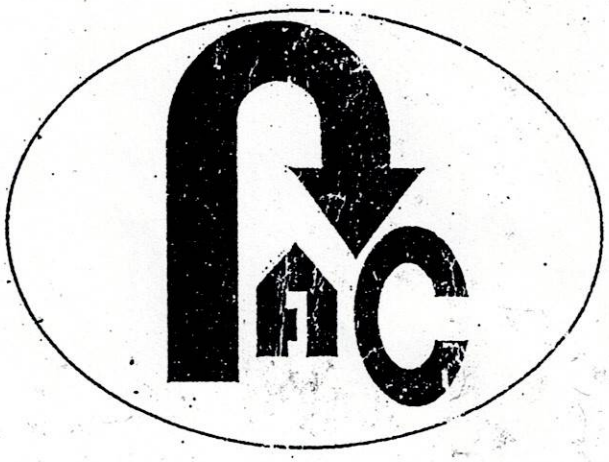

Proactive Alternatives for Change

Training Component

Trainee Packet

PROACTIVE ALTERNATIVES FOR CHANGE

TRAINING COMPONENT

TRAINEE PACKAGE

The enclosed materials are intended for your use following, initial PAC training. The package is divided into the following:

I. Philosophy
II. Understanding Violence
III. A Systematic Approach to Treatment
IV. Non-physical Intervention Techniques
V. Physical Intervention Techniques

This package is not to be reproduced for general distribution, nor is it intended to be used as a substitute for formal PAC training. It is, rather, a guide for you and your fellow PAC Trainees to be used as you review, discuss, and practice PAC treatment philosophy, treatment plan formulation, and intervention principles and strategies.

If at any time during your initial PAC training or at any time during the year, you or your fellow Trainees feel the need for assistance, do not hesitate to contact directly those individuals who were your PAC Trainers. There is any inherent responsibility and bond between PAC Trainees and Trainers that crosses professional, administrative, and agency lines. That responsibility and bond begins with a common commitment to work with those individuals who come into care in a humane, respectful, and therapeutic manner.

I. PHILOSOPHY

PAC Training encompasses a wide variety of therapeutic interventions for the prevention of aggressive behavior. In everything we do, our primary mission is to insure the safe, humane, and dignified treatment of individuals by equipping you with a broad repertoire of mental, emotional, and behavioral skills. In this process, we adhere to the following principles:

A. **Empathy** - All interventions must be built on the foundation of an empathetic understanding of the needs of the individual.

B. **Prevention** - Prevention of violent incidents should be our first concern and can be accomplished to a significant degree with effective assessment and planning.

II. UNDERSTANDING VIOLENCE

A. *The Nature and Causes of Violence:*

1. Aggression is an inherent part of human nature.
2. ~~Aggression is a consequence of social learning that is reinforced in the environment.~~
3. Aggression is a consequence of frustration and life situations.
4. Aggression is a means of communication.
5. Aggression is a means of territorial protection of space.

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B. *Cycle of Escalation:*

1. Individual experiences feelings of entrapment, helplessness, and vulnerability.
2. Individual is then impelled to reduce these psychological/physiological feelings
3. Individual resorts to behaviors, which give feelings of control and perceived reduction of stress.
4. The violence gives intense/immediate POWER, while decreasing anxiety temporarily.

C. *Principles of Violence*

1. Violent feelings usually grow over time
2. There are usually warning signs.
3. Individual often fear their loss of control.
4. Violence is short-lived, calm is longer, equals periods to work with individuals.
5. Violence brings out feelings in staff (Awareness helps to not over/under react).

D. *Potential Causes of Frustration:*

1. Sense of lack of control over a situation or one's life
2. Lack of support
3. Attention needs
4. Frustration
5. Medical distress
6. Not being able to express oneself or be understood
7. Sexual suppression
8. Lack of privacy
9. Lack of sleep
10. Hunger
11. Self-image
12. Having to meet a deadline (pressure)
13. Interpersonal conflict
14. Family problems
15. Loneliness
16. Living conditions
17. Others' tensions
18. Change
19. Lack of stimulation
20. Too much stimulation
21. Lack of money
22. Expectations that are too high or too low

23. Learned, maladaptive behavior
24. Physical impairment (limitations)
25. Weather
26. Moon
27. Death (loss)
28. Disappointment
29. Addictions
30. Success

E. Comprehending Assault:

When working with potentially assaultive individuals there are several points to keep in mind.

1. **Your response**

It is natural to have a powerful response to violence or the threat of violence. As. members of the animal kingdom, we share many of the physiological responses common to other animals. When we feel threatened, our pulse quickens, muscles tense, breathing becomes shallower, and senses become more alert the classic "fight/flight" response. These bodily experiences affect our capacity to evaluate and respond to the escalating individual. Our ability to moderate our responses and avoid either extremes will increase effective management of these situations.

2. **Fear**

Escalating individuals often fear their own loss of control. Having remembered the consequences of their last outburst (restraint, seclusion, guilt, shame, isolation from others, etc.), some individuals will inform staff of an impeding loss of control by asking to be taken to the seclusion room, etc. Two means of reducing this fear are expectation and control. Over and over again, research demonstrates that individuals respond to the expectations of those around them. If we expect violence, we will tend to get it. If, on the other hand, we expect self-control, we will tend to get that. Communicate your expectations that the individual will remain in control. Also helpful is reassurance about the availability of external control: "We will keep you and others safe through seclusion/time out, restraint, or medication if necessary."

3. **Time**

Most assaults are the result of feelings that have grown over time and eventually become intolerable. Understanding and recognizing cues and hierarchies, therefore, and intervening at early point in this process of escalation are crucial. Most people, however, do not have a cut off point: if violent feelings exceed a certain level, violent behavior will follow.

4. **Vulnerability**

Many people who become violent do so out of feelings of powerlessness and vulnerability. Helping this person feel stronger and safer is a major means of reducing the threat of assault.

5. **Cues**

Most people exhibit "cues," or warning signs that indicate their intention to assault. Knowledge of these and their typical order of occurrence is a key aspect for the prevention of assault.

III. A SYSTEMATIC APPROACH TO TREATMENT

The treatment plan is the key element in successful intervention with the "potentially aggressive individual." In the absence of a plan, we move like a ship without charts or a rudder from intervention to intervention, with little sense of where we want to go or what it takes to get there. The interdisciplinary, holistic treatment planning process provides us with a clear vision of what needs to be accomplished as well as the tools to make it happen. The following is a guide/outline that is intended to be used when formulating treatment plans for the involved individual. Each component builds on the previous component, starting with clinical assessment and following through to treatment plan review. Each component has a value of its own but is more fully appreciated when it is seen as part of the whole. Assess and develop treatment plans only after all essential information is obtained and all treatment team members are familiar with the individual being planned for.

Treatment Plan Formulation includes:

A. History (clinical) birth – 6 months ago
B. Current Status 6ago – now
C. Strengths/Capabilities
D. Areas of Need/Needs Assessment
E. Cues
F. Hierarchies
G. Baseline Information
H. Intervention Principles and Strategies
I. Treatment Plan Formulation

A. HISTORY

A clinical history provides essential information needed in the assessment of and treatment planning for a particular individual. A clinical history should be inclusive from birth to the current status assessment and should state that we are looking for factual information that will be brought to the team for interpretation. There will always be some degree of interpretation when gathering information, but it should be a team effort as much as possible. Individual history includes 4 areas:

1. Medical
   a. seizures
   b. organic
   c. bio-chemical
   d. hospitalization
   e. medication (list)
   f. significant information

Allergies

2. Social
   a. family
   b. institutional
   c. peer relations
   d. social skills
   e. community exposure
   f. community skills
   g. sexual identification
   h. significant information

3. Psychological
   a. diagnosis
   b. hospitalization
   c. evaluation data (testing)
   d. medication history
   e. treatment interventions (results)
   f. major needs
   g. significant information

4. Program/History
   a. work/educational experience
   b. functioning potential
   c. peer interactions
   d. work/educational as a positive ?
   e. work/educational as a negative ?
   f. significant information

B. CURRENT STATUS

The current status is a summary assessment of the present functioning of an individual in several specified areas. When gathering information for a current status assessment, the records from 6 months prior to the assessment should be reviewed and any major changes noted. Current status includes 4 areas:

1. Medical
   a. medical needs assessment
   b. medications
   c. immediate concerns

2. Social
   a. family involvement
   b. peer relations
   c. community experience

3. Psychological
   a. mental status – awareness of time, place and person
   b. assessments
   c. potential for self-abuse, aggression
   d. supportive interventions
   e. medications

4. Program/History
   a. daily routine
   b. degree of structure support needed
   c. reaction to structure
   d. communication skills

C. STRENGTHS/CAPABILITIES

+ Weakness

A list of individual strengths should be developed from the information in the history and current status. Strengths include the individual's skills, interests, and any positive responses to people or programs that the individual has been involved with. Treatment plans should be built on individual strengths as well as need areas, and a list of assets may help determine the general approach the team will take (e.g. responds to verbal praise, enjoys music, able to express needs, family involvement).

D. AREA OF NEED/NEEDS ASSESSMENT

Combine historical assessment with current status information to identify objectives and essential life needs. Assess each individual with historical perspective, environmental awareness, and psychological appreciation. This combination will aid in the development of an accurate needs assessment.

E. CUES

Cues are observable actions that may reflect a pattern of behavior leading to a particular action.

Examples include:

pacing
rapid speech
sweating
teeth grinding
rocking
muttering
self-abuse
withdrawal
voice change
self stimulation
personal hygiene
facial expressions
touching
working
spitting
stripping
incontinence
crying
continual laughing
talking to self
waving hands
abusive language
hallucinations
physical abuse
smiling
laughing
socializing

H. GUIDELINES

Guidelines for developing specific interventions and comprehensive treatment plans have been developed by DMR/DMH. We are mandated to follow these principles when developing an individual's service plan (ISP).

Contracts, treatment plan procedures, reinforcement opportunities, and any restriction of rights must be reviewed and negotiated with the individual to the extent possible.

The treatment plan must:

1. Be within DMR/DMH Human Rights Guidelines and Regulations.
2. Be individual-centered and should incorporate input from the individual whenever possible.
3. Be developed with specific goals and objectives.
4. Have staff consensus.
5. Have consistent delivery.
6. Be consistent with overall treatment plan.
7. Include baseline date in its development.
8. Be movement oriented.
9. Be time limited.
10. Have an established review process.

IV. NON-PHYSICAL INTERVENTION TECHNIQUES

To be consistent with the philosophy of using the least restrictive intervention whenever possible, we must be ready with a variety of effective responses. Often times it is possible to entirely avoid the necessity of using physical interventions with an escalating individual by the use of the following less restrictive alternative interventions:

1. ASSESSMENT SKILLS & SELF-AWARENESS

Although not intervention per se, the ability to rapidly assess the level of escalation of a given individual at a given time is necessary to the successful use of any intervention. In addition, your ability to be conscious of your feelings and your behavior in a crisis situation will be a key ingredient in determining your ability to be effective.

a. Recognize Danger Signals

Though the best predictors of violent behavior is a history of the use of the same, we can never truly know what is going on inside another human being. We can however, make educated guesses and predictions based on the observation we make of behavior and environment. You should be on the lookout for changes in several key areas. Any of these can be an indicator of inner turmoil and thus a clue to proceed with caution.

Physiological

- Physical illness or pain, particularly in psychotic and/or non-verbal individuals
- Sleep patterns; irregularities or loss of sleep
- Malnourishment or excessive consumption of caffeine
- Intoxication: alcohol or other drug
- Medication change
- Surgical Intervention

Behavioral

- Clenched fists
- Rapid, choppy gestures
- Arms wrapped around self tightly
- Distancing from others
- Pacing
- Glaring/angry staring
- Rapid/heavy breathing
- Tension, rigidity
- Nervousness/jumpiness
- Lack of response
- Suddenly quiet

Verbal

- Loud voice
- Rapid rate of speech
- Statements of frustration, mistrust, rage
- Insistent demands for attention
- Request for control (e.g. "Give me some meds")
- Verbalized fear of losing control (e.g. "I feel like I'm going to kill someone."; "I'm going to loose it." ; "I'm going to explode.")
- Response to hallucinations, especially those "commanding" individuals to hurt/kill others
- Verbalized persecutory or grandiose delusions
- Threats

Environmental

- Intimidation by another individual
- 'Baiting' by staff
- Visitors
- Losses (living arrangements, job, family, etc.)
- Denial of privileges
- Proximity of discharge, commitment hearing, etc. ?

These are only a few of the many indicators of imminent violence commonly reported by workers in the mental health field. In addition to the ones noted above, each individual also has unique cues of impending behavior that can be derived through observation and gathering of good Clinical History.

b. Staying Conscious

When confronted with an angry, escalating individual, the natural response is often to 'freeze up' mentally and act on instinct rather than rationality. Awareness is vital to gaining control of yourself and the situation.

Emotion

It is much more helpful to be honest with yourself about how you feel when threatened (e.g. afraid, angry, etc.) than to attempt to deny it or to cover it up with bravado. The latter is a sure way to further escalate the situation.

Non-Verbal Communication

When people escalate into the potentially assaultive state, the higher functions of the brain are reduced with the lower, more primitive and instinctual parts assuming more prominence. When this happens, less attention is paid by the escalated person to verbal communication. Therefore, what you as an intervener are doing with your body --your non-verbal behavior-- becomes a much more powerful channel of communication.

Non-verbal communication is an exceptionally powerful means of transmitting and receiving feelings. By definition: **messages between people given without words.**

Non-verbal communication is transmitted by:

1. Voice tone and pitch (paralinguistics)
2. Body movement, position, and posture (kinesic)
3. Spatial relations or distance between bodies (proxemics)
4. Touch (haptics or tactile)

The essence of our safety is conveyed to our aggressor through sound, touch, and positioning of our body and body parts. Slapping, grabbing, and gripping are cues that project our own fearful over-reaction and should never be utilized.

Remember, if you feel anything strongly about another person, you are probably leaking this into the environment. Constant awareness to our non-verbal communication is very important. Need to: Learn when we do it and how to know.

2. NON-VERBAL BEHAVIOR: WHAT TO AVOID & WHAT TO DO

Face & Eyes, the most communicative parts of the body.

Avoid:

1. Staring. A direct, unblinking stare is very aversive and can be interpreted as challenging.
2. Deadpan, expressionless face. This evokes negative feelings.
3. Grinning. May be interpreted as "laughing at me" (ridicule).
4. Winking. May be interpreted as flirting (sexual connotation).

Do:

1. Make intermittent eye contact.
2. Keep your face animated.

Voice tone/rate: How you can say something to an escalating individual is often more powerful than what you say.

Avoid:

1. High pitch, high volume. It connotes fear/hostility.
2. Rapid speech. It can also connote fear.

Do:

1. Speak slowly, softly, with low volume to project calm and control.

Space: Understand that as a individual escalates, his/her "threat zone" gets larger.

Avoid:

1. Crowding
2. Standing above
3. Fast movement towards individual

Do:

1. Give horizontal space back off ?
2. Equalize vertical space -- sit if individual is sitting
3. Move slowly when approaching

Body Cues: These will often be sensed first and outweigh whatever words you might say.

Avoid:

1. Rigidity conveys fear
2. Clenched fists conveys hostility
3. Direct face to face confrontation conveys challenge
4. hands in pocket
5. arms crossed
6. pointing ?

Do:

1. Be as relaxed as possible
2. Have open hands
3. Stand at 45 degree angle to individual

Tactile Cues: Recognize the escalating individual's exaggerated sensitivity to touch.

Avoid:

1. Touching; it can be interpreted as assault.

Do:

1. If you must touch, avoid areas that could be construed as sexual.
2. Always tell the individual that you will be touching them as well as where and why.

3. ✶ NON-PHYSICAL ALTERNATIVES

A. Giving Space
B. Verbal Intervention
C. Redirection
D. Ignore
E. Reinforcer others Peer - pressure?? Turn - over
F. Humor
G. Relaxation / Exercise Time out
H. Modeling

A. GIVING SPACE

Everyone has a "comfort zone" of space that physical distance from others with which we feel comfortable. When someone intrudes on that space, we feel threatened. For escalating individuals, that space tends to grow as their anger, fear, frustration, etc., increases. Space can be thought of in terms of physical distance or time away from a heated situation. Giving space to a individual can often help him/her to regain control by separating him/her from the source of anger or frustration for a period of time.

For example: John is becoming anxious and aggressive during break time because there are many individuals in the small workshop and they are loudly enjoying their free time. Some good things to say might be, "John, why don't you go sit in the lounge until the end of break or "John, let's take a short walk together outside."

B. VERBAL INTERVENTIONS

Your mouth and your ability to use it effectively are your most valuable tools in dealing with the individual who is escalating. It is in employing verbal techniques that you will be able to bargain for time, let the individual know that you are attending to his/her concerns, and, therefore, defuse a crisis in the making.

There are a couple of things to keep in mind when considering verbal interventions. First, are you the best person to intervene? It may be that a particular staff person has built a rapport with a given individual and should, therefore, be brought into the process. Secondly, is this the time for verbal intervention? When many individuals reach a certain point in the hierarchy of cues, verbal intervention may be ineffective and may also serve to aggravate the situation even more. Finally, avoid an authoritarian stance -- don't shout, command, demand. Sound like an ally rather than an authority/enemy.

Having rapidly assessed the situation and concluded that your verbal intervention is the best course of action, try the following strategies:

1. <u>Report and Reflect</u> to the individual what you observe about their behavior and what they may indicate about their feelings state, e.g., "Gee, Mary -- you're clenching your fists. You look angry."

2. Accept. When a individual does tell you what they're feeling and why, be prepared to accept their statements without judgment or defensiveness.

3. Clarify. Help the individual to narrow their focus on issues specific to their anger. Attempt to prevent the snowballing effect of run-away anger.

4. Model. People tend to imitate each other. By consistently maintaining your poise, you encourage your individual to do likewise. There are several ways to convey coolness in the face of agitation. SLOW DOWN TONE DOWN. SOFTEN UP.

   a. Slow Down
   We tend to speak rapidly when we're afraid or angry. Slow down the rate of your speech.

   b. Tone Down
   When we're afraid or angry, our vocal chords tighten and our voices sound higher. Relax your vocal chords and lower the tone of your voice.

   c. Soften Up
   Angry and frightened people often tend to speak loudly. Convey your level-headedness by softening the force of your delivery to just below normal conversational level.

5. R.A.S. = Reassurance and Support When individuals exhibit the behavior of escalation, they are usually feeling fearful of their own potential loss of control as well as of the violence of others. Your assurance that you are there to help and provide a safe environment is important to your individuals. Your statements of support and confidence in their ability to cope are highly valued.

6. Be a Person: Personalize and individualize your encounter to avoid the "us/them" mentality that produces fear, anger, and "pre-emptive strikes."

7. Ask the individual what would be helpful.

8. Respond to valid concerns: The individual's bad feelings may be the result of an external situation that can be rectified or of a misunderstanding that can be corrected.

9. Expand the individual's options: The more upset we get, the more we tend to have "tunnel vision." Offer and explore alternatives to physical acting-out.

10. Set limits: Let the individual know that you will not allow people to get hurt, either they themselves or others. This must be used judiciously and respectfully as it can by interpreted as a challenge.

11. Listen: Use active-listening skills to let the individual know that you are hearing them. When we are afraid, we tend to get rigid and quiet. This will make most individuals feel that we are not "with" them and intensify their anger.. Loosen up, nod, gesture, say "uh-huh", paraphrase what's been told to you, reflect feeling, etc.

C. REDIRECTION

Redirection consists of involving a individual who is beginning to escalate in an activity which is enjoyable to them in an attempt to distract their attention from the source of the anger and to channel the destructive impulses of the moment towards a more appropriate activity.

For example: John is being teased by Mary at the counter before cooking class. He becomes upset and threatens to hit her. Redirection would consist of saying something like "John, please go over to the stove and start stirring the soup for us." (Stirring soup being an activity that he enjoys.)

D. IGNORE

Ignoring the target behaviors can be very effective during early stages of escalation. Often times individuals are looking for staff 's attention and have learned that negative behaviors can get staffs attention. Ignoring involves staying neutral and not providing any interactions with the individual while they are exhibiting early stage negative behaviors.

E. REINFORCING OTHERS

Another effective technique in working with individuals who are exhibiting early stage negative behaviors is to reinforce other individuals who are engaging in positive behaviors. For example, it is dinnertime and typically a family style meal is served and four individuals and two staff usually share their meals. John comes to the table and appears slightly agitated and begins to raise his voice and bang his knife on the table. Staff's initial interaction is to verbally reinforce John's peers for having nice dinner manners, sitting quietly and sharing events of their day. If John wants staff attention he may quickly follow the appropriate mealtime behavior of his peers. John should receive immediate feedback from staff if he in fact lowers his voice and stops banging the knife on the table.

F. HUMOR

Humor can be very effective in distracting an individual from their source of frustration. Caution should be used whenever trying this technique however, as you must know the individual very well so your intervention is not misinterpreted.

G. RELAXATION

Relaxation may include deep breathing exercises, massage, taking a warm bath etc. These procedures should be developed through the team process with input from a trained clinician. Again, you must know the individual well to determine if they are responsive to these type of interventions especially if they have a history of being tactilely defensive i.e., do not like being touched.

H. MODELING

Modeling refers to staff demonstrating the behavior they would like the individual to display. This can be very effective during early stages of escalation and staff shows the individual how to calm. For example, Mary is getting very agitated about a situation at work and is not responding to direct verbal intervention. She begins to raise her voice, speaking very rapidly, and her body is very tense. You continue your verbal intervention but model for Mary speaking slowly and quietly in a relaxed manner i.e., SLOW DOWN, TONE DOWN, SOFTEN UP.

V. NON-VIOLENT PHYSICAL INTERVENTION

The following techniques are used as a last resort to control physically aggressive behaviors that endanger the individual, other individuals, staff, or others when other interventions outlined in an individuals treatment plan are not effective. They are presented in a sequence of least restrictive actions to most restrictive. Least restrictive measures (non-physical) should always be utilized first, whenever possible. Palms are always open because an individual may read aggressive cues into a closed fist.

A. ✶ PRINCIPLES OF PHYSICAL ENGAGEMENT

1. Attitude: Our concern is for the welfare of all involved, the aggressor included. Approach the intervention with empathy and caring, not as the "enforcer" or "victim." The latter two will more likely get you injured than the former.

2. Affiliation: not confrontation, should be the basic mode of approach non-verbally, verbally, and physically. One of the ways we convey this is through a natural posture with open palms.

3. Balance/Imbalance: Your ability to maintain balance especially when in motion is crucial. Many of the interventions described below combine this ability with that of unbalancing an aggressor to effect release or control.

4. Full Body Force: A small person using the focused force of their whole body can be much more effective than a large person relying only on the strength of their arm or leg. We, therefore, teach you to use your whole body when intervening, paying special attention to maximizing the often forgotten power in your legs.

5. Flexibility: Many injuries result from adopting a rigid posture when threatened. The capacity to be loose, to retreat in a fluid manner, and to avoid blows smoothly are important components of all interventions.

6. Rotation: Rather than attempting to meet force with force, it is usually more helpful to diagonally rotate away from a grasp or a blow.

7. Leverage: Just as one can lift a 400 lb. boulder with a 2 lb. board, so can we use our limbs and whole bodies to gain release and control with aggressive individuals.

8. Natural Exits: Whenever an aggressor grasps, holds, or chokes, there is a "natural exit" through the weakest point where the fingers and hands meet. Focused full-body force, rotation, and leverage are directed at these areas.

9. Redirection of Energy: Moving with and redirecting the force of an aggressive act (e.g. a punch) is much more effective and healthy than attempting to stop it with your body.

10. Modulation and Disengagement: As noted earlier, we avoid giving "Threat Cues" by matching the force of intervention to the degree of escalation exhibited. It is also important to disengage physically as soon as the resistance or intensity diminishes.

B. BLOCKS AND EVASIVE MOVEMENTS

are used when an aggressor is striking, kicking, or flinging objects. These size defensive movements and awareness. In situations where an aggressor is in the of striking another, the employee should be in a position to block or grab the arm of the aggressor committing the act, or pull (don't push) the threatened party danger.

1. Hands in Front of Face

- For defense against objects being thrown
- Place both hands close together, palms facing outward, thumbs crossed behind ?
- Place in front of face, spread fingers, and turn head slightly to side
- Block thrown object down and away

2. Side Step

- Turn body to side, keeping palms open
- Keep eyes on aggressor as you back away
- Maintain balance, don't get cornered

3. Arm Deflection

- Use forearm between elbow and wrist and open palm to deflect blows coming at you
- Do not cross midline
- Meet blows, don't strike out, side step away

4. Parry -- For straight punch

- With arm on same side as punch, make hand contact with outside of aggressor's forearm
- Guide inward and away towards midline
- Pivot on front foot to 45 degree angle
- Side step away with open palms

Variation – To gain control

- With arm on same side as punch, make hand contact with outside of aggressor's forearm
- Guide inward and away towards midline without releasing aggressor's arm
- Pivot on front foot to 45-degree angle
- Grasp Wrist with opposite hand, sliding other hand Up forearm to above the elbows
- Execute two-person arm hold (if help is available)

5. **Parry For overhand blows (with or Without weapon)**

- Step towards aggressor with opposite side foot than aggressor's arm
- With opposite side arm, block arm underneath between aggressor's elbow and shoulder
- Guide arm away from you and side step away

Variation --To gain control

- While guiding aggressor's arm, slide your arm down and grab aggressor's wrist
- With other arm, execute one person arm hold (if help is available)

6. **Redirect**

- Use arm deflection, blocking aggressor's arm between the elbow and wrist
- Grasp aggressor's arm briefly, rotating individual 1/2 turn to the side, and direct away from you
- Push off on shoulder is optional

C. RELEASES

These are used to disengage from an aggressor who has made physical contact. These rely on using full body force in combination with keeping the aggressor off balance, working through the "natural exit," and using the principle of leverage.

1. **Front Neck Releases -- (front choke hold)**

a) Explode

- Place both hands on one of the aggressor's wrists
- Push that wrist out horizontally from your neck
- Step to that same side while lifting off and ducking under the held wrist
- Release and side-step away (or control)

b) Push off

- Bend knees, step into aggressor
- Sharply turn/rotate shoulder 1/4 turn
- Step into aggressor
- Move up with entire body force
- Side step away, keeping eyes on aggressor

c) Swim Technique Front
- Tuck chin to chest to maintain airway
- Raise one arm above head
- Turn body to opposite side of raised arm, bringing shoulders through aggressor's arms to effect release
- This move is choice of last resort due to excessive pressure put on aggressor's wrists when turning body and because you end up with your back towards aggressor

2. Rear Neck Releases

a) Life Saving Release
- Tuck chin into crook of aggressor's arm
- Secure aggressor's arm with one hand under elbow and other over the wrist
- If aggressor is using two arms, tuck chin into crook of bottom arm, secure wrist of bottom arm
- Drop down sharply on bent knees, pushing aggressor's elbow over your head
- Step behind aggressor and release hold on aggressor's arm; direct in desired direction; quickly letting go of aggressor's arm after effecting release is essential to prevent injury to aggressor

b) Swim Technique -- Back
- Tuck chin to chest to maintain airway
- Raise one arm above head
- Turn body to same side as raised arm, bringing shoulder through aggressor's arms to effect release
- Be prepared to deflect and side-step away since you will be directly in front of the aggressor
- Be careful in executing release since excessive pressure can be put on aggressor's wrist

3. Hand Wrist Releases (one hand on one arm)

When wrist is being held by one hand and from same side of the body i.e., left to right (least restrictive to most restrictive):

a) --Step to that side of aggressor
--Bring elbow and forearm slowly in line with aggressor's

or

b) --Twisting arm, push out and away from grasp
--Exit between thumb and index finger

4. **Hand Wrist Releases (one hand on one arm)**

When wrist is being held by one hand from opposite side of the body i.e., left to left of right to right (least restrictive to most restrictive):

a) --Step toward aggressor with opposite foot from hand being held
--Twisting arm, pull out and away from grasp, exiting between thumb

or

b) --Step toward aggressor with opposite foot from hand being held
--Place cupped hand over aggressor's wrist and pull away

5. **Hand Wrist Release (one hand on each wrist)**

- Bend knees and drop down, pulling aggressor forward and down (off balance)
- Moving up with entire body force, twist wrists and drive both arms up and over shoulders
- Open palms
- Move downward if aggressor's thumbs are pointed down

6. **Hand Wrist Release (both hands on one wrist)**

- Reach over and between aggressor's two arms and grasp hand being held
- Bend knees, pulling aggressor downward
- Straighten up, leaning back and pull arms up and over shoulders (Caution: avoid hitting individual in the head)
- Pull downward if aggressor's thumbs are pointed down

7. **Clothes Release**

a) Least Restrictive Clothes Release
- With arm on opposite side of aggressor's
- Put your palm to aggressor's palm
- Push out perpendicular to knuckle line

b) More Restrictive Clothes Release
- With arm on opposite side of aggressor's grasp, cup your hand over back of aggressor's just below the little finger
- Roll aggressor's hand, with little finger rotating upward. Should this fail, summon help and effect finger peel
- Open aggressors grasp beginning with pinky and holding finger with the other hand

8. **Break from Bite**

- Force body part that is being bitten into aggressor's mouth; squeeze aggressor's nostrils closed until bite is released
- If unsuccessful, hold aggressors head and summon staff

9. Hair-Pull Release

- Cup hands over aggressor's hand(s)
- Press hand(s) into head, bend knees and drop down
- Rotate body away from aggressor 180 degrees
- If unsuccessful, hold hands and call staff

If from rear, follow the same procedure

D. COME ALONGS

These are used to move an aggressive individual to a safer area after he/she has been give the option to move under his/her own will.

1. Rear Belt Hold
   - Step to side and slightly behind aggressor
   - Take hold of aggressor's arm at wrist and rotate palm toward ceiling
   - Grab belt or waistband from behind
   - Keep individual unbalanced by moving him/her to a safer area while using weight; shift from side to side

2. Breaking Up a Fight
   - If alone, use verbal interventions. If this fails to de-escalate the situation, get help
   - Two people move in from behind the aggressors, quickly moving them close together to contain movement
   - Secure aggressor's shoulders and turn away
   - Secure aggressors in one or two person arm hold if needed and move them away from one another to separate areas

3. One Person Arm Hold -- to be used only in emergency situations when second employee is not present
   - Take hold of aggressor's arm at wrist and rotate palm to ceiling
   - Place other hand on aggressor's arm above the elbow, pushing into shoulder (arm should be lower than shoulder, if possible)
   - Step to the side and slightly behind aggressor
   - Keeping aggressor's arm extended and abducted to the side, move aggressor in desired direction (This is effective even if aggressor flexes arm.)

4. Basketthold -- to be use <u>only in emergency</u> situations when second employee is not present or on van transport
   - Use arm deflection position
   - Use redirection to grasp arm and rotate it across in front of you
   - Switch hands, putting other hand on top of wrist
   - Pass held wrist across front of aggressors chest, step to the rear, while reaching behind back with your other hand meeting held wrist at opposite shoulder, transfer grip

- Original hand, now free, is placed on closest shoulder applying pressure inward while holding/pulling held wrist
- Should aggressors free hand become available, hold that wrist also and lean away while supporting their weight on your thigh.

5. Two Person Arm Hold second person

- Step to side and slightly behind aggressor
- Take hold of aggressor's arm at wrist and rotate palm toward ceiling
- Use other hand to cross on top of aggressor's lower arm (below elbow) and lock you arm around his/her arm
- inform leader that. aggressor is secured, at which time he/she will effect lower arm hold
- Move aggressor in desired direction, if possible
- Slide up into upper arm hold (above elbow) if more control is needed (upper is more restrictive) -
- If necessary, use third person to secure head of aggressor from behind, holding along the chin line; this helps provide balance as well as preventing biting and head butting

6. Two Person Escort If aggressor cannot be moved with Two Person Come

- Go back into lower arm hold
- Reach between held arm and around back of individual
- Grab belt on opposite side from you
- If not possible to grab belt, clasp hands/wrist with partner

NOTE: Turning off or preventing locomotion to a person using a wheelchair is considered physical restraint. Such action can only be used according to DMR policies on restraint or as part of a fully approved behavior intervention plan. In most cases PAC blocks and releases will be sufficient interventions for persons who are not ambulatory.

E. TAKEDOWN AND RESTRAINT

This is used only when all previous efforts at deflection or cooling the aggressor down have been ineffective. It is imperative that a leader is identified to call the moves throughout the process and that at least two employees are involved. Conversation should be limited to dealing with the situation.

1. Safe Takedown Skills

With the exception of automobile accidents, falls account for more deaths and injury in the United States annually than any other accidental causes. Falls are a far more serious threat than violence. Dangerous falls are also a serious problem in individual-staff conflicts. Therefore, we have provided a list of general safety guide-lines which are useful aids, though not intended to be hard and fast rules.

a) Learning safe falling methods are an important part of learning safe take down skills.

b) Fearful overreactions appear to be the major source of injury in takedown situations,

d) Off-balancing is an effective means of creating structural weakness in the resisting individual.

e) Creating postural reaction in the individual is an effective off-balancing technique. This usually involves applying initial power in the opposite direction from that of the intended takedown, thereby using and manipulating individual energy.

f) As always, do the minimum that is necessary for safe restraint or defense. Do not attempt a takedown unless the following conditions are present:

1) The situation demands this option (i.e., serious threat of injury to staff or individual such as throwing chairs, breaking windows, or intense assault.).

2) It can be executed without serious risk (i.e., there are additional staff to assist).

3) You and/or your co-worker are unable to simply restrain the individual in a standing position and wait for available help (i.e., individual continues to escalate).

4) Other options appear to pose greater danger (i.e., individual is not contained by standing restraint, will be in greater danger if released and will continue to escalate).

3. Takedown

- When aggressor is secured in a two-person upper arm hold, pull him/her sharply forward from shoulder girdle.
- Take half step forward with outside leg; quickly reverse your force, go down on inside knee, and bring individual to sitting position.

4. Immobilization Restraint Skills

Full immobilization, usually by restraining individual with your body, is the most - serious application of restraint skills. This option should be employed only when the individual is clearly a danger to him/herself or others.

Immobilization is a humiliating and often fearful experience. In some people it arouses a kind of claustrophobic panic, a genuine feeling of being smothered or drowned. Therefore, it is essential to the humane goals of our training that in applying such drastic measures, every possible caution and intention of containment should be conveyed to the individual. This can be transmitted in many ways including voice tone and pitch, and quality of touch. These channels of communication are especially useful for individuals who are non-verbal.

Practical reassuring feedback will help control or de-escalate the intensity of individual resistance. Remember that even though restraint may be successfully applied, it is possible that negative feelings from the restraint incident may later explode toward yourself or other targets.

By playing the role of the immobilized individual in restraint training, you have a very illuminating opportunity to develop a realistic understanding of what this process may feel like for the individual. The phenomenal experience is essential to the training. Ideally, a greater sense of awareness and sensitivity is developed, which is one of the central goals of our programs.

Staff members who are less physically capable or skillful may possess communication and human relation skills that are far more valuable and effective in actual situations.

If you must touch someone, the way you touch them can be a powerful communication. Likewise, the quality of your tone of voice may mean far more than the content of your words.

RESTRAINT (If aggressor cannot be contained in sitting position)

- lower aggressor to his/her back
- one staff person takes both arms which have been fully extended above aggressor's head and crossed at the wrists
- second staff person moves down torso to secure legs, straddling lower legs with hands placed just above knees

1. If aggressor is kicking or bucking, wrap arms around legs just above knees, placing your chest over thigh and body at a 90 degree angle to individual with legs spread apart.

2. If aggressor is deaf or hard of hearing (necessitating use of sign language), place your knees outside individual's knees, bringing your lower legs over aggressor's legs and your feet between aggressor's feet.

3. Protect aggressor's head by holding it down with your hand or place something under it i.e., towel or foot.

4. Variations: If 3 staff persons are available, two take the arms.
   If 4 staff persons are available, one on each limb.

5. If the aggressor ends up lying on the floor on his/her stomach, attempt the "Log Roll."

   Log Roll
   - Cross aggressor's arms and legs in the same direction
   - Place hand just above the knee and just below the shoulder of crossed limbs
   - Roll aggressor over onto back

6. Precaution: Use the least amount of force possible but maximize your control of movements yours and the aggressor's.

WHEN PHYSICAL INTERVENTIONS ARE USED:

- Ask nurse to check the individual (and staff if necessary) for injury. The nurse should be notified even if there is no apparent injury, in case of bruises, etc., are noted later.
- Insure that all staff involved are calm and able to return to work. Provide coverage for a short break, if necessary.
- Make sure all necessary documentation is done before the end of the shift: individual log, progress notes, accident/injury reports, physical and! chemical restraint forms. Inform the individual's day program/residential program of incident.
- Meet with team and all staff involved to discuss incident. Develop treatment plan and submit to Human Rights Committee if similar interventions were used before.
- Use discretion discussing incident with individual. To some individuals, this would be an aid to self understanding. With other individuals a discussion of the incident may be ineffective or harmful.

SAFETY ISSUES IN THE COMMUNITY

Teams need to use a good assessment process prior to bringing individuals who have problems with safe behavior in the community. If it becomes necessary to physically restrain an individual while on the van, staff can either restrain the individual by holding their arms while seated behind them or by lying the person on the seat and holding them.