequences of using these more negative strategies and write their responses next to each item. Be sure to point out that while these activities may help them feel better in the moment, they most likely will hurt them in the long-run, especially with repeated use.

Ask the group to point out the answers on the chart/board that are constructive ways of nurturing themselves, and put a plus sign next to these answers. Acknowledge that the group already has some positive ways to self-soothe. Ask them to notice that most of these things are either free or cost a minimal amount of money (e.g., walking, calling a friend, praying or meditating, reading, etc.).

**Exercise:**

Pass out index cards with “POSITIVE WAYS TO COMFORT MYSELF” written across the top, and ask the group to write out as many positive (feasible!) ways they can think of to soothe and nurture themselves, whether it be in the hospital, in a community program, or at home. Ask them to try to use at least two of these positive strategies some time between now and the next session, and report on the experience next time. Point out that, if the techniques work, they may want to talk with staff about adding them to their Advance Crisis Plans.

**Conclusion:**

Ask them to put this card in their pockets or somewhere else that is convenient, so they can refer to it whenever they feel they need a break or when they are stressed out. Eventually, however, these approaches will become second nature, and they will not need their cards anymore.

**②Relaxation**

**Purpose:**

To show patients how to use simple relaxation techniques to help them de-escalate or unwind when they're feeling tense (which can be used in the hospital or the community)

**Introduction:**

"There are times in everyone's lives when things get stressful or tense. It is quite common to hold this tension inside, sometimes until it builds up and causes physical and mental health difficulties. Relaxation techniques are simple and convenient ways to release tension and prevent these potentially harmful situations. In this session, we will be going over two easy and effective relaxation techniques."

**Facilitator:**

If you have it, put on some relaxing or calming music. Ask everyone to spread out around the room, so that they have plenty of personal space. Tell them that when they do relaxation exercises at home, they can incorporate things that they find soothing, such as turning down the lights, lighting a candle, or putting a warm washcloth over their eyes.

**Exercise 1:**

Ask the group to sit as comfortably in their chairs as possible, closing their eyes if they feel comfortable doing so. Otherwise, ask that they focus on something on the wall, outside the window, or anything else that helps to calm them and keep them in the present.

Ask the group (using a calm, quiet, soothing voice) to take a few deep, slow breaths, in through the nose and out through the mouth, allowing themselves to begin to experience a sense of calming. As they breathe out, ask that they imagine themselves letting go of tension and anything else that is troubling, confusing, or cluttering.

As they take their next deep breath inwards, ask that they tense the muscles in their arms and hands. As they exhale, ask them to release this tension, at the same time imagining themselves releasing feelings of heaviness and stress. Repeat twice. On their next deep inhalation, ask the group to tense the muscles in their legs and feet, and release the tension and the stressful feelings upon exhalation. Repeat this twice. Continue this same process three more times, doing two repetitions for each, once using their stomach muscles, once their neck and face muscles, and once their entire bodies.

Finally, ask them to take a few more deep, slow breaths, allowing themselves to savor this sense of calm, and then, ask them to open their eyes and sit back upright in their chairs.

**Facilitator:** While the group can use this technique any time they feel stressed out or want to relax, they also can use a mini-version of it for a quicker “pick-me-up.” Let them know that this quick relaxation technique may be useful if they feel triggered on the unit.

**Exercise 2:** In this mini-version, ask the group to tense all of their muscles as they inhale deeply, and release them as they exhale. Ask them to repeat this twice and to savor the feeling of calm as they release tension. Request that they end by taking a few long, deep, relaxing breaths.

**Conclusion:** Remind the group that it is healthy and positive to learn to release tension and stress in their lives. Ask that they give relaxation techniques a try next time they have these feelings, in or out of the hospital. Perhaps those who still are on the unit/in the program can share their experiences during the next group meeting. If deep breathing works for them, then they may wish to discuss with staff adding this to their Advance Crisis Plans.

### **③Keeping safe**

**Purpose:** To go over the meaning of “safety” and some general ways to facilitate keeping themselves safe on the unit or in the program

**Introduction:** “Self-soothing is a powerful technique that you can use when you are feeling tense, stressed, or overwhelmed. Self-soothing also can be done when you are feeling unsafe. In this session, we are going to talk about ways to feel safe by talking about what safety means. We’ll also talk about some things that you can do to help you feel personally safer.”

**Discussion:** Ask the group to talk about what “safety” means to them, and write their answers on a flip chart or board, if possible.

**Facilitator:** It is important to allow each group member to share a definition of safety, as the next discussion will build directly upon her/his answers. Therefore, give each person time to think before answering, and encourage exploration by asking questions such as “why,” “how so,” and “could you explain what you mean by that?”

**Discussion:** Now, ask the group what kind of things they can DO to facilitate this sense of safety, and write those answers on the chart or board. Encourage discussion and sharing among the group.

**Facilitator:** Most likely, the group members will have many different and varying ideas on this topic, focusing on both things that they themselves can do to feel safer, as well as things that others can do for them. This distinction is important to point out, as a sense of safety often is affected by others’ understanding of and reactions to our needs. This knowledge can help each member to respect and respond to their peers’ needs for safety while on the unit or in the program.

**Conclusion:** Explain to the group that increasing feelings of safety is the primary goal of Advance Crisis Planning on the unit or in the program. Recognizing and understanding their own feelings about safety is the first step to learning more about calming and de-escalation. The second step is to actually use calming techniques to feel safer and more in control.

#### **④Physical boundaries**

**Pre-session:** Prepare the room for the boundaries exercise by moving any furniture to the side, and creating large square, triangular, and rectangular shapes with masking tape on the floor of the group room. Make these shapes large enough to stand or sit in, with some closer together and some farther apart. Make approximately five more boxes on the floor than

there are group members. This should take about twenty minutes for you to complete prior to group.

- Purpose:** To explore the importance of personal space, and do a short exercise to make patients more aware of their own personal, physical boundaries
- Introduction:** "People who have been in mental health treatment often have had their physical space violated, through such things as medical testing, room checks, and the use of physical restraints. Therefore, these clients may have a hard time understanding what constitutes safe personal space. This session will help us to develop a better understanding of the importance of personal space, as well as become more aware of our own personal physical boundaries."
- Discussion:** Ask the group what they think the word **boundary** means, and allow for a brief discussion of the word.
- Exercise:** Tell the group that the shapes on the floor represent boundaries. Ask them to choose one shape, inside of which they would feel safest and most comfortable. Then, ask them to stand or sit in this shape in whatever way makes them feel most comfortable or safest. Give them about five minutes to choose and to sit/stand comfortably in their chosen shape.
- Discussion:** Once the group is finished, ask each member why he or she chose that particular shape, what is the location of the shape, how far or near it is to someone else's shape, whether he or she is facing or turned away from others, and which other shape he or she would choose if offered a chance.
- Facilitator:** This is an opportunity for you to be creative and point out the ways individuals chose their shapes. Make the connection that this is symbolic of the different needs of different people. Also point out the importance

After the list is generated, open a discussion about which methods they think are healthy, and write a positive sign next to those, and which ones they think are unhealthy and write a negative sign next to those.

**Conclusion:** Finish this session by going over all of the positive methods that the group mentioned, and discuss how the group can use these more often. If there is time, you can discuss how some of their effective anger management techniques could be added to their Advance Crisis Plans.

### ⑦ Aggressiveness vs. assertiveness

**Purpose:** To go over how to ask for what they need using an assertive approach (by learning to control voice volume, hand gestures, mood, responses when asked to do something they don't like, etc.)

**Introduction:** "Sometimes, we might have a hard time telling the difference between assertiveness and aggressiveness. Assertiveness is when a person stands up for her rights, expresses personal beliefs, values, or needs, requests to be treated with respect, says no when he does not want to do something, accepts compliments or criticisms comfortably, and disagrees with others without losing her temper. Aggressiveness is when a person expresses himself in an angry, intolerant, and/or offensive manner. Assertive, rather than aggressive, interactions lead to the best feelings for everyone involved.

**Discussion:** Ask the group to give examples of ways to assertively request something from a staff member at either the hospital or a community program, for example, a razor with which to shave. Allow each group member to practice this assertive approach.

Now, ask the group to make the same request, but this time aggressively. Allow each member to make this request aloud to the group.

Initiate a discussion on the differences between the two approaches in terms of how they changed their voice volume, hand gestures, demeanor,

## **⑥ Dealing positively with anger**

**Purpose:** To explore positive approaches to manage anger

**Introduction:** “Anger is a perfectly normal, human response that we all feel sometimes. The challenge, however, is finding ways to deal with it that are not harmful to us or others in our lives. Even though it may seem beneficial in the short-term, venting anger by “blowing up” often causes more harm than good for everyone involved.”

**Facilitator:** Remind the group that there is a range of consequences for expressing intense anger, both in the hospital and out. Some examples include: losing friends or being generally disliked by others; increased physical ailments (such as headaches or increased blood pressure); being “written up” in treatment records as being “explosive,” a “risk for harm to self and others,” or even “dangerous,” being kicked out of a program; and being at higher risk for restraint and seclusion.

**Discussion:** Ask the group to describe methods of coping with anger that they themselves have used or that they have seen others use, and write the responses on a chart or board under three separate headings:

1. Problem-solving techniques (e.g., talking with someone, writing a letter, asking questions)
2. Ways to cool off or expend the negative energy (e.g., listening to music, exercising, fighting, using humor)
3. Methods of distraction (e.g., substance abuse, eating, forgetting, ignoring)

**Facilitator:** Explain how each coping method they suggest fits under one of these headings; once they get the hang of it, ask them to place their suggested methods in one of the three categories. Point out again that there are various methods for coping with anger, and most are valid even if not entirely healthy.

**Discussion:** Ask the group what they think it means to have a positive, healthy sense of self, and write their answers on a chart or board, if possible. Next, ask the group what it means to have low self-esteem, and write out those answers as well. Point out and discuss the differences between the two.

**Exercise:** Pass out index cards with "MY STRENGTHS AND ACHIEVEMENTS" written across the top, and pens. Explain to the group that they should write their personal strengths and achievements on these cards (you should help those who have difficulty writing). Allow approximately 10 minutes to complete their cards.

**Facilitator:** Tell the group only to use sentences that start with "I" such as "I have a good sense of humor," or "I am courageous." Some other examples you can suggest to get people going are: I came to this group to help myself; I am determined; When I set my mind to something, I persist; I am a good friend, etc. If someone says that s/he just can't think of anything, suggest something positive about her/him based on what you've seen on the unit or from group interactions (e.g., "I think you are a good listener" or "I think you have a lot of strength because you have survived a lot of tough stuff in life.")

After they have completed their cards, ask each member to get up in front of the group and read her or his favorite self-statement. Remind them that doing this does not mean they are vain or stuck-up, but that they are able to recognize their own strengths and achievements. Many members may giggle or laugh when making the statement, but still will be able to do it with enough encouragement. If someone doesn't want to participate in the activity, she or he should not be forced.

**Conclusion:** Ask the group to give themselves a hand in congratulations for all of their achievements, and recommend that they try to say something positive about themselves in the mirror every day to feel better about themselves.



of respecting others' physical space, and how we all have different needs in this area.

After each person talks about his/her choice of shape, ask the group to talk about how much physical space they need in their relationships, as well as in different situations, such as on a bus, in a group meeting, in a hospital room, or in a waiting room. Point out the inherent differences in need for space depending on the situation (e.g., being at home versus in the hospital or a public place) and familiarity with others (e.g., being with loved ones versus case managers, nurses, other clients, or strangers).

**Conclusion:**

Close the session by initiating a short discussion about things they can do to maintain a comfortable amount of personal space while on the unit or in the program, and write their answers on the chart or board. Of course, if the clients are in the hospital, it is sometimes not possible to avoid a violation of personal space. Nonetheless, there are things they can do to maximize their control over boundaries. Some examples, if they have trouble, are standing 3-4 feet away from people with whom they interact, moving to another chair if someone is sitting too close to them, or requesting some time alone in their rooms.

**⑤Self-esteem**

**Purpose:**

To go over the meaning of positive self-esteem, and ways in which they can nurture a positive sense of self by recognizing their strengths and achievements

**Introduction:**

"Many people in American society struggle to develop positive self-esteem, since our larger culture and media tend to focus on unrealistic ways people are supposed to look, feel, and act. Often, feelings of inadequacy and self-doubt arise when people cannot reach these ideals in one way or another. Having a diagnosis of mental illness, due to the stigma and misconceptions surrounding it among the public, can further complicate the development of positive self-esteem."

and mood for each. Ask the group to brainstorm how the person to whom they are making the request would likely react to each approach, and why.

***Facilitator:***

Initiate a discussion about how it is more beneficial and effective for them to use assertive approaches when asking for things. Also point out that there will be times when using assertive methods will NOT get them what they are requesting, due to rules on the unit/in the program or other circumstances, and they must be prepared to accept this fact in a mature fashion.

**Conclusion:**

End this session by discussing how they would feel if someone asked them for something using an assertive approach versus an aggressive approach. Tell them that, inside and outside the hospital, people respond much more positively to assertiveness.

**⑧Limit setting**

**Purpose:**

To talk about how limit setting is an important, yet difficult, part of feeling more secure and in control of situations in their lives. To discuss barriers to effective limit setting, as well as past success in limit setting.

**Introduction:**

"Setting limits is an important part of feeling in control and safe. By limit setting we mean being able to say "no" to something you can't do, letting people know of your needs in a respectful manner, or being able to put appropriate conditions on requests ("I can do X but not Y). The first steps in getting more comfortable with setting limits are: understanding that, within reason, we deserve to get what we want; deciding what we want; and making a conscious choice to pursue what we want. This is a continual process that often takes time and effort. The goal of this session is to explore getting more comfortable with setting limits through making conscious choices."

**Facilitator:** Begin by telling the group that, while it may seem like an easy thing to do, setting limits on others' behaviors, requests, or actions can be difficult and scary. There are many reasons why it can be hard to say no or to set limits:

1. First of all, many people are raised to believe that putting oneself first is selfish, while pleasing others above all else is unselfish.
2. Secondly, it can be difficult to accept that it is truly okay for us to refuse others' requests, especially during those times when we have our own needs to consider.
3. Third, saying no can be hard because it takes an understanding that we will not always be able to give others what they want. It is hard for all of us to disappoint loved ones, friends/peers, coworkers, bosses, etc., but sometimes putting oneself first may involve just that.
4. Finally, setting limits can be scary because it may make some people angry, but conversely, others will come to respect us more for being strong and decisive.

**Discussion:** Ask the group to brainstorm situations and conditions in which they had a hard time setting limits (or saying no) and the reasons why, writing their responses on a chart or board, if possible. Discuss the similarities and differences in their answers, connecting them to the four points above. Now ask the group in what situations they have set limits on others, why it was necessary to do so, and how it made them feel, writing these responses on the chart or board.

**Facilitator:** Make the point that sometimes we cannot refuse certain requests, even when we don't want to meet them, such as those made by bosses or our children. Making sacrifices is a part of adult life, but we want to be sure that we're not being "walked on" or treated poorly. Make a conscious effort to point out and praise the fact that they already have been able to set some limits in their lives, and these achievements should be used as proof and motivation for them to continue setting appropriate limits.

**Conclusion:**

End the session with a short discussion on how they can use effective limit-setting in the future to continue to feel more secure and in control of their lives.