Enhance your training with the CPI App.

crisisprevention.com/app
Review core Nonviolent Crisis Intervention® content and gain 24/7 access to video scenarios and other supplemental information.

Connect with us on social media.
facebook.com/CPI.Training
twitter.com/CPI_Training
youtube.com/crisisprevention

Be a part of the CPI Instructor Community.

Become the best part of the Instructor Community. It’s easy. Just sign in to your My Account at crisisprevention.com, click on the Instructor Community icon, and follow the on-screen prompts.

Yammer

CPI Certified Instructor’s Association Membership Information

Name: ____________________________________________________________________________________

Instructor Number: _________________________________________________________________________

Your Training Dates: ________________________________________________________________________

Your Global Professional Instructor(s): ________________________________________________________

CPI Certified Instructor Support: 877.877.5390 (US & Canada)
crisisprevention.com

The Crisis Prevention Institute is accredited by the International Association for Continuing Education and Training (IACET). The Crisis Prevention Institute complies with ANSI/IACET Standard, which is recognized internationally as a standard of excellence in instructional practices. As a result of this accreditation the Crisis Prevention Institute is authorized to issue the IACET CEU.

CPI® and Nonviolent Crisis Intervention® are registered trademarks of CPI.

© 2018 CPI. All rights reserved. This work is protected by the copyright laws of the United States and other countries and remains the sole and exclusive property of CPI. This work may not be reproduced in any manner without the express written permission of CPI.

Important information about your license to use teaching materials.
CPI hereby grants CPI Certified Instructors a perpetual, nonexclusive, and nontransferable license to use this work in teaching this program to staff within the Certified Instructor’s Base of Employment, as defined in the Instructor Guide. This license is site-specific to the Certified Instructor’s Base of Employment and includes the right to distribute this work to program participants for use during this training. Any other use of this work is strictly prohibited and will be considered a breach of this license and a violation of applicable copyright laws. Certified Instructors are not agents (implied, apparent, or otherwise) or employees of CPI and do not have any authority to act for or on behalf of CPI.

CPI® and Nonviolent Crisis Intervention® are registered trademarks of CPI.
# Table of Contents

Introduction to *Nonviolent Crisis Intervention® Training* ................................................................. 2
Facilitation Dynamics ......................................................................................................................... 3
Quality Standards and Instructor Association .............................................................................. 6
*Nonviolent Crisis Intervention®* Training Options ........................................................................ 7
Quality Standards and Instructor Association ............................................................................. 9
CPI Instructor Certification .............................................................................................................. 10
Why *Nonviolent Crisis Intervention®* Training? ........................................................................ 13
Program Objectives ......................................................................................................................... 14
Introduction to *Nonviolent Crisis Intervention® Training* ........................................................... 16
Icon Glossary .................................................................................................................................. 17
Participant Materials and Instructor Training Tools ........................................................................ 18
Instructor Note and Overview of Participant Materials for Blended Learning Program .................. 19
Due Care Guidelines for Participants ............................................................................................... 20

## PART 1

Part 1: Course Agenda ....................................................................................................................... 21
Part 2: Course Agenda ....................................................................................................................... 22
Course Introduction ........................................................................................................................... 23
Pre-Test Discussion Notes ................................................................................................................. 25
Unit 1: The CPI Crisis Development Model® ............................................................................... 29
Unit 2: Nonverbal Communication ................................................................................................. 35
Unit 3: Paraverbal and Verbal Communication ............................................................................. 45
Unit 4: Verbal Intervention .............................................................................................................. 49
Unit 5: Precipitating Factors, Rational Detachment, Integrated Experience .................................. 63
Unit 6: Staff Fear and Anxiety ......................................................................................................... 69
Unit 7: Decision Making .................................................................................................................. 73

## PART 2

Review and Application Activities ................................................................................................. 85
Review and Application Activity 1: Individual Application .......................................................... 86
Review and Application Activity 2: Group Application ................................................................. 89
Review and Application Activity 3: Situational Application ....................................................... 90
Units 8 and 9: Physical Interventions ............................................................................................ 93
Unit 10: Postvention ......................................................................................................................... 95
Post-Test With Answers and Evaluation Forms ............................................................................. 101
Post-Test With Answers ................................................................................................................ 102

## PHYSICAL INTERVENTIONS

Guidance for Teaching CPI Physical Interventions – Disengagement and Holding Skills .......... 103
Unit 8: Physical Interventions – Disengagement Skills ................................................................ 105
Unit 9: Physical Interventions – Holding Skills .......................................................................... 127

## GLOSSARY AND APPENDICES

Glossary of Terms ............................................................................................................................ 147

*Nonviolent Crisis Intervention®* Training Program: A CPI collaboration for the Management of Actual or Potential Aggression ......................................................... 149
Understanding the Risks of Physical Restraints ........................................................................... 155
Additional Resources and References ............................................................................................ 160
Welcome to your Nonviolent Crisis Intervention® Certified Instructor Guide and CPI’s Instructor Association!

Congratulations on your successful completion of CPI’s Nonviolent Crisis Intervention® Instructor Certification Program.

You are joining a network of over 30,000 CPI Certified Instructors representing a multitude of professions—from education, residential settings, healthcare, behavioral/mental health, law enforcement/security, and other human services—who train staff in the Nonviolent Crisis Intervention® program. This program matters because CPI Certified Instructors commit to the highest quality standards in its delivery. Thank you for joining this important mission.

This is your Instructor Guide and it will be your primary resource for facilitating Nonviolent Crisis Intervention® training programs. As you build your proficiency and capabilities as an Instructor, this guide will evolve with you. Use it to record examples to tailor your programs and keep notes from your own experiences in facilitating training. These will be important references as you engage in continued Instructor development opportunities with CPI.

As you gather additional resources from CPI throughout your certification, reference them in this Instructor Guide to increase its relevance as you implement an ongoing training process for staff at your organization.

The Instructor Guide is designed to support you with all the essential information you need to effectively and efficiently deliver quality training programs. It includes details relating to:

- Nonviolent Crisis Intervention® training content
- Facilitation methods to promote learning retention and transfer to workplace circumstances
- CPI training quality standards
- CPI Instructor Association membership and support

Additional resources are available at crisisprevention.com.

We invite you to take advantage of expansive resources and consultation with CPI training experts, and connect with others in the CPI Instructor Association through the avenues outlined on the inside front cover of your Instructor Guide.

2
Facilitation Methods for Nonviolent Crisis Intervention® Training

The Nonviolent Crisis Intervention® program is uniquely designed to teach you critical skills for preventing and defusing disruptive or risk behavior, and the immediate transfer of learning to your workplace practice. Specific facilitation methods and course continuity structures provide the path for you to customize Nonviolent Crisis Intervention® training for your staff. Understanding these methods will help you facilitate training that has a positive impact on your workplace practice.

Advance Preparation

✓ Take time to prepare and practice.
✓ Learn the material.
✓ Use your own words.
✓ Follow teaching sequence.
✓ Reference unit objectives.

Instructional Goals

Care, Welfare, Safety, and Security℠
Facilitation Dynamics

**Facilitation Formulas**

Declarative knowledge → knowing **what**

Term → Definition → Examples

Tips:

---

Procedural knowledge → knowing **how**

Demonstrate/describe → Participate/practice → Explain/expand

Tips:
Facilitation Dynamics

Responding to Participant Questions

- Seeking clarity or information
- Validation or confirmation
- Apprehension/fear of unknown; what if
- Challenging
- Processing—connecting to experiences

Suggestions for Co-Facilitating

- CPI recommends team teaching with up to three Instructors.
- Review any training needs assessment information.
- Meet before training to assign units.
- Determine timings and plan for physicals.
- Develop transitions between units and when changing presenters.
- Plan, prepare, and practice as a team.
- Respect each other’s strengths and styles.
- Discuss possible questions and problem solve issues that may arise.
- Model Care, Welfare, Safety, and SecuritySM.
Quality Standards and Instructor Association

CPI’s training quality standards encompass elements to advance the best use of program components and facilitation methods. As a Certified Instructor, you are prepared to train your staff in a manner which builds confidence and competence, so learning is effectively transferred to workplace circumstances. Ultimately, you will demonstrate improved capabilities in preventing or reducing risks, through interventions that prioritize Care, Welfare, Safety, and Security™. Instructors certified by CPI commit to quality standards in two categories: Training Continuity and Relevance, and Instructor Proficiency.

<table>
<thead>
<tr>
<th>Training Continuity and Relevance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>CPI TRAINING QUALITY STANDARDS</td>
<td>CPI INSTRUCTOR SUPPORT</td>
</tr>
<tr>
<td>Provide Nonviolent Crisis Intervention® training, following Instructor guidance:</td>
<td></td>
</tr>
<tr>
<td>a. <strong>For staff within established Base of Employment.</strong></td>
<td><strong>Train staff where you work</strong> for relevance and support.</td>
</tr>
</tbody>
</table>
| b. **Using CPI Participant Workbooks with pre-tests and post-tests.** | CPI training materials are uniquely designed to promote training accuracy and learning transfer. **Use your Instructor Guide:** It promotes training continuity while assuring relevance through your customization. Provide your participants with a Nonviolent Crisis Intervention® program Participant Workbook (or Participant Job Aid for blended learning):  
  - Reinforces learning through note-taking and takeaway resource.  
  - Ensures content is authorized by CPI.  
  - Records and validates learning. |
| c. **Validate training through documentation and staff participant Blue Card™ confirmations.** | **CPI Training Validation Procedures**  
All participants will receive a Blue Card™. Documentation:  
- Staff members (up to 40 per class) who successfully completed training.  
- All Certified Instructors involved in facilitating the program.  
- Training hours corresponding to the Training Content Outline.  
**CPI maintains records,** documenting all authorized training facilitated by Certified Instructors and staff participants. Organization training records can be easily accessed by Certified Instructors (and other organization designees) on the CPI Instructor Association website or on the CPI App. |
Nonviolent Crisis Intervention® Training Options

You are authorized to teach all components of CPI’s Nonviolent Crisis Intervention® Foundation training program using either a traditional or blended learning delivery format. Based on the training needs of your staff, use your Instructor Guide and corresponding Training Content Outline as references to customize training programs. The following training options provide additional guidance when planning to facilitate Nonviolent Crisis Intervention® Foundation training programs to meet the needs of your staff, organization, and the persons you serve. The training is split into two sections, Part 1 and Part 2.

**Traditional Classroom Delivery Format**

<table>
<thead>
<tr>
<th>TRADITIONAL</th>
<th>CLASSROOM DELIVERY TIME</th>
<th>CUSTOMIZATION CONSIDERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Nonviolent Crisis Intervention® Foundation training program</td>
<td>12–14 hours</td>
<td>• Comprehensive programs may omit specific physical intervention skills and practice based on the needs of the organization and the staff.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Part 1 would most likely take place the first day of training, and Part 2 would be covered during your second day of training.</td>
</tr>
<tr>
<td>Abridged Nonviolent Crisis Intervention® Foundation training program</td>
<td>6–12 hours</td>
<td>• Abridged programs (6–8 hours) focus on prevention and verbal intervention practice (covered in Part 1) and may significantly limit or eliminate physical intervention skills (covered in Part 2).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Abridged programs (8–12 hours) may expand on prevention and intervention practice while limiting or eliminating physical intervention skills.</td>
</tr>
<tr>
<td>Nonviolent Crisis Intervention® Foundation refresher programs</td>
<td>3–14 hours</td>
<td>• Refresher training includes a pre-test, review of Nonviolent Crisis Intervention® core models, practice of any physical intervention skills previously taught, and a post-test. If adding skills not previously taught, refresher training time is extended.</td>
</tr>
</tbody>
</table>
## Blended Learning Delivery Format

<table>
<thead>
<tr>
<th>BLENDED LEARNING</th>
<th>CLASSROOM DELIVERY TIME</th>
<th>CUSTOMIZATION CONSIDERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive <em>Nonviolent Crisis Intervention®</em> Foundation Blended Learning training program</td>
<td>5–8 hours</td>
<td>• The online portion of the training includes all <em>Nonviolent Crisis Intervention®</em> concepts, principles, and models. Part 1 and Module 10 are taught in the online modules.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• In-class training activities provide participants with opportunities to review, practice, and apply <em>Nonviolent Crisis Intervention®</em> physical intervention skills and Postvention (covered in Part 2).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Instructors may omit specific physical intervention skills and practice based on the needs of the organization and the staff.</td>
</tr>
<tr>
<td>Abridged <em>Nonviolent Crisis Intervention®</em> Foundation Blended Learning training program</td>
<td>4–7 hours</td>
<td>• The online portion of the training includes all <em>Nonviolent Crisis Intervention®</em> concepts, principles, and models but does not instruct on responses to physical risk behaviors. Part 1 and Module 10 are taught in the online modules.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• In-class training activities provide participants with opportunities to review, practice, and apply <em>Nonviolent Crisis Intervention®</em> prevention and intervention (verbal and physical) skills.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Instructors may expand on prevention and intervention practice while limiting or eliminating physical intervention skills (covered in Part 2).</td>
</tr>
<tr>
<td><em>Nonviolent Crisis Intervention®</em> Blended Learning refresher programs</td>
<td>3–8 hours</td>
<td>• The online portion of the training includes all <em>Nonviolent Crisis Intervention®</em> concepts, principles, and models. Part 1 and Module 10 are taught in the online modules.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• In-class training includes a review of <em>Nonviolent Crisis Intervention®</em> core models and practice of any physical intervention skills previously taught. If adding skills, refresher training time is extended.</td>
</tr>
</tbody>
</table>

**Please note:**

- Policy/procedure and learner-specific needs should determine if a program will be comprehensive or abridged.
  - CPI’s Training Department has an Abridged Training Considerations document and corresponding webinar to help Certified Instructors with their training planning. Please contact CPI for more information.
- If specific physical intervention (disengagement/holding) skills are omitted from a program, pages depicting these skills should be removed from the *Nonviolent Crisis Intervention®* Participant Workbook.
- Instructors are strongly encouraged to maintain a record of each program facilitated and the names of those persons who participated in their program.
# Quality Standards and Instructor Association

<table>
<thead>
<tr>
<th>Instructor Proficiency</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CPI TRAINING QUALITY STANDARDS</strong></td>
<td><strong>CPI INSTRUCTOR SUPPORT</strong></td>
</tr>
<tr>
<td><strong>a. Teach two times per year.</strong>&lt;br&gt; To maintain familiarity and facilitation capabilities, Certified Instructors conduct <strong>at least two</strong> <em>Nonviolent Crisis Intervention®</em> training programs each certification year.</td>
<td><strong>Use it or lose it. Prevent training drift.</strong>&lt;br&gt; Additional resources for support and to help customize your training are available through the CPI Instructor Association. Call <strong>877.877.5390</strong> or visit <strong>crisisprevention.com</strong>.</td>
</tr>
<tr>
<td><strong>b. Review and renew every two years.</strong>&lt;br&gt; To gauge proficiency and prevent training drift, Certified Instructors participate in and complete testing at a renewal training program every two years.</td>
<td><strong>Instructor renewal program options</strong>&lt;br&gt; - Attend a <em>Nonviolent Crisis Intervention®</em> certification program (minimum two days with a post-test).&lt;br&gt; - Attend the <em>Nonviolent Crisis Intervention®</em> blended learning renewal.&lt;br&gt; - Attend an advanced training program.</td>
</tr>
<tr>
<td><strong>c. Ongoing Instructor development.</strong>&lt;br&gt; Remain an active member of CPI’s Instructor Association (nominal annual fee).</td>
<td><strong>Access on-demand, online resources to build expertise and expand relevance of staff training.</strong>&lt;br&gt; Other Instructor Association benefits include:&lt;br&gt; - Phone consultation to discuss training implementation issues with a CPI Training Director as often as needed. Monday through Friday 7:30 a.m. to 6:00 p.m. CT.&lt;br&gt; - Refresher training, including online eRefresher modules.&lt;br&gt; - Invitation to CPI’s International Instructors’ Conferences.&lt;br&gt; - Exclusive access to the Instructor Association website, which features resources, tutorials, interactive learning activities, and an online networking community exclusively for CPI Certified Instructors.&lt;br&gt; - Subscriptions to the <em>Journal of Crisis Prevention</em>, the <em>Instructor Forum</em>, and the <em>Supportive Stance</em>, an online newsletter.&lt;br&gt; - Instructional materials and resources, including issue-specific DVDs or Video on Demand for refresher courses.</td>
</tr>
</tbody>
</table>
CPI Instructor Certification

CPI Instructor Association

Mission: The CPI Certified Instructor Association promotes best practices in *Nonviolent Crisis Intervention*® training and implementation.

Core Values: The CPI Instructor Association prioritizes values which help professionals balance responsibilities for *Care, Welfare, Safety, and Security*®. These core values are foundational to person-centered care and organizational efforts to reduce and ultimately eliminate restrictive practices. The Association recognizes that training to achieve improved outcomes in care is a continuous process and further recognizes that CPI training quality standards are baseline expectations for Certified Instructors worldwide.

Benefits: CPI Instructor Association members benefit from affiliation with a worldwide network of professionals dedicated to the same mission and values. CPI is committed to supporting Association members through professional consultation with training experts, Instructor development resources, and structures to connect Certified Instructors. Detailed information about membership benefits can be found at crisisprevention.com.

More information on your Instructor Association can be found at crisisprevention.com.

Certified Instructor Association Pledge

After understanding the mission and goals of the CPI Instructor Association, describe your commitment to different groups impacted by your work as a CPI Certified Instructor (also consider your interest in advancing values that balance responsibilities for *Care, Welfare, Safety, and Security*®):

---

**CPI**

**Your Participants**

**The Individuals in Your Care**

**Your Organization**
CPI Instructor Certification

CPI Instructor Certification Agreement

About Instructor Certification
As a Certified Instructor, you are joining thousands of human service professionals around the world who teach the Nonviolent Crisis Intervention® program. Earning and maintaining your certification authorizes you to teach the Nonviolent Crisis Intervention® program to staff within your Base of Employment as defined in your Instructor Guide. Your certification also initiates your membership in the CPI Instructor Association and entitles you to all Association support and benefits. Please visit crisisprevention.com for more information.

As a Certified Instructor, I affirm that:

1. I agree to abide by the Instructor Standards, Policies, and Procedures of CPI.

2. I pledge myself to high standards of ethical practice.

3. I understand that I am authorized to teach only within my Base of Employment.

4. I understand that fees are not to be generated from the use of CPI’s programs.

5. I will notify CPI in the event of a move from one Base of Employment to another.

6. I will not hold myself out as being in any way affiliated as an employee or agent of CPI.

7. I will not alter or reproduce any printed or visual materials originating with CPI without its express written consent, and understand that CPI’s program must remain intact to preserve its integrity and effectiveness.

8. I will use the material and information provided to me by CPI for the purpose of teaching within my Base of Employment and for no other purpose, nor will I aid or assist any other person in the use or reproduction of such materials and information for any other purpose.

9. I agree to not use CPI’s name and Marks (“CPI®” and “Nonviolent Crisis Intervention®”) in any manner which may reflect adversely upon CPI’s name and goodwill, and agree that the materials and activities on and in connection with which CPI’s Marks are used will be of a quality consistent with the goal of promoting the Nonviolent Crisis Intervention® crisis management method taught by CPI.

10. I agree to keep CPI advised of the manner of use of CPI’s Marks, and if necessary to provide CPI with samples of the uses of CPI’s Marks, and to work with CPI on any quality concerns that may arise.

11. I understand that any intranet or interoffice postings with respect to CPI’s principles, method, and program will be solely for the purpose of training staff.

12. I understand that any Internet postings must be reviewed and approved by CPI prior to use.

13. I understand that all materials, whether printed, visual, or digital, provided by or originating with CPI and the Nonviolent Crisis Intervention® method and program are copyrighted by and proprietary to CPI, and I will not use them for any purpose or in any manner other than that expressly authorized hereunder and will not copy, reproduce, publicly perform, display, or publicly distribute them nor aid anyone else in doing so, except as expressly authorized herein.
First Steps to Success as a CPI Certified Instructor

Aim to implement the most effective and efficient Nonviolent Crisis Intervention® training programs at your organization.

1. **Converse.** Plan key conversations. Consider your learning from the Instructor Certification Program. Think about your motivation to educate staff, empower improvements, and enrich lives through Nonviolent Crisis Intervention® training. Plan to have a conversation with relevant leaders at your organization and/or other CPI Certified Instructors as soon as possible. Review your learning and this Instructor Guide. Convey your commitment. Ask and answer questions to assure overall clarity.

2. **Rehearse.** Find time to teach the program as you just experienced it. Select six or more participants and facilitate the comprehensive Nonviolent Crisis Intervention® training program. This will help embed your learning and go a long way in establishing your proficiency and expertise as an Instructor. Whether or not you will be involved in instructing the comprehensive program at your organization, it is important that you have solidified your learning about all components through teaching to others. This is especially necessary if you will be called upon to facilitate abridged or refresher training programs. Abridgement decisions are best made from a perspective that has fully experienced delivery of all program components.

**Training Preparation Checklist**

- Determine number of participants.
- Confirm training location and room setup (review room set-up guidance at crisisprevention.com).
- Ensure you have Participant Workbooks for each staff member attending.
- Organize other instructional materials and technology (flip chart, projector, screen, etc.).
- Review Instructor Guide and make notations for examples you want to include given participants attending.
- Meet and rehearse with other Certified Instructors who will co-facilitate.

**Before Training**

- Arrive early to set up training environment (put out materials, nametags, posters, technology, flip charts). Ensure you have adequate space and plan to facilitate activities.
- Check technology.
- Check out views of visual presentation from different parts of room.
- Put out sign-in sheets you may need.

**After Training**

- Review program and participant input (with all Instructors involved) and make notes in Instructor Guide where relevant.
- Organize post-tests and participant Blue Card™ numbers for documentation.
- Document training at crisisprevention.com/My-Account/My-Training.

For more preparation tips, visit crisisprevention.com.
Nonviolent Crisis Intervention® Values and Philosophy: Care, Welfare, Safety, and Security™

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>Demonstrating respect, dignity, and empathy; providing support in a nonjudgmental and person-centered way.</td>
</tr>
<tr>
<td>Welfare</td>
<td>Providing emotional and physical support; acting in the person’s best interests in order to promote independence, choice, and well-being.</td>
</tr>
<tr>
<td>Safety</td>
<td>Protecting rights, safeguarding vulnerable people, reducing or managing risk to minimize injury or harm.</td>
</tr>
<tr>
<td>Security</td>
<td>Maintaining safe, effective, harmonious, and therapeutic relationships that rely on collaboration.</td>
</tr>
</tbody>
</table>

Authorization and Approval Considerations for Use of Physical Interventions

Your employer has selected CPI’s Nonviolent Crisis Intervention® training recognizing that the philosophy, lessons, and skills taught in the program align with organizational values. Physical intervention procedures taught in this program are based on typical behaviors and risks you may encounter at work. Balancing objectives to provide for the best possible care and welfare, while maintaining safety and security, requires ongoing consideration, study, and practice. In addition, participants in this training must remember that use of any physical intervention needs to be guided by:

- Organizational policies and procedures.
- Relevant legal and regulatory frameworks.
- Professional standards for best practice.

Please Read Carefully:

In the Nonviolent Crisis Intervention® training program, you will be involved in practicing intervention strategies. You should understand that some of these methods involve physical contact and include risk of injury. It is important to follow the directions of the Instructor and the Due Care guidelines of the program.

CPI makes no warranty or representation that the skills, principles, and methods taught in this program comply with all local laws, rules, regulations, and ordinances that may be applicable to persons utilizing same. CPI’s physical intervention principles should be used only in a manner that aligns with local laws. CPI assumes no liability for any bodily injury, loss, or damage caused by the misuse or incorrect application of the skills, principles, and methods taught in this program, or by the illegal or inappropriate use of same, whether or not such injury, loss, or damage is foreseeable.
Program Objectives

Units 1–6: Prevention and Deceleration Strategies

**Key Learning Objective:** Identify behavior that indicates an escalation toward aggressive and violent behavior and take appropriate measures to avoid, decelerate, and/or de-escalate crisis situations.

After completing, you will be able to:

1. Define workplace aggression and violence and describe the responsibilities of employers and employees.
2. Describe the typical behavioral responses associated with the development of a crisis and choose an appropriate intervention for each level of behavior.
3. Describe elements of good interpersonal behavior and demonstrate how nonverbal strategies can be used to decelerate behavioral responses associated with a crisis.
4. Describe typical verbal behavior associated with crisis situations and demonstrate the use of verbal deceleration and de-escalation principles.
5. Explain the importance of effective listening and identify key approaches associated with Empathic Listening.
6. Identify Precipitating Factors for crisis behavior and explain how these impact you and individuals in your care.
7. List a range of nonphysical approaches that can be implemented to prevent or reduce the likelihood of challenging, aggressive, and violent behavior.
8. Explain the importance of professional values in promoting Care, Welfare, Safety, and Security℠ of all involved in a crisis.

Unit 7: Decision Making

**Key Learning Objective:** Assess the level of risk associated with crisis behavior and make appropriate decisions related to the management of such risks.

After completing, you will be able to:

1. Explain the importance of providing person-centered, proactive services.
2. Describe the principles of risk assessment and risk reduction and demonstrate how to undertake a behavioral risk assessment.
3. Provide a legal and professional rationale for decision making and give justification for actions made in relation to risk behavior including the use of physical interventions.
4. Determine how professional values support effective decision making during a crisis situation.
Program Objectives

Units 8 and 9: Managing Behavioral Risk Using Disengagement and/or Holding Skills

**Key Learning Objective:** Use suitable and acceptable physical interventions to reduce or manage risk behavior.

After completing, you will be able to:
1. Demonstrate the ability to respond to risk behavior using nonverbal, verbal, and physical approaches appropriate to the person, situation, and level of risk.
2. Demonstrate the use of physical interventions that are consistent with a set of physiological principles.
3. List the risks associated with the use of physical interventions.
4. Describe the warning signs associated with the adverse impact of physical interventions and identify the necessary corrective actions to minimize harm.
5. Identify the impact of the professional values of *Care, Welfare, Safety, and Security* when using physical interventions.

Unit 10: Postvention Approaches

**Key Learning Objective:** Identify the impact of crisis events and describe Postvention responses that can be used for personal and organizational support and learning.

After completing, you will be able to:
1. Describe the potential impact crisis situations have on you and individuals in your care.
2. Use a Postvention model for action that will help bring about necessary closure, debriefing, and the re-establishment of a positive and productive relationship with the individuals involved.
3. Describe the importance of recording and reporting, and list the key information that should be documented and reported following a crisis event.
4. Summarize the importance of *Care, Welfare, Safety, and Security* to support growth and change.
Introduction

These CPI Crisis Development ModelSM represents a series of recognizable behavior levels that an individual may go through during a crisis moment and the corresponding staff attitude/approach used to de-escalate challenging behaviors. This unit is the foundation of the training program. All other content is based on this solid foundation. Please take notes as I introduce and discuss this model.

Instructional Objectives

1. Define crisis development in terms of four distinct and identifiable behavior levels.
2. Match each behavior level with an appropriate corresponding staff attitude/approach.
3. Identify relevant examples of behavior and approaches.

Key Points to consider when presenting each unit:

- Elaborate and discuss one behavior level and staff attitude/approach at a time, rather than showing the entire model at once.
- Focus lecture on describing behaviors. Use relevant work-based examples.
- Encourage note-taking.
- Use teaching sequence of Term—Definition—Examples as you deliver this information. Add participant examples to flip chart.
- Introduce concept of Integrated Experience.

Consider elements of your own behavior that you can manage. These include your nonverbal behavior as well as the sound of your voice.

Text that should be read aloud to classroom participants will be indicated with a Say Icon.

Teaching notes for all activities and discussions.

Sample transitions to help connect content.

This type of handwritten font indicates suggested notes that participants should write in their workbook and may also reflect what is shown in the Electronic Presentation.
The following icons will help you use this Instructor Guide effectively. The icons serve as visual markers indicating when you will deliver a discussion versus an activity.

<table>
<thead>
<tr>
<th>ICON</th>
<th>TITLE</th>
<th>DEFINITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Say Icon]</td>
<td>Say</td>
<td>Sample scripting. These are suggested introductory comments, discussion points, or questions. Certified Instructors are encouraged to adapt the sample scripting to fit your style and organization's realities.</td>
</tr>
<tr>
<td>![Activity Icon]</td>
<td>Activity (demo)</td>
<td>Refers to a demonstration of an upcoming activity or experience relevant to the corresponding section.</td>
</tr>
<tr>
<td>![Activity Icon]</td>
<td>Activity (group)</td>
<td>Refers to a group activity or experience relevant to the corresponding section.</td>
</tr>
<tr>
<td>![Visual Icon]</td>
<td>Visual</td>
<td>Refers to areas of content that can be further reinforced through an audiovisual. Examples include the Electronic Presentation, a flip chart, whiteboard, etc.</td>
</tr>
<tr>
<td>![Transition Icon]</td>
<td>Sample Transition</td>
<td>Example of the logical connection of one term, concept, or skill to the general framework of the next term, concept, or skill to be covered.</td>
</tr>
<tr>
<td>![Think About Icon]</td>
<td>Think About</td>
<td>Refers to areas of additional consideration for Certified Instructors. This may include background information, research, and deeper background knowledge.</td>
</tr>
<tr>
<td>![Key Points Icon]</td>
<td>Key Points</td>
<td>These points are relevant to the effective facilitation for each unit of the program. Review these before presenting a unit.</td>
</tr>
<tr>
<td>![Tip Icon]</td>
<td>Tip</td>
<td>Additional information you can use to improve facilitation.</td>
</tr>
<tr>
<td>![Teachable Moment Icon]</td>
<td>Teachable Moment</td>
<td>An opportunity to offer additional insight or ask questions that can help deepen understanding of a concept or skill.</td>
</tr>
<tr>
<td>![Workbook Page Icon]</td>
<td>Workbook Page</td>
<td>Refers to content that corresponds to a specific Participant Workbook page.</td>
</tr>
<tr>
<td>![Job Aid Page Icon]</td>
<td>Job Aid Page</td>
<td>Refers to the page in the Participant Job Aid (online only).</td>
</tr>
<tr>
<td>![Electronic Presentation Icon]</td>
<td>Electronic Presentation</td>
<td>Refers to the slide numbers on the Electronic Presentation.</td>
</tr>
</tbody>
</table>
Participant Materials and Instructor Training Tools

For the Instructor

- Instructor Guide
- Electronic Presentation

For the Participant

- Participant Workbook (Classroom)
- Learner’s Guide (Blended Learning)
- Participant Job Aid (Blended Learning)
- Online Foundation Course (Blended Learning)
The Instructor role in blended learning shifts from facilitating the learning of new knowledge and skills to facilitating context-based application and practice of prerequisite learning (learning that occurred in the online component of the training). Facilitation methods used in the classroom portion of the Nonviolent Crisis Intervention® blended learning program will focus on four main areas:

1. Clarifying and reinforcing what was learned online through facilitated discussions.
2. Leading structured activities that focus on applying knowledge and skills in different contexts related to participant work circumstances.
3. Fostering solution-focused collaboration among participants to connect Nonviolent Crisis Intervention® concepts to workplace examples.
4. Assessing and providing feedback to participants to guide their learning and learning application.

This guide and the participant materials listed below will help you in facilitating discussions, activities, and help participants apply their knowledge. Review and become familiar with these materials and how you will use them in your blended learning class.

**The Nonviolent Crisis Intervention® Participant Job Aid**

Please hand out a Participant Job Aid to each participant at the start of the classroom session. The Participant Job Aid gives participants a place to reference and reinforce definitions, models, and frameworks learned in their online class. It also contains practice/apply instructions and the Blue Card™. The Participant Job Aid becomes an important part of the ongoing Training Process. Staff will be encouraged to refer to this information on the job, allowing them to apply it in their day-to-day practice.

**The Nonviolent Crisis Intervention® Online Learner’s Guide**

Completed during the online portion of blended learning, it has a place for participants to complete self-assessments and reflect on how they will apply what they learned to their workplace.
Due Care Guidelines for Participants

Participants in this training are asked to take responsibility for the Care, Welfare, Safety, and Security℠ of themselves and others in the class by adhering to these classroom expectations:

- I will respect other participants as peers.
- I am responsible for the safety of others with regard to my actions.
- I am responsible for gauging myself with regard to any past/current injuries and my comfort level performing any given skill. If I have any concerns, I will see my Instructor at a break.
- I will not engage in horseplay.
- I will not teach other skills.
- In all role-plays/skills, I will act only on my Instructor’s direction.
- I will cooperate, not compete.
- I will take time to physically prepare before performing any physical activity, and I will drink plenty of fluids throughout the day.
- I will be conscious of the space around me and always consider safety while practicing physical skills. I must remember that there are others who are practicing near me.
- During physical activities, the Instructor and any participant can ask to stop the activity at any time, for any reason. If, while practicing physical activities, my partner asks me to stop the activity, I will take the request seriously and immediately discontinue the activity.
- I will inform my Instructor prior to class of any injuries or limitations.
- I will report all injuries to my Instructor immediately.
- I will have respect for confidentiality when sharing examples of persons in my care.

The term “Due Care for Participants” and portions of the procedural safety outline were taken from the document “Training Injury Liability Management,” developed by Gary T. Klugiewicz, Milwaukee County Sheriff Department; James G. Smith, Milwaukee, Wisconsin Police Department; Robert Willis, New Berlin, Wisconsin Police Department; and Tim Powers, Fitness Institute for Police, Fire & Rescue, New London, Wisconsin.
## Part 1: Course Agenda

Times listed are approximate and may be adjusted based on number of participants, total time available, etc.

<table>
<thead>
<tr>
<th>TRAINING COMPONENT</th>
<th>SUGGESTED TIME</th>
<th>LEARNING OBJECTIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction/Pre-Test</td>
<td>45 minutes</td>
<td>Independent study and discussion.</td>
</tr>
<tr>
<td>Unit 1: The CPI Crisis Development Model&lt;sup&gt;TM&lt;/sup&gt;</td>
<td>45 minutes</td>
<td>Categorize behaviors into four distinct levels and identify responses most appropriate to prevent escalation or de-escalate crisis situations.</td>
</tr>
<tr>
<td>Unit 2: Nonverbal Communication</td>
<td>45 minutes</td>
<td>Describe key elements of nonverbal communication, and demonstrate ways to adjust your own nonverbal communication to prevent escalation or to de-escalate crisis situations.</td>
</tr>
<tr>
<td>Unit 3: Paraverbal and Verbal Communication</td>
<td>15 minutes</td>
<td>Explain three distinct components of the vocal part of speech and how each can impact the perception a listener forms about the message conveyed.</td>
</tr>
<tr>
<td>Unit 4: Verbal Intervention</td>
<td>90 minutes</td>
<td>Demonstrate the use of verbal and nonverbal intervention strategies effective for different types of defensive behavior.</td>
</tr>
</tbody>
</table>
| Unit 5: Precipitating Factors, Rational Detachment, Integrated Experience | 30 minutes | • Recognize internal and external factors that may contribute to behavior escalation and staff responses.  
• Convey an understanding of how behaviors and responses influence each other. |
| Unit 6: Staff Fear and Anxiety | 15 minutes | • Recognize physiological and psychological reactions that may be triggered by real or perceived threats and ways these may impact staff responses in crisis situations.  
• Describe what might influence whether fear and anxiety lead to an unproductive reaction or productive response in critical moments. |
| Unit 7: Decision Making | 45 minutes | • Categorize risk behaviors, considering likelihood and severity, linking perceptions of risk to Rational Detachment, Integrated Experience, and fear and anxiety.  
• Convey reasoning for responses to varied risk behaviors that are rooted in professional values. |

**Note:** Individuals who participated in Part 1 online will cover Unit 10 as well. There is an alternate activity for them to participate in during their classroom session for Part 2.
## Part 2: Course Agenda

<table>
<thead>
<tr>
<th>TRAINING COMPONENT</th>
<th>SUGGESTED TIME</th>
<th>LEARNING OBJECTIVES</th>
</tr>
</thead>
</table>
| Review and Application Activities         | 120 minutes                           | Create a bridge between Part 1 and Part 2 through:  
  - Individual Application  
  - Group Application  
  - Situational Application |
| Unit 8: Physical Interventions – Disengagement Skills | 90 minutes (for class sizes greater than 15, please allow for up to 90 more minutes) | - Describe principles used in disengagement skills.  
  - Demonstrate how to apply these principles safely when responding to physical risk behaviors while applying a framework to evaluate whether a chosen response is safe, effective, acceptable, and transferable. |
| Unit 9: Physical Interventions – Holding Skills | 150 minutes (for class sizes greater than 15, please allow for up to 30 more minutes) | - Describe and demonstrate proper use of the Principles of Holding for an individual presenting physical risk behaviors.  
  - Utilize the Physical Skills Review Framework to convey reasoning for the level of restriction used as a response to risk presented. |
| Unit 10: Postvention                      | 30 minutes                            | Describe key areas that must be addressed after a crisis incident and how these areas apply to both staff and individuals involved in any level of crisis behavior.                                                                                                                     |
| Post-Test, Course Evaluations, Concluding Comments, and Closure | 30 minutes                            | Assess learning outcomes. Collect feedback.                                                                                                                                                                                                                                                                                                        |

**TIP**

If your participants went through Part 1 online, then they will have already covered Unit 10. During Part 2 for these individuals, feel free to have them go through the Postvention Activity listed on page 99.
Thank you for attending and welcome to Nonviolent Crisis Intervention® training. The Nonviolent Crisis Intervention® program is a safe, nonharmful behavior management system designed to help human service professionals provide the best possible Care, Welfare, Safety, and Security® of disruptive, assaultive, and out-of-control individuals—even during their most violent moments. (See Think About and share why your organization has chosen CPI.)

Each of you has received a Participant Workbook. I encourage you to use this book as a place to capture your notes and reference information that you may find useful when returning to your job. Program objectives are outlined in the Participant Workbook.

Let’s review a couple of housekeeping items before we begin. For example:

- Today’s session is scheduled to last approximately _____ hours.
- We’ll take regular breaks throughout. Restrooms, break rooms, and fire exits are located _________.
- Let’s review the Due Care guidelines as listed in your workbook.

What other information do I want to share?

Begin the program with a pre-test or assessment that will help to set the stage for the learning experience.

THINK ABOUT

A sample introduction is provided. Consider adding your own comments to make your participants feel welcome. Include information regarding why your organization has chosen Nonviolent Crisis Intervention® training, organizational expectations for participants, as well as what you expect of participants during the training program. Be sure to validate the knowledge and experience of your participants.

TIP

The introduction is your opportunity to make a great first impression on your participants. Plan and prepare for your introduction to be enthusiastic and motivating. Include comments about why your organization has chosen this training and express what you believe is the value of this course.
Sample Introduction

The pre-test will get you started. The pre-test will outline the content of the program and begin to establish a working language that you can use relating to a crisis. Consider those you support as you answer these questions. Please take a few moments to think about and write your answers.

Instructional Objectives

1. Explore and discuss participants’ experiences with challenging behavior.
2. Connect professional values with Nonviolent Crisis Intervention® program philosophy and values.
3. Clarify the program intent.

KEY POINTS

» Review suggested key points for each question.
» Include other issues you wish to discuss that especially apply to your facility.
» The pre-test is intended as a teaching tool.
» Encourage participants to reflect on their own experiences when answering questions.
» The pre-test is not graded.
» Many Instructors collect the pre-test. This allows you to include participant answers as examples during the course.

TIP

The importance of the pre-test is to allow your participants to write and reflect on their thoughts and experiences, even if they do not wish to share them with the group.
1. Define aggression and violence. List the two types that you may encounter in your job.

Aggression can be defined as behavior that is characterized by vigorous, intense, or hostile actions. Violence can be defined as any behavior where force is used to injure or abuse another person, usually intending to cause injury.

What examples did you write down? Common responses are verbal and physical, or examples of verbal and physical aggression. Each of these behaviors may require a different response from staff. Most staff have experienced situations where the people they work with demonstrate impulsive and irrational behavior. Within this program, you will explore strategies for intervening with verbally and physically aggressive behaviors.

2. What are the core values that underpin your work practice?

Your core values will influence how you respond to aggression and violence in the workplace. What are some of your examples for this question? (Record these on the flip chart). Include values like respect, dignity, trust, safety, individuality, equality, rights, and diversity. The program philosophy of Care, Welfare, Safety, and Security\textsuperscript{SM} is described in your workbook on page 2. (You can ask volunteers to read the description of each word in the philosophy to the group.)

There may be concerns of physical interventions being misused or abused, especially in relation to vulnerable children and adults. When you focus on Care, Welfare, Safety, and Security\textsuperscript{SM} as common central values, these provide you with a solid base for making decisions. This program will reinforce the perspective that you should avoid using physical interventions unless absolutely necessary to manage risk and minimize harm. In other words, as a last resort.
3. List the levels of behavior an individual may experience (or you may observe) in a crisis situation and give an appropriate staff response to each.

<table>
<thead>
<tr>
<th>Crisis Development/Behavior Levels</th>
<th>Staff Attitudes/Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td>4.</td>
</tr>
</tbody>
</table>

The purpose of this question is twofold. First, it helps you think about the fact that there are levels of behavior an individual experiences when in crisis. Second, it introduces the idea that there is a relationship between individual and staff behavior and that different behaviors require different responses.

4. **Crisis results in a traumatic experience for those involved. True or False.**

How many of you answered this question as true? How many answered as false? Did anyone answer maybe or that you aren’t sure? These are all correct. The outcome of a crisis situation is affected by how you intervene, and by an individual’s ability to cope or take advantage of available support systems.

What can you do as staff members that can influence crisis situations in either positive or negative ways? One of the goals of the program is to find positive ways of managing crisis situations so they are not traumatic or so that the degree of trauma is lessened. Crises can be learning experiences for everyone involved, and the results can lead to growth and change.
5. **What are your responsibilities after a crisis event?**

Possible responses to this question may include recording and reporting incidents or ensuring all involved in the crisis are alright. Wider responsibilities may include providing access to debriefing for staff and individuals that displayed challenging behaviors. Debriefing is a tool for minimizing any resulting trauma and will be addressed in more detail later in the program.

Look back at question 3 with the examples of behavior an individual may experience in a crisis situation and appropriate staff responses. Use your examples as an outline for the foundation of the program, the CPI Crisis Development Model™.
Unit 1: The CPI Crisis Development Model<sup>SM</sup>

**Introduction**

The CPI Crisis Development Mode<sup>SM</sup> represents a series of recognizable behavior levels that an individual may go through during a crisis moment and the corresponding staff attitudes/approaches used to de-escalate challenging behaviors. This unit is the foundation of the training program. All other content is based on this solid foundation. Please take notes as I introduce and discuss this model.

**Instructional Objectives**

1. Define crisis development in terms of four distinct and identifiable behavior levels.
2. Match each behavior level with an appropriate corresponding staff attitude/approach.
3. Identify relevant examples of behavior and approaches.
4. Build capabilities to convey values related to *Care, Welfare, Safety, and Security<sup>SM</sup>* during interventions.

**KEY POINTS**

- Illustrate and discuss one behavior level and staff attitude/approach at a time, rather than showing the entire model at once.
- Focus lecture on describing behaviors. Use relevant work-based examples.
- Encourage note-taking.
- Use teaching sequence of Term—Definition—Examples as you deliver this information. Add participant examples to flip chart.
- Introduce concept of Integrated Experience.

**THINK ABOUT**

How can you help your participants connect the program philosophy of *Care, Welfare, Safety, and Security<sup>SM</sup>* to their own work values?

**This unit contains:**
- Lecture
- Discussion
- Workbook
  - Pages: 6–7
- Presentation
  - Slides: 6–15
- Materials Needed:
  - Flip chart, markers

**Lecture**

**Activity**

**Discussion**

**This unit contains:**
- 45 minutes

**Materials Needed:**
- Flip chart, markers

**Workbook**
- Pages: 6–7

**Presentation**
- Slides: 6–15
### Unit 1: The CPI *Crisis Development Model*<sup>SM</sup>

#### Crisis Development/Behavior Levels

|------------------------|----------------------|----------------------|----------------------|

#### Staff Attitudes/Approaches

|------------------------|----------------------|--------------------------|-----------------------|

---

### 1. Anxiety

**Definition:** A change in behavior

A nondirected expenditure of energy (e.g., pacing, finger drumming, wringing of the hands, or staring). It is the first level in the *Crisis Development Model*<sup>SM</sup>.

**Examples:** Pacing, wringing hands, withdrawal

---

### 1. Supportive

**Definition:** An empathic, nonjudgmental approach

Attempting to alleviate anxiety. It is the recommended staff attitude/approach to an individual at the Anxiety level.

**Examples:** Listen, allow time

---

**TIP**

It will be easier to identify anxious behavior in those individuals you know well because a change from that person’s typical behavior will be more apparent to you. Building relationships with those in your care will be a great asset in identifying anxiety and increasing your ability to intervene early.
### Unit 1: The CPI Crisis Development Model℠

<table>
<thead>
<tr>
<th>Crisis Development/Behavior Levels</th>
<th>Staff Attitudes/Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2. Defensive</strong></td>
<td></td>
</tr>
<tr>
<td><em>Definition:</em> Beginning to lose rationality</td>
<td></td>
</tr>
<tr>
<td>At this stage, an individual may become belligerent and challenge authority. It is the second level in the Crisis Development Model℠.</td>
<td></td>
</tr>
<tr>
<td><em>Examples:</em> Refusal, belligerence, shouting</td>
<td></td>
</tr>
<tr>
<td><strong>2. Directive</strong></td>
<td></td>
</tr>
<tr>
<td><em>Definition:</em> Decelerating an escalating behavior</td>
<td></td>
</tr>
<tr>
<td>An approach in which a staff member takes control of a potentially escalating situation. Provide a clear instruction requesting compliance.</td>
<td></td>
</tr>
<tr>
<td><em>Examples:</em> Give a simple directive: Jeff, stand up.</td>
<td></td>
</tr>
<tr>
<td>Rather than: Jeff, why are you still at your desk? Get up and move on. It’s time for you to pick up your books, put them in your backpack, and move to the auditorium.</td>
<td></td>
</tr>
<tr>
<td>Keep the directive simple and break it down into smaller steps if necessary. When/if you get compliance for a small step, it is a sign that the individual may have rational perception of what is being requested.</td>
<td></td>
</tr>
<tr>
<td>Set limits if necessary. We’ll discuss and practice this intervention more in Unit 4.</td>
<td></td>
</tr>
</tbody>
</table>
### Crisis Development/Behavior Levels

<table>
<thead>
<tr>
<th>3. Risk Behavior</th>
</tr>
</thead>
</table>

**Definition:** Behaviors that may present a risk to self or others

The total loss of control, which may result in physical behavior that presents a risk to the person or others. At this point, physical interventions may be considered to minimize harm.

**Examples:** Hitting, biting, self-injury

<table>
<thead>
<tr>
<th>3. Physical Intervention</th>
</tr>
</thead>
</table>

**Definition:** Disengagement and/or holding skills to manage risk behavior

A safe, nonharmful, and last-resort response to a person in crisis displaying risk behavior posing a threat to self or others. Skills are reasonable and proportionate to the level of risk behavior presented.

**Examples:** Lower-, medium-, and higher-level disengagement and/or holding skills
Crisis Development/Behavior Levels

4. Tension Reduction

Definition: Decrease in physical and emotional energy

... that occurs after a person has escalated and begins to regain rationality. It is characterized by signs of remorse, lack of clarity, embarrassment, fear, sadness, confusion, etc. It is the fourth level in the Crisis Development Model™.

Examples: Crying, apology

Behaviors seen in individuals during Tension Reduction (crying, apology) may look very similar to Anxiety behaviors. Many staff believe that once the crisis is in Tension Reduction, no further action is required. However, there is a real possibility that the individual may re-escalate. This is one of the reasons that establishing Therapeutic Rapport is so important. While you cannot control how an individual escalates or de-escalates, you can control your own responses to ensure they convey professional values, and the Care, Welfare, Safety, and Security™ of those in your care.

Staff Attitudes/Approaches

4. Therapeutic Rapport

Definition: Re-establish communication

... with an individual who is experiencing Tension Reduction.

Examples: Listen carefully, debrief

Consider elements of your own behavior that you can manage. These include your nonverbal behavior as well as the sound of your voice.

TIP

Before transitioning to Unit 2, point out the Integrated Experience arch, which conveys the influence of staff behavior on individuals in their care and vice versa.
Unit 2: Nonverbal Communication

Introduction

In this unit, you will explore nonverbal communication beginning with an activity. Please choose a partner and join me in the open space.

⭐ TIP

The Crisis Development Model℠ can now be connected to the experiences of your participants. These activities will reinforce the successful approaches that staff currently engage in while uncovering behaviors that staff may not know that they are displaying. Through these activities, participants can experience how the behaviors of one person can impact the behaviors of another. This is the concept of Integrated Experience. Participants begin to recognize how their nonverbal communication may impact the individual in crisis, and actively decide whether their approach is yielding the results they are looking for or if a change in approach is needed.

Instructional Objectives

1. Raise awareness of nonverbal communication during interventions.
2. Illustrate how personal space, or proxemics, affects the behavior level of an individual.
3. Illustrate how body posture, motion, and touch can affect the behavior level of an individual.
4. Emphasize prevention, deceleration, and de-escalation of crisis situations by fostering an awareness of nonverbal communication.
5. Build capabilities to convey values related to Care, Welfare, Safety, and Security℠ during interventions.

KEY POINTS

» Keep the introduction to this unit brief. Avoid providing too much explanation about the activities.
   – Allow participants to experience these concepts first and then connect these experiences to workplace realities.
» Use Demonstrate-Participate-Explain teaching sequence.
» When facilitating activities, provide clear, specific instructions.
» When organizing the activity, encourage participants to choose partners whom they do not know.
» Ensure that all participants have the opportunity to experience the activities.
» Briefly summarize each activity.
» Change partners frequently to enhance the learning experience for all.
Proxemics, Kinesics, and Haptics Activities

Part 1: Proxemics

Demonstrate

1. Ask participants to choose a partner, preferably someone they do not know extremely well.
2. Instruct participants to form two lines approximately 8 to 10 feet apart, facing their partners.
3. Ask a volunteer to help you demonstrate.
4. Walk toward your volunteer. Stop when the person indicates for you to stop.
5. Explain to the group that on your cue they will simply walk toward their partners. Their partners will convey nonverbally when they want them to stop.

Participate

6. Following your demonstration, ask the group in one line to maintain their ground. Ask the participants in the other line to walk directly toward their partners as you demonstrated. For maximum effectiveness, instruct participants to maintain eye contact and to refrain from talking.
7. When participants have stopped, ask them to observe the space between each other and the space between others in the group. Ask participants to return to their original positions.
8. Repeat the activity, reversing roles. Those in the group who stood their ground will now do the walking, and those who did the walking will now stand their ground.
9. Describe behaviors you observed (giggles, shifting stance, changes in facial expression) and ask the group for examples they observed. These are examples of positive expressions of anxiety and appropriate for this activity. Ask how behaviors might change if your partner was beginning to escalate.
10. Briefly explain the concept of personal space. Remember, you will be giving a discussion on this material after the group finishes the activities.

Explain

This first activity gives you an opportunity to illustrate the idea of proxemics, or personal space. Each of us has a personal space, or a boundary. The key to personal space is to understand that it changes from person to person, situation to situation, and environment to environment. You’ve just had the opportunity to experience how managing personal space relative to the person in your care can have an impact on your ability to intervene during the early moments of a crisis.
Part 2: Kinesics

Demonstrate

1. Rotate the group so that each participant has a new partner for the next activity.
2. Choose a new volunteer for the demonstration.
3. As in Part 1, walk directly toward your volunteer and stop about one leg-length away, briefly maintaining a face-to-face, eye-to-eye, shoulder-to-shoulder stance.
4. Next, take a large step toward your volunteer.
5. Take one small step closer (4 to 6 inches) and maintain this position briefly, continuing to maintain eye contact.
6. Finally, take one step back and pivot to the side, with the front of your body angled away from your partner. This allows you to demonstrate the Supportive Stance™.

Participate

7. Following your demonstration, ask the participants in one line to hold their ground while you cue the other line to:
   a. Walk toward their partner, stop one leg-length away, and hold a face-to-face, shoulder-to-shoulder position. Keep participants in this position approximately 5–10 seconds without talking and while maintaining eye contact.
   b. Take a large step toward their partner. Keep participants in this position 5–10 seconds; remind them not to talk to each other.
   c. Take a small step closer. Maintain for 5–10 seconds; refrain from talking.
   d. Take one step back and pivot to the side, with the front of their body angled away from their partner.
8. Reverse roles and have partners who held their ground repeat the same steps on your cues.
9. After the participants complete the activity, identify the signs of anxiety you observed, such as nervous laughter, flicking of the fingers, failure to maintain eye contact, increased breathing rates, and others.

TIP

Throughout the activity, look for obvious and subtle signs of a change in behavior (loss of eye contact, shifting weight, blushing, etc.), as these are nonverbal signals that staff can use to gauge if their behavior/actions are escalating the situation even if it is unintentional.
Unit 2: Nonverbal Communication

Explain

This activity illustrates the idea of kinesics, or body language. Most people perceive a shoulder-to-shoulder/face-to-face position as challenging. Kinesic behavior is also communicated through eye contact, hand gestures, facial expressions, etc. Combining the concepts of proxemics and kinesics allows you to illustrate the Supportive Stance℠. The Supportive Stance℠ allows you to consider your position, posture, and proximity relative to that of individuals in your care.

Part 3: Haptics

Demonstrate

1. Rotate the group so that each participant has a new partner for the next activity.

2. Choose another volunteer for demonstration and to stand as before, maintaining face-to-face, eye-to-eye contact during the activity. Throughout the activity, you will be giving directions to the group.

3. Walk directly toward your volunteer and stand using the Supportive Stance℠.
   a. Reach forward and place your hand on your partner’s shoulder for 2 to 3 seconds, maintaining a light pressure, and observe their nonverbal behavior.
   b. Repeat the activity while placing your hand on the outside of your partner’s elbow.
   c. Finally, take hold of your partner’s wrist, but this time maintain the contact and gently begin to increase the pressure of your grip until you notice nonverbal signs of discomfort. (Remember that the aim of the activity is not to hurt your partner but to demonstrate the impact of touch.)

   - Your partner may start to pull their wrist away, may change facial expressions, or even vocalize discomfort. As you notice signs of discomfort, release your grip.
Unit 2: Nonverbal Communication

**Participate**

4. Following your demonstration, have participants in one line hold their ground while you cue the other group to:
   a. Walk toward their partner and adopt the Supportive Stance<sup>SM</sup>.
   b. Reach forward and touch their partner’s shoulder.
   c. Reach forward and touch their partner’s elbow.
   d. Reach forward and firmly hold their partner’s wrist. As participants do this, give clear instructions to increase the pressure of the grip until they notice (or their partner indicates) that the grip is becoming uncomfortable.

5. As the participants are performing the activity, identify the signs of anxiety you observe.

6. Reverse roles and have partners repeat the same steps.

**Explain**

Haptics, or touch, may generate different messages in different situations. In this training environment, the message received through touch may differ greatly from the message received by someone who is in crisis, even if the “quality” of the touch is identical. What other factors might affect the message received through touch?

Imagine yourself in a crisis situation. Often in a situation in which an individual feels threatened, the same anxieties displayed by staff could easily escalate the individual’s behavior to the point of physical risk behavior. It is very important to consider the impact haptics has on an individual as you consider your physical responses to risk behavior.

**Please return to your seats for an expanded discussion and a chance to write your thoughts and notes.**

**TIP**

Depending on time, this activity can be repeated by approaching from the side or rear, or by approaching someone who is sitting down.
Nonverbal Communication Discussions

Proxemics

*Definition: Personal space*

Proxemics refers to the interpersonal space between people, or personal space. It is an area surrounding the body, approximately 1.5 to 3 feet in range, which is considered an extension of self.

Why did you stop your partner at the point you did? (Record examples on flip chart.)

Examples: Distance, gender, culture, relationships

Everyone has an area around them that is considered an extension of the physical self. Any invasion into this space, and in particular the intimate space, may be perceived as uncomfortable, inappropriate, or threatening.

A person generally has three zones—the intimate zone, the personal zone, and the social zone (use a flip chart to illustrate this). The closer someone gets to you, the more control you want as you may start to feel threatened or vulnerable. Generally across all cultures and genders, you only allow people you know and trust into your intimate zone. Also, personal space is oval rather than circular. In other words, you can tolerate people being much closer from the side than you can if they are directly in front of or behind you.

**TIP**

Summarize the activities with a discussion that allows you to expand on observations made during the activities. It is important to connect people's experience in the activity to the discussion points. Encourage note-taking.

**THINK ABOUT**

In the second part of the activity you were asked to move closer to your partner into these zones. What was that experience like?
Unit 2: Nonverbal Communication

Kinesics

*Definition: Body language*

Kinesics refers to body language, including postures, gestures, stance, and movement. The nonverbal message transmitted by the motion and posture of the body.

*Examples: Gesture, stance, and movement*

What other nonverbal signs of anxiety did you observe in your partner during this activity? Did these change as you began to invade each other’s space and maintain eye contact? How? Kinesic behavior can escalate or de-escalate behavior in any given situation. A body position that appears challenging or confrontational may increase anxiety when approaching an individual. Did you feel more comfortable when you stepped back and turned to the side?

Next, add the nonverbal component of touch, or haptics.

**Haptics**

*Definition: Communication through touch*

Examples: Handshakes, holding hands, backslapping and high fives, a pat on the back, or brushing against arms

Haptics refers to touch as nonverbal communication.

Remember when individuals stepped away from their partners and turned their bodies to the side. This position is called the *Supportive Stance*™.

**THINK ABOUT**

In the final part of the activity, you were asked to touch your partners. What reactions did you have? What reactions did they have? Where is this concept relevant in your workplace?
The Supportive Stance℠

The Supportive Stance℠ is maintained by keeping a distance of one leg-length from the person and by remaining at an angle.

Reasons for Using the Supportive Stance℠

1. Using a Supportive Stance℠ helps manage nonverbal behavior, supports attempts to decelerate the situation, and reinforces Therapeutic Rapport.

2. By consciously adopting the Supportive Stance℠ when you work with individuals, you can benefit from the fact that it helps you to:
   - Communicate respect: Maintain an appropriate interpersonal distance.
   - Convey a Nonthreatening or nonchallenging position.
   - Maintain safety: Maintain personal safety by offering an escape if the person engages in physical risk behavior.

Position, posture, and proximity are part of nonverbal communication.

Position: Where you are in relation to others—your orientation.

During the course of your work, you may need to approach people from different directions including the front, the side, or the rear. Additionally, the person could be above or below you, depending on the situation.

Approaching people from the side rather than directly from the front or the rear, or stepping to the side of the person, places you in a safer position where you are less threatening and less vulnerable.
Unit 2: Nonverbal Communication

Posture: How you hold and move your body.

Standing, sitting, kneeling, lying down. Also the way you move your body by using hand and arm movement, head movement, eye contact, and facial expressions to communicate.

Using your hands and arms in an open gesture; being conscious of your facial expressions, eye contact, and head movement; and adopting a posture with your feet shoulder-width apart helps you remain balanced and nonthreatening.

Proximity: Distance between individuals.

Consider gender, culture, relationships, activity, or context. Managing the space (distance) between yourself and the person will help you keep safe. If possible, try to remain at least one arm’s length away in order to limit the person’s ability to strike you. If you are unable to do this, moving as close as possible will help you become safer, particularly if you need to move past the person in order to create distance.

In addition to nonverbal communication, you also want to consider how you sound when attempting to defuse an escalating situation.

THINK ABOUT
How can you communicate safety and respect through position, posture, and proximity?
Unit 3: Paraverbal and Verbal Communication

Introduction

In this unit of the program, I’ll demonstrate and discuss the concept that how you say what you say, or the sound of your words, is equally, if not more, important than the words you use. We’ll start with an activity.

Instructional Objectives

1. Foster an awareness of the fact that how a verbal statement is delivered impacts how a message is received.
2. Identify the three key components involved in paraverbal communication.

KEY POINTS

» Begin with an activity to experience paraverbal communication.
» When facilitating the activity, provide clear, specific instructions.
» Develop examples relevant to your organization.
» Describe effective communication skills.

15 minutes

This unit contains:
✓ Lecture
✓ Activity
✓ Discussion

Workbook
Page: 9

Presentation
Slides: 20–21

Materials Needed: Flip chart, markers, prepared note cards
Unit 3: Paraverbal and Verbal Communication

Paraverbal Communication Activity

Demonstrate
1. Ask for a volunteer to take on the role of an individual who is uncertain of the procedures on their first day in a new facility, school, etc. You will act as a staff member.

2. Approach your volunteer and use a simple statement or question such as, “Hello, my name is _________. How can I help you?” Use a typical, calm tone of voice.

Participate
3. Divide participants into pairs. One person will act as the individual in the facility or school, the other as the staff member.

4. Write the statement you used in demonstration on the flip chart. (e.g., “Hello, my name is _________. How can I help you?”)

5. Provide a note card to each participant acting as staff. Staff will read the statement on the flip chart to their partner in a way that conveys the word or emotion on the card. For example, angry, sarcastic, rushed, or disinterested.

Explain
This part of communication is called paraverbal communication. It is the link between nonverbal (proxemics and kinesics) and verbal communication.

6. Solicit feedback. What was the experience like for the individual? For the staff?

7. Compare to your earlier demonstration using a calm tone.

Let’s return to the workbook to capture some key points.

TIP
It is important to use the same words during this activity to accurately illustrate the impact of paraverbal communication.
Paraverbal Communication

*Definition:* The vocal part of speech, excluding the actual words one uses.

Two sentences containing identical words can convey completely different meanings.

The three key components of paraverbal communication are:

- **Tone** – Quality and pitch (e.g., sarcasm, impatience, kindness). Use caring, supportive tones.
- **Volume** – Loudness and intensity (e.g., shouting, whispering). Keep the volume appropriate for the situation.
- **Cadence** – Rhythm and rate of speech (e.g., how fast or slow you speak). Deliver message with an even cadence.

Connect this discussion to the activity.

Awareness of nonverbal and paraverbal communication is important at all levels of crisis escalation. The next unit will allow you to practice nonverbal, paraverbal, and verbal communication skills in response to examples of escalating behavior.

---

**THINK ABOUT**

How might the examples of paraverbal communication experienced in the activity influence escalating behavior?
Unit 4: Verbal Intervention

Introduction

Let’s reference the Crisis Development Model℠ from Unit 1 and begin with an activity. This unit will address the Defensive level of behavior escalation and the corresponding staff attitude or approach, Directive. Continue to consider the concept of the Integrated Experience as you participate.

Instructional Objectives

1. Identify different levels of defensive behavior in the Verbal Escalation Continuum℠.

2. Experience what an individual in the second level of crisis may experience while exhibiting different defensive behaviors.

3. Respond to verbal behavior using appropriate verbal responses to decelerate and defuse the potential crisis situation.

4. Illustrate how inappropriate staff reactions may cause an escalation in behavior.

5. Build capabilities to convey values related to Care, Welfare, Safety, and Security℠ during interventions.

KEY POINTS

» Complete the activity before explaining specifics of the Verbal Escalation Continuum℠. This provides participants with a recent, common experience as a reference point for lecture and discussion.

» Establish a safe learning experience for participants. This allows participants to feel comfortable engaging in examples of defensive behavior and practicing different approaches to managing verbal behavior.

» Reinforce existing feedback loops for staff members.

» Ensure all participants are able to experience all roles during activities: individual, staff, and observer.

» Encourage participants to demonstrate the different examples of verbal escalation in a manner that is realistic for their work environments.

» Establish a cue or signal to indicate the end of an activity.
Questioning Activity

Set Up

1. Divide participants into groups of three or four. Each group will identify one person as:
   - The individual in crisis.
   - The staff member.
   - The observer(s).

2. Instruct each participant who is acting as staff to think of a directive to give the individual in crisis. The directive is a routine task, not something unusual. Examples may be: “Vacuum the floor,” “Take this medicine,” “Get out your math book,” or “Leave the unauthorized area.”

3. The observer will watch the interaction between staff and the individual in crisis and note the behaviors displayed by both parties. The observer(s) should:
   - Identify behaviors being displayed by the person in crisis.
   - Identify nonverbal and paraverbal elements in the behavior of the individual in crisis and staff responses. How did they impact the interaction?

4. Bring the participants who are acting as the person in crisis to the side or out of the room so that the staff member and observer cannot hear the instructions. Instruct them to respond to the directives by asking two types of questions: information-seeking (productive) questions and challenging (unproductive) questions. Challenging questions challenge authority or evade the directive.

Demonstrate

5. Demonstrate briefly using an example from each.

   Examples of information-seeking questions:
   - Where’s the vacuum cleaner?
   - Did the doctor prescribe this medicine?
   - What page are we on?
   - Where should I go?

   Examples of challenging questions:
   - Why don’t you clean the floor?
   - Who are you to tell me to take this poison?
   - Since when do you know how to teach math?
   - Why don’t you try and make me leave?

6. Instruct participants who are acting as the individual in crisis to consider how the staff members are managing the scenario. If the staff are reasonable and appropriate, then the individuals in crisis may comply with their direction. However, instruct the individuals in crisis to continue responding by challenging and questioning the staff if they feel the staff are not responding to their questions in a reasonable way.
Participate

7. Ask groups to reconvene. Direct the staff members to approach the individuals in crisis and try to verbally get them to follow an instruction or request. Observe nonverbal and verbal behaviors displayed by staff and the individual in crisis, and note staff success.

8. Let the activity proceed until the staff members succeed in their task—about 2 or 3 minutes. Signal the end of the activity.

Explain

9. Briefly discuss participant experiences. Ask staff what they heard from the individual in crisis. Point out the two types of questions that may have been heard. Elicit feelings and frustrations of both staff members and the individuals in crisis. Invite observers to share observations focusing on the program concepts previously discussed (elements of nonverbal or paraverbal communication). How did staff manage personal space, body language, and paraverbal communication?

10. Identify and briefly explain the behavior. Move to the next part of the activity.

**Verbal Escalation Continuum™**

![Verbal Escalation Continuum Diagram]

**TIP**

Each of the following activities for the *Verbal Escalation Continuum™* will continue in the same manner.
Refusal Activity

Set Up
1. Ask participants to remain in their groups and switch roles. Ask the new staff to think of a new directive or use the example from the Questioning level.

2. Take aside the participants in the role of the individual in crisis. Explain that when staff give them a directive, they will respond with questions (information-seeking and/or challenging) and quickly escalate to Refusal behavior. For example: “I’m not doing it. You can’t make me.” or “No, I won’t. Leave me alone.” Remind them that they are demonstrating verbally challenging behavior, and instruct them to make it very clear to the staff member that they will not cooperate.

Participate
3. Ask groups to reconvene. Direct the staff members to approach the individual in crisis and try to verbally get the individual in crisis to cooperate with their requests. Observe nonverbal and verbal behaviors displayed by staff and the individual in crisis, and note staff success.

4. Let the activity proceed until the staff members succeed in their task—about 2 or 3 minutes. Give your signal to end the activity.

Explain
5. Briefly discuss participant experiences. Ask for feedback about what worked for staff members, and elicit the feelings and frustrations of both staff members and the individuals in crisis. Identify and briefly explain the behavior. Move to the next part of the activity.

Verbal Escalation Continuum

Refusal

Questioning
Unit 4: Verbal Intervention

**Release Activity**

**Set Up**

1. Switching roles again, instruct the staff to think of another directive.

2. Again, take aside the participants in the role of the individual in crisis. In this part of the activity, you want them to begin responding with the previous behaviors of Questioning and Refusal and then quickly escalate to the third stage: Release. This is the stage at which individuals are verbally letting off steam (e.g., shouting, screaming, or swearing).

3. You may wish to cue the group acting as the individual in crisis in some way (e.g., clapping your hands, blowing a whistle, or flicking the lights off and on) to begin venting at the same time. This can add to the effectiveness of the activity.

**Participate**

4. Ask groups to reconvene. Direct the staff members to approach the individuals in crisis and try to verbally get them to comply with their requests. Observe nonverbal and verbal behaviors displayed by staff and the individual in crisis, and note staff success.

   Let the activity proceed until the staff members succeed in their task—about 2 or 3 minutes. Observe behaviors of the group. Signal the end of the activity.

**Explain**

5. Briefly discuss participant experiences. Ask for feedback about what worked for staff members, and elicit the feelings and frustrations of both staff members and individuals in crisis. Identify and briefly explain the behavior. Move to the next part of the activity.

**Verbal Escalation Continuum**

```
  Release
     /   \
    /     \
  Refusal
     \
     /   \
  Questioning
```
Intimidation Activity

Set Up

1. Once again, ask the group members to switch roles. Ask the staff to think of a directive.

2. Take aside those in the role of the individual in crisis and explain that they will begin this activity demonstrating the previous stages and then escalate to the fourth stage: Intimidation. At this stage, they are to verbally or nonverbally threaten the staff in some way. Remind them that they should not touch their partners.

Participate

3. Ask groups to reconvene. Direct the staff members to approach the individuals in crisis and try to verbally get them to comply with their requests. Observe nonverbal and verbal behaviors displayed by staff and the individuals in crisis, and note staff success.

Let the activity proceed until the staff members succeed in their task—about 2 or 3 minutes. Signal the end of the activity.

Explain

4. Briefly discuss participant experiences. Ask for feedback about what worked for staff members, and elicit the feelings and frustrations of both staff members and individuals in crisis. Identify and briefly explain the behavior.

5. Ask participants to return to their seats and begin the discussion.

Verbal Escalation Continuum SM
Tension Reduction Activity

The fifth stage of the Verbal Escalation Continuum℠—Tension Reduction—will be discussed in greater detail later in this program.

You may also have partners shake hands to acknowledge they were “playing a role” during the activities and did not mean anything personal. This can serve as a model for the Tension Reduction stage.

Verbal Escalation Continuum℠

The next discussion focuses on the appropriate staff interventions for the behaviors identified in the continuum. Staff’s goal is to decelerate the situation. Think about your experiences in this activity as you engage in the discussion.
The \textit{Verbal Escalation Continuum}^{SM} Discussion

This model provides staff with verbal interventions to address defensive behavior. There is no guarantee that an agitated person will not present risk behavior to self or others. Nevertheless, this model outlines effective interventions that can be used to decelerate and defuse verbally escalating behavior.

The \textit{Verbal Escalation Continuum}^{SM} helps you recognize behaviors seen at the Defensive level. It is important to recognize that behaviors can escalate in any order and a person may move rapidly from one behavior to another. Or you may encounter several of these behaviors at the same time.

The goal of the model is to provide a reference for you when verbally intervening so that you may better determine what responses might be most appropriate.
Prior to beginning this lecture, direct the participants to write “Defensive” in the center of the diagram, helping the participants to connect the Verbal Escalation Continuum\textsuperscript{SM} to the Defensive level of the Crisis Development Model\textsuperscript{SM}.

As you near completion of this lecture, ask the participants to draw lines between Release-Questioning and Intimidation-Refusal. Conclude with the idea that the Verbal Escalation Continuum\textsuperscript{SM} is NOT a sequential model. Staff may encounter combinations of these behaviors and/or the behaviors may emerge in varying order.

**The Verbal Escalation Continuum\textsuperscript{SM}**

**Intimidation**

The individual is verbally and/or nonverbally threatening staff in some manner. A hands-on approach at this time may trigger physical risk behavior.

**Interventions:**
- Take all threats seriously. Avoid physical intervention unless there is no safer alternative.
- Seek assistance. Wait for colleagues to arrive.
  - Try to avoid individual intervention, as this is more likely to jeopardize the safety and welfare of both staff and the individual.
- Avoid physical intervention unless there is no safer alternative.

**Release**

Verbal and emotional outburst; loss of rationalization; letting off steam; screaming, swearing, high-energy output.

**Interventions:**
- Allow venting. If possible, remove the audience or the person.
- State directives that are nonthreatening.
- Use an understanding, reasonable approach.
- Be prepared to enforce any limits you set.

**Refusal**

Noncompliance; slight loss of rationality.

**Intervention:**
- Set limits. Redirect the person’s focus and attention to the desired outcome.

**Tension Reduction**

Decrease in physical and emotional energy.

**Intervention:**
- Establish Therapeutic Rapport. Re-establish communication with the individual.

**Questioning**

1. Information-seeking: A rational question seeking a rational response.
   - Give a rational response.

2. Challenging: Questioning authority; attempting to draw staff into a power struggle.
   - Downplay the challenge. Stick to the topic. Set limits.
Limit-Setting Discussion

Limit setting is a recommended intervention at several levels in the Verbal Escalation ContinuumSM. Setting limits (or expectations) involves listening to what the person is saying and responding in such a way as to ensure you decelerate the person's behavior and defuse a crisis.

When setting limits, you recognize that you cannot force individuals to act appropriately; staff should recognize that they cannot force individuals to respond to requests, follow directions, or act appropriately. Attempting to force an individual to do something often results in a nonproductive power struggle. By setting limits, you are offering a person choices, as well as stating the result of those choices (more-desirable and less-desirable).

Limits are usually better received when the positive choice and consequence are stated first. Starting with a negative consequence may be perceived as a challenge or an ultimatum, and the individual may not even hear the positive choice.

Keys to Limit Setting

- **Simple/clear.** Keep the limit statement short and simple; use a clear, calm, and even tone.
- **Reasonable.** Don’t expect too much from the person and avoid placing too many requests or demands at the same time.
- **Enforceable.** Ensure you can make it happen—if you set the limit, you need to be sure it will or won’t happen.

These keys are expanded in the following examples of limit setting.
Unit 4: Verbal Intervention

Examples of Limit Setting

Setting verbal limits helps to decelerate situations so that you can positively influence people’s behavior and avoid risk behavior. It is helpful to use specific verbal patterns for deceleration to develop a range of responses.

- **Interrupt and Redirect Pattern**
  This pattern helps the person stop and consider an alternative positive behavior.
  Example: (Interrupt)—“John, you are shouting at me.” (Redirect) “Please speak quietly.”

- **When and Then Pattern**
  This pattern helps the person consider a positive behavior and the immediate impact this will have.
  Example: “John, when you have tidied your room, then we can go to the movies.”

- **If and Then Pattern**
  This pattern helps the person reflect on their current behavior and the impact it is having on others. It also helps the person consider a positive alternative behavior.
  Example: “John, if you make your bed, then we can go to the movies. If you don’t, then you will be unable to go.”

Now you’ll practice these limit-setting examples.
Unit 4: Verbal Intervention

**Verbal Escalation Continuum**<sup>SM</sup> Activity: Limit Setting

**Demonstrate**

1. Divide participants into groups of three with one person acting as the individual in crisis, one as a member of staff, and one as an observer.

2. Take aside the people acting as staff members. As in the previous activity, staff will make a request or give a directive (a routine task or activity) to the individual in crisis. Give them one of the limit-setting patterns identified and some time to think about how they will use this to respond to the individual in crisis.

3. Next, take aside the people acting as the individual in crisis and explain that they are to respond to the request or directive with Questioning (information seeking or challenging), Refusal, or even Release behaviors as in the previous activity. Instruct them to listen carefully to how the staff member responds and to continue to question, refuse, or release unless they feel the staff member is being reasonable. If they feel that in a real event they would respond positively, instruct them to do so.

4. Observers will provide feedback to the person acting as the member of staff.

**Participate**

5. Ask the people acting as the staff to approach the individuals in crisis, give the directive, and use the limiting-setting pattern to encourage them to comply or change their behavior.

6. Allow approximately 2 to 3 minutes and stop the activity. Ask for feedback starting with the individuals in crisis. Ask them to describe the staff’s behavior and if they could identify the limit-setting statement each staff member used. Continue to debrief by asking for comments from the staff members and observers.

7. Repeat the activity until each of the limit-setting patterns has been used.

**Explain**

8. Discuss the limit-setting patterns observed. These patterns begin with an influencing statement. This can help staff to manage their own verbal behavior, with the goal of preventing escalation.

Another key skill to develop for effective intervention at all levels of a crisis is Empathic Listening.
Unit 4: Verbal Intervention

Empathic Listening
An active process to discern what a person is saying.

It is a powerful tool for building relationships with the individuals in your charge. By taking the time to listen, you not only demonstrate your commitment to them, you also communicate the message that they are people of value and worth. Empathic Listening is one of the best ways to strengthen trust and rapport with those in your care. Key elements in Empathic Listening include:

- Nonjudgmental
- Undivided attention
- Listen carefully (focus on feelings and facts)
- Allow silence for reflection
- Restate and paraphrase

Listening empathically can help you to begin identifying why a person engages in challenging behavior.

The activities and discussions so far have focused on identifying behaviors and potential staff interventions. Do you know what might cause an individual to engage in challenging or risk behavior?

THINK ABOUT
How are these points demonstrated nonverbally?
Unit 5: Precipitating Factors, Rational Detachment, Integrated Experience

**Introduction**

The causes of an individual's escalating behavior are often affected by factors over which staff have little or no control. By understanding underlying causes of escalating behavior, you can portray a more professional attitude and minimize personal conflicts. Staff also need to recognize that their behaviors have an impact on the behaviors of those in their care and vice versa. This concept, called the Integrated Experience, was introduced in Unit 1 of the program, and you will explore this concept more in this unit.

**Instructional Objectives**

1. Identify underlying factors that may precipitate escalating behavior.
2. Maintain professional attitudes during a crisis intervention by using Rational Detachment.
3. Understand the reciprocal relationship between the behavior of staff and the behavior of those in their charge, especially during crisis intervention.
4. Build capabilities to convey values related to *Care, Welfare, Safety, and Security* during interventions.

**KEY POINTS**

» You can choose to use large or small group discussions with this section. Maintain control and focus; facilitate the discussion.

» When gathering feedback on Precipitating Factors, focus on developing awareness of the causes of challenging behavior.

» Reviewing the behavior levels will draw focus back to corresponding staff attitudes and the basics of the program.

» Be prepared to answer questions addressing the behavior levels, as the participants have had time to digest the information.

» For each concept, add examples relevant to your setting.
Precipitating Factors Activity

Set Up

1. Hand out sticky notes and pens to the participants. Ask them to think about the individuals they support and about specific example(s) of a physical risk behavior that the person engages in and write that behavior or behaviors on sticky notes (e.g., hitting, biting, etc.).

Participate

2. Divide participants into smaller groups. Ask each group to talk about the behaviors they have identified and to discuss the reasons they think may cause the person to engage in the behavior identified. Participants can also record these in their workbooks.

3. After approximately 3 to 5 minutes of group discussion, ask each group to share with the larger group and record examples in their workbooks. After each group has shared several examples, ask them to consider which of the examples may be considered internal (e.g., illness, pain) and which may be considered external (e.g., environment, trauma).

Modified Activity: The activity can be shortened simply by omitting point 2 above and asking participants as a group to give you the information about the reasons for people's behavior.

*Ask participants to keep the sticky notes, as they will need them for an upcoming activity.*
Additional examples are provided here. You may choose to share some of these if they have not already been discussed during the activity. You may also choose to ask participants for examples of their own personal Precipitating Factors or examples from their working lives.

**Possible Internal Factors** (not necessary to share all)
- Impaired cognitive ability (e.g., as a result of intellectual disabilities, mental illness, dementia).
- Impaired communication skills.
- Fear, anxiety, phobias, stress.
- Lack or loss of esteem; loss of control or personal power; lack of self-determination.
- Failure.
- Low expectations or expectations that are too high.
- Unmet need for love, affection, recognition, etc.
- Coping mechanisms (e.g., displaced anger, projection, learned helplessness).
- Trauma or previous life experiences.

**Possible External Factors**
- Attitudes and behavior of others.
- Physical environment (people, space, cleanliness, noise, temperature).
- Stimulus response (behavior occurs as an interaction between the person and their environment).
- Level of value, dignity, and respect afforded to people.

**Explain**
Observable behaviors occur as a result of the interaction between the person and their environment. CPI uses the term Precipitating Factors to describe possible reasons why behaviors occur.
Unit 5: Precipitating Factors, Rational Detachment, Integrated Experience

Precipitating Factors Discussion

*Definition:* Factors that influence behavior. These are internal and/or external causes of behavior over which you have little or no control.

**Precipitating Factors**

Discussion Points:

Understanding Precipitating Factors can help you to:

- Depersonalize crisis situations by recognizing that you are seldom the sole cause of the risk behavior.
- Address factors that lead to crisis situations.
- Avoid becoming a Precipitating Factor yourself. Proactively address factors.

If you take challenging behavior personally, it is more likely that you become a part of the problem causing behavior to escalate.

Rational Detachment Discussion

*Definition:* The ability to manage your own behavior and attitude and not take the behavior of others personally.

**Discussion Points:**

- Stay calm. You may not be able to control Precipitating Factors, but you can control your own responses to risk behaviors.
- Maintain professionalism so that you can manage the situation by responding appropriately.
- Do not take behaviors of others personally.
- Find positive outlets for the negative energy absorbed during a crisis.

Precipitating Factors impact behavior levels on the *Crisis Development Model*™, and Rational Detachment impacts your attitudes/approaches. Recognizing this shows the significance of the Integrated Experience.

**TIP**

You may wish to have an open discussion with participants at this time, soliciting suggestions for ways in which staff members are able to rationally detach. For example: debriefing and outside activities. Begin by sharing some of your own examples.
Integrated Experience Discussion

**Definition:** Behavior influences behavior. The concept that behaviors and attitudes of staff impact behaviors and attitudes of those in their care and vice versa.

**Discussion Points:**

Understanding this can help you to:

- Consider how your behavior impacts those in your care.
- Treat those in your care respectfully.
- Make objective decisions.

If you aren’t aware of the possibility that behavior is impacted by Precipitating Factors, your Supportive responses are limited and you may miss opportunities to decelerate behavior through meaningful limit setting.

If you are unable to rationally detach, your response to behavior may contribute to escalation rather than defuse a situation.

Identifying a person’s behavior level within the Crisis Development Model℠ helps you to reflect on the behavior and choose a suitable and appropriate attitude/response, which will build rapport and decelerate (rather than escalate) the situation. Staying in control of your attitude and behavior will allow you to offer the best Care, Welfare, Safety, and Security℠ to the people you work with.

A very commonly identified Precipitating Factor is the emotion of fear—an emotion you may be uncomfortable talking about. What level of behavior may be the most likely to cause staff to feel fear and/or anxiety? In the next unit, let’s look at how you react to this emotion and ways to use your reactions productively.
Unit 6: Staff Fear and Anxiety

Introduction

Fear is a natural—and sometimes beneficial—emotion in a crisis situation. Fear results from a lack of knowledge and understanding, while anxiety is a form of fear in which you anticipate what may or may not occur. In this unit, you will learn about the productive and unproductive reactions to fear and anxiety. It can be difficult to eliminate your own fear; however, you can learn to control and use it to your own advantage.

Instructional Objectives

1. Understand the causes of fear.
2. Identify the productive and unproductive behaviors caused by fear.
3. Learn how to make fear and anxiety work for you in a crisis situation.

KEY POINTS

» Conduct the activity before introducing unit concepts.
» Share a personal example of your own responses of fear and anxiety to reinforce to participants that everyone experiences these reactions.
» Focus the discussion on productive and unproductive responses. This helps staff think about fear and anxiety in a more positive way.
Unit 6: Staff Fear and Anxiety

Staff Fear and Anxiety Activity and Discussion

Set Up

- On a break prior to this unit, privately ask a volunteer to assist you in an upcoming unit. Tell them you will give them a cue as you begin Unit 6 (for example, you can say the person’s name; put your hand on your head; or say, “Let’s think about fear at work.”).

- Ask the volunteer to plan to make a loud noise (e.g., shout or bang on table, etc.) when they hear/see this cue. Explain that you want this to be unexpected so as to surprise/startle the group. Explain that this will help you introduce concepts from the unit on fear and anxiety.
  - Ensure that your volunteer understands that the goal of the activity is to catch the other participants by surprise. Instruct the volunteer to wait until you start to introduce the unit before undertaking the activity.

Explain

The responses you are having are psychological and physiological. Has the behavior of an individual in crisis ever surprised you or caught you off guard? Has apprehension of what might happen ever concerned you? Fear and anxiety are universal human emotions and may also be referred to as the fight or flight response. How did the unexpected noise impact you?

| TIP | Your responses generally fall into two categories, productive and unproductive. |

Unproductive

Reactions to fear and anxiety include:

- **Freeze**—inability to react to a situation (e.g., stage fright).

- **Overreact**
  - Psychologically—perceiving a situation as worse than it really is.
  - Physiologically—motor skills do not function normally.

- **Respond Inappropriately**
  - Verbally—saying things that are not pertinent to the situation, using offensive or inappropriate language.
  - Physically—striking out at someone, not being able to control your actions.

Productive

Reactions to fear and anxiety as a result of stress hormones (catecholamines—adrenaline and noradrenaline) prepare the body for action.

- **Increased speed and strength** (physiological response)—Increase in motor reaction, increase of oxygenated blood to the muscles in preparation for movement.

- **Increased sensory acuity** (psychological response)—Alertness or sharpening of your senses; decrease in cognitive reaction and decision-making time (you make judgments about perceived threats very quickly).

- **Decreased reaction time.** You may need less time to react or respond physically.
Maximizing Productive Responses

- Learn to keep yourself safe.
- Learn how to keep the individual in crisis safe.
- Use a team approach.
- Understand what makes you afraid and drives your decisions.

At times, you may also experience anxiety or fear because of perceived legal implications relating to how you respond—or perhaps don’t respond. Therefore, what makes you afraid may go beyond the actual behavior. So it is important to have accurate information about this, as well as information and skills to respond in ways that minimize risks.
Unit 7: Decision Making

Introduction

This unit enables you to practice making decisions using a framework relating to risk at all levels of crisis development, especially when considering the use of physical interventions. This unit explores a range of factors that need to be considered when making a situational or behavioral risk assessment, introduces the Decision-Making Matrix, and discusses how decisions can be made that may be justified and defended from a legal and professional perspective.

Instructional Objectives

1. Utilize the Decision-Making Matrix to undertake a situational or behavioral risk assessment based upon the individual, specific behaviors, and the prevailing risk.

2. Explore the concepts of reasonable, proportionate, and least restrictive physical responses to risk behavior based on the current legal and professional framework and national or sector-specific guidelines for best practice.

KEY POINTS

» Review any relevant organizational policies or procedures related to decision making and physical risk behavior.

» The Decision-Making Matrix will also be referenced with Units 8 and 9.
Key Legal and Professional Considerations Discussion

• Risk is a dynamic process. A response decision that is defendable in one situation may not be justified in another situation that presents the same or similar risk.

• You need to be prepared to not only explain but justify reasoning for your decision in responding to risk behavior.

• You have a professional and legal obligation to ensure that physical interventions are least restrictive and used as a last resort. It is also important to consider whether a physical intervention used is reasonable and proportionate to the prevailing risk.

• Review the definition of risk behavior. Ask participants for examples of any key legal or professional considerations relevant to decisions they make about responding to risk behavior. Record these examples on the flip chart. Summarize with the points on the slide.

  - Accreditation and regulation
  - Professional codes of practice
  - Benchmarks for good practice
  - Criminal/civil law

Key themes related to decision making include:

  - Duty of Care
  - Best interests
  - Reasonable and proportionate
  - Last resort and least restrictive
  - The risk of doing something and the risk of doing nothing
  - Human rights
Think about a specific behavior you have encountered at work that may have caused you to feel anxious or fearful. The next activity will ask you to consider the level of risk perceived in these example behaviors.

**Activity 1: Decision Making**

Provide participants with sticky notes and ask them to write down a behavior of concern or use the behavior written on the sticky note during the discussion of Precipitating Factors in Unit 5. Ask them to be as specific as possible. Prompt participants to accurately describe the behavior rather than use generalized terms (e.g., aggressive, threatening, violent). It may help participants if they think of an individual they work with.

**Demonstrate**

On a flip chart or whiteboard, draw three columns and label as below. Use an example of your own to demonstrate how a behavior can be placed under one of the columns to represent a perceived level of risk.

<table>
<thead>
<tr>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Participate**

Ask participants to consider the behavior they have written down and to place it in the column they feel equates to the perceived level of risk.

**Explain**

Why did you choose to put the behaviors in different columns? I notice identical behaviors appear in more than one column. Remember, levels of risk are assessed based on an individual’s perceptions and a range of factors including the people involved, the situation, previous experiences, your level of fear or anxiety, etc.
Decision-Making Matrix Discussion

The ability to effectively assess risk regarding physical risk behavior is essential to critical decision making during a crisis event. Developing critical decision-making skills enables you to remain in control of your own emotions and behaviors in order to make appropriate judgments about the necessary actions required. The ability to determine the level of risk is important, as this helps you determine if physical intervention is necessary and at which level.

TIP

Staff often find it difficult to reach an objective critical decision about risk and risk behavior because they confuse risk with concern or fear. It is important to remember that staff can have high levels of concern about low-risk behavior and, by comparison, have low levels of concern about a high-risk behavior, since they often make decisions subjectively rather than objectively.
Unit 7: Decision Making

The Decision-Making Matrix is a tool that can help you reach objective critical decisions about risk. These are the key terms and descriptions to understand how to use this model.

**Risk:** The chance of a bad consequence.

**Likelihood:** The chance that an event or behavior may occur.

Likelihood can be viewed along a continuum. For example, on the matrix, the horizontal continuum ranges from “unlikely” on the left-hand side to “likely” in the middle and then “definitely will happen” at the right-hand side.

These labels are not absolutes, but they are there to give you a guide when making decisions about the likelihood of a behavior occurring.

**Severity:** The level of harm that may occur. Severity can be viewed along a continuum. For example, on the matrix, the vertical continuum goes from “no harm” at the bottom to “minor harm” in the middle and then “major harm” at the top.

As with likelihood, these labels are not absolutes, but they are there to give you a guide when making decisions about severity of harm that can occur as a result of the behavior.

Using the likelihood and severity variables, risk can be determined in the following way.

---

**TIP**

Everyday life involves some degree of risk, which can be viewed along a continuum from lower risk to higher risk. When reaching a decision about risk, it is important that you objectively consider two key variables: likelihood and the severity of harm. When introducing these two variables to participants, it is important to provide examples that do not relate to their day-to-day work, as this will be done at a later point during this unit. The examples given below illustrate the risks associated with different forms of travel.
Unit 7: Decision Making

Lower Risk: A decision about lower risk can be reached by comparing the following possibilities:

- An unlikely event or behavior with a high severity of harm. Example: Traveling by air is lower risk. It is unlikely that a plane will crash, but if it does occur, the severity of harm is likely to be high. This example illustrates the difference between risk and concern. While air travel is lower risk, many people have high levels of concern about flying, with some people’s concerns causing them to never fly.

- A likely event or behavior with a low severity of harm. Example: Traveling by car is lower risk. It is likely that a car will be involved in a collision, but if a collision does occur, the severity of harm is likely to be low. This example can illustrate the difference between risk and concern. While car travel is lower risk, most people have low levels of concern because although they are more likely to be involved in an accident when driving a car, the severity of harm is likely to be low.

Higher Risk: A decision about higher risk can be reached by comparing the following possibility to the previous examples.

- A likely event or behavior with a high severity of harm. Example: Traveling by motorcycle is higher risk. It is likely that a motorcycle will be involved in a collision, and if it does occur, the severity of harm is likely to be high.

All three examples illustrate the difference between lower risk and higher risk. However, it is important to remember that risk is a judgment and not a predictive process. Regardless of risk, many people travel by plane, by car, and by motorcycle without coming to any harm. The whole purpose of the Decision-Making Matrix is to help you make objective judgments of risk on which you will base your decisions to take a suitable course of action in relation to risk behavior.
Unit 7: Decision Making

Activity 2: Decision-Making Matrix

1. Place the Decision-Making Matrix poster on the wall and ask participants to collect their sticky notes from the previous activity and use the variables of likelihood and severity to determine the risk. Demonstrate by showing where you would place an example on the Decision-Making Matrix poster in the column you feel equates to the level of risk of the behavior. Invite participants to do the same using their examples.

2. Debrief/discuss. Ask why participants chose to put the labels in different risk columns and ask how many people assessed the risk differently from the first activity and why.

3. Highlight that this is a decision-making tool, and that the variables enable you to make a more considered and objective judgment, as well as to provide evidence of your decision to others.

In a crisis, decisions are made by a team. The Decision-Making Matrix can help to choose the most appropriate intervention. Now discuss how teams can be organized.
Team Intervention

Reasons for Team

- **Safety** - A team is able to manage a crisis more safely than an individual staff member.
- **Professionalism** - Team members provide support. This increases your ability to rationally detach.
- **Litigation** - Intervening as a team provides witnesses to the situation.

Team Leader

- **First on the scene** is the most likely person to begin the intervention.
- **Confident/competent**: The team leader most able to effectively manage the crisis.
- **Best rapport** with the person engaging in challenging or risk behavior.
Auxiliary Team Member Duties

1. Check
   - The physical and psychological status of the individual in crisis.*
   - The safety of the environment. Remove dangerous objects.

2. Address
   - What needs to happen to de-escalate the crisis?
   - Are there any safety concerns?
   - In physical interventions, are Control Dynamics being utilized safely?

3. Recognize
   - Additional assistance when needed.
   - The need to change intervention strategies. (Examples: Is it time to enforce limits? Is it time to discontinue physical management?)

4. Engage in
   - Verbal de-escalation with the escalating individual (if directed by the team leader).
   - Support to other team members.

*Please see next page for more information on restraint responses that indicate distress.
**Warning Signs of Distress**

The events leading up to a crisis situation and the struggling that occurs during any type of restraint can result in a great deal of stress for the individual who is being restrained. This negative stress is sometimes called distress. Consequently, it is not unusual for a restrained individual to show signs of distress, and staff should be trained to check for these signs. The chart below provides some examples of responses to restraint that may indicate a serious problem.

<table>
<thead>
<tr>
<th>If this sign of distress appears:</th>
<th>This system of the body may be involved:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shallow, rapid breathing</td>
<td>Cardiopulmonary</td>
</tr>
<tr>
<td>Grunting</td>
<td></td>
</tr>
<tr>
<td>Bluish tinge to fingernails or around mouth</td>
<td></td>
</tr>
<tr>
<td>Flushed or pale complexion</td>
<td></td>
</tr>
<tr>
<td>Cold extremities</td>
<td></td>
</tr>
<tr>
<td>Nasal flaring</td>
<td></td>
</tr>
<tr>
<td>Absence of breathing</td>
<td></td>
</tr>
<tr>
<td>Confusion/disorientation/flashbacks</td>
<td>Neurological</td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
</tr>
<tr>
<td>Vomiting</td>
<td></td>
</tr>
<tr>
<td>Diarrhea</td>
<td></td>
</tr>
<tr>
<td>Difficulty breathing/hyperventilation</td>
<td></td>
</tr>
<tr>
<td>Unconsciousness</td>
<td></td>
</tr>
<tr>
<td>Headache</td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td>Bruising/redness</td>
<td></td>
</tr>
<tr>
<td>Discoloration</td>
<td></td>
</tr>
<tr>
<td>Swelling</td>
<td></td>
</tr>
<tr>
<td>Crepitus, or a crackling, crinkling, snapping, or grinding feeling or sound under the skin, around the lungs, or in the joints</td>
<td></td>
</tr>
</tbody>
</table>

**Please Note:** This chart is for informational purposes only and is not intended to substitute for consultation with your facility’s medical advisors regarding other specific concerns that may affect the population you serve. Your policies and procedures should address elements such as: what signs staff are to look for, how staff will be trained to monitor these signs, and what protocol is to be followed if signs of distress appear.
Unit 7: Decision Making

Team Leader/Incident Manager Duties

- **Planning**
  - Consider known Precipitating Factors.
  - Assess level of risk. Identify team leader.
  - Direct and cue staff.

- **Decision Making**
  - Include team in making effective decisions.
  - Consider the needs of the individual in making decisions with a person-centered focus.

- **Communication**
  - Ensure clear, calm communication.
  - Team leader may delegate role of communicator with individual.
  - Ensure that the person being held is able to understand and follow instructions.

- **Safety**
  - Focus on Care, Welfare, Safety, and Security℠ of all involved.
  - Continually assess for potential signs of physical distress, even after the hold is discontinued.

- **Postvention Approaches**
  - Delegate team member to monitor individual.
  - Debrief with individual and team members.

**TIP**

If you'd like to expand on Postvention from here, you can move ahead to Unit 10. This would be applicable especially if you are not teaching Units 8 and 9.
Introduction

This section provides a bridge between Part 1 and Part 2 of the program. It is an opportunity to assess whether participants understood and retained information from Part 1, regardless if completed online or in classroom training. This component of the program is also important in helping participants apply knowledge and skills learned in Part 1 to their daily work responsibilities. Key outcomes from this section are to:

- Validate learning from Part 1 of program.
- Check Part 1 learning retention and comprehension.
- Fill in learning gaps.
- Encourage staff teamwork in problem solving and decision making utilizing course concepts.
- Promote thinking to realistically apply knowledge and skills to daily work responsibilities.

Application Activities

There are three application activities:

1. Individual
   - Participants independently reflect and recall key program concepts from Part 1 learning.
   - Instructor assesses participant comprehension of Part 1 learning.

2. Group
   - Pair or small groups discuss key concept application and relevance to work circumstances.
   - Pairs or small groups present perspectives on relevance with the class.

3. Situational
   - Apply concepts and skills from Part 1 through a scenario-based learning activity.

**TIP**

If you teach a group where some participants were in the classroom for Part 1 and some took Part 1 online, you may want to start Part 2 off with a question that allows participants to say something about what they found most valuable during Part 1. This will build rapport in the group and allow you to confirm that all your participants are on the same page.
Introduction

We are going to take time to reflect on your learning from Part 1 of the program and learn from your collective experiences. I am going to show you five reflection questions and ask that you jot down notes as you consider them. Feel free to use any notes you have taken from Part 1. After you have considered each of the questions, I will go through each question and randomly ask each of you for input as we review as a group.

Application Activity Instructions

- Put questions up one at a time, and allow participants 30–60 seconds per question to write down notes.
- Once all questions are completed, debrief the questions one at a time.
- Ask participants to offer answers that were not already mentioned by another participant. Go around the room, ensuring each participant has the ability to answer at least one question.
- The points in italics are for the group discussion after all questions have been posted for individual reflection and note-taking.

Individual Reflections

1. What are the four words that describe the underpinning values of Nonviolent Crisis Intervention® training? How do these relate to the work that you do?
   - Call on different participants to provide one word each, and explain how that word relates to the work you do.
   - These four words represent the values that guide staff decision making through the chaos that can happen during a crisis.

2. Convey your understanding of the Crisis Development Model℠.
   - Choose level 1, 2, or 4 of the Crisis Development Model℠.
   - Define the level.
   - Describe how that level of behavior appears in your work.

KEY POINTS

» In the individual application activity, pay attention to nonverbal communication from participants. Are they considering the questions and writing notes? Do they seem confused or appear to be recalling concepts? Your observations may tell you that it is important to do a more thorough review instead of the second group application activity.

» Based on the content knowledge of your group, you can choose to adapt these application activities to meet their needs.
Review and Application
Activity 1: Individual Application

- Describe what response you would use to intervene with an individual displaying this behavioral level.
  - Draw the “T-chart” for the Crisis Development Model™. Be sure to also draw the arrow for Integrated Experience.
  - Ask participants to individually share their response to the second reflection. While participants answer, fill in the T-chart with the terms as they are identified by the participants. The goal is to review terms, as well as to encourage specific connections to everyday situations. Continue until the entire Crisis Development Model™ is filled in.
  - Remind participants of the importance of the Integrated Experience.
  - The model allows you to consider the best type of response.

3. What are two examples of behavior you may see if someone is at the second level of crisis development? What might be one thing you do when you see these behaviors?

- Draw the Verbal Escalation Continuum™ outline on a flip chart.
- Have one participant give an example of defensive behavior, and then have a different participant describe what they would do in response to that behavior. The goal is to review defensive behaviors and responses for de-escalation. Fill in the Verbal Escalation Continuum™ as the topics are bought up.
- Continue to call on participants in this manner until all the terms and concepts of the Verbal Escalation Continuum™ are discussed (information-seeking questions, giving directives, setting limits, removing the audience, allowing an individual to vent, listening, and taking threats seriously.)
- Discuss how being directive at this defensive stage can help you stay on track for defusing a crisis situation.
4. What might influence an individual demonstrating a level of crisis behavior? What might influence staff and their approach?

- Return to the flip chart page with the Crisis Development Model℠.
- Have individual participants give their answers. Be sure to cover the topics of Precipitating Factors and Rational Detachment.
- Discuss how you can only control one side of the model—your responses. Being aware of these factors can help you to understand what might be most relevant to the individual in your care. This self-awareness and control can help you to detach and maintain your professionalism during challenging crisis situations.

5. Consider what you learned about nonverbal or paraverbal communication. Give an example of how you would use one of the concepts to manage your own behavior in responding to an individual in any level of crisis.

- Ask participants to individually share their responses to the fifth reflection.
- Add the words to a flip chart until all of the following concepts have been described: Proxemics, Kinesics, Position, Posture, Proximity, Haptics, Supportive Stance℠, Paraverbal Communication, Tone, Volume, and Rate/Cadence.
- Discuss how all these concepts are important to provide the best possible care and welfare while maintaining safety and security.
Introduction

The purpose of the group application is to stimulate deeper thinking about the concepts, terms, and definitions explored in Part 1 of the program and to help you connect these to experiences you have had or anticipate having in meeting your work responsibilities.

Each person in the group must contribute to the presentation. Each group should use program language and terms in their presentation. Groups need to be prepared to answer questions posed by their Instructor.

Group Presentation Reviews

• During this section, participants should be referencing their notes from Part 1.

• Assign pairs or groups of participants to discuss and present one section of the program.

• Examples of topics could be:
  – Crisis Development Model℠ (can be split into two groups with each group presenting on two levels)
  – Nonverbal Communication
  – Paraverbal Communication
  – Verbal Escalation Continuum℠
  – Limit Setting
  – Decision-Making Matrix

• Each group will answer the following questions regarding their topic:
  – Why is this concept important in preventing or intervening with actual or potential aggression you may encounter in your work?
  – Describe or demonstrate how the concept applies to a specific workplace scenario.

• After each group or pair presents their section, ask questions:
  – to clarify something presented.
  – to promote concept application.
  – to prompt deeper thinking.

KEY POINTS

» If you identify that participants have a low level of recall for the content, then you could facilitate this as an Instructor-led discussion.

» If a small group of individuals have a low level of content knowledge, you can pull them aside while the rest of the group works on the group activities.
Introduction

Scenarios provide an opportunity for practical application of the information covered during training. The purpose of this application activity is to consider how the concepts you have learned so far can be applied.

Note: The scenarios can be used effectively at this point in the program or at the end of each section if the course is being divided into a number of training sessions.

Application Activity

1. Ask for five participants that are willing to volunteer.

2. Assign three of them with the following roles, giving instructions to volunteers 1 and 2 together, but giving instructions to volunteer 3 privately. (Let the other two volunteers know that you will give them more direction further into the activity.)

   • Volunteer 1
     Inform this person that they are acting as an individual in crisis, and should engage with staff member(s) by displaying intimidating behaviors (not engaging in physical threats).

   • Volunteer 2
     Inform this volunteer that they are an individual in the Anxiety level of crisis development and should act increasingly anxious as volunteer 1 interacts with staff.

   • Volunteer 3
     Inform this person privately that they are acting as a staff member that has had a bad day and is having a hard time rationally detaching.

3. Before beginning the scenario, set up the scene for your participants.

   • Identify your volunteers. Volunteers 1 and 2 are individuals at a facility; volunteer 3 is a staff member at a facility.

   • Describe scene: Staff find these two individuals in an unauthorized area. What you know about volunteer 2 (use their actual name) is that they are normally friendly and bubbly towards staff.

4. Give instructions to the rest of the participants who are observing. Identify rows or tables of observers and give them specific topics within the situation to focus on as they watch the scenarios unfold. Topic examples could be nonverbal communication, paraverbal communication, precipitating factors, and verbal interventions.

<table>
<thead>
<tr>
<th>Volunteer</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Individual in Care (Defensive)</td>
</tr>
<tr>
<td>2</td>
<td>Individual in Care (Anxiety)</td>
</tr>
<tr>
<td>3</td>
<td>Staff Member (not rationally detached)</td>
</tr>
<tr>
<td>4</td>
<td>Staff Member (assisting volunteer 3)</td>
</tr>
<tr>
<td>5</td>
<td>Individual in Care (doesn’t like volunteer 1)</td>
</tr>
</tbody>
</table>
Review and Application
Activity 3: Situational Application

5. Remind group that there will be no demonstration of physical risk behavior. Let everyone know your cue to stop the action (e.g., clapping, time-out sign, stop).

6. Cue groups to begin. Carefully observe participants for examples you can share when debriefing.

7. Allow the situation to play out for about 5 minutes. Then have the volunteers pause, and discuss the following with the whole group:
   - Ask what levels of behavior the audience noticed. (Participants should be able to identify that the first individual in care is at the Defensive level and the second individual in care is in Anxiety. They might also notice that the staff member is struggling to rationally detach.)
   - Point out that you actually instructed volunteer 3 to act as if they were having a bad day and struggling to rationally detach. Acknowledge that the volunteer was coached to engage in inappropriate responses.
   - Ask the group for examples of how they could identify that from the staff member’s behavior. Call on individuals for their answers.
   - Ask the group to consider what skills they might use as a staff member who observed this type of scenario unfolding at their organization.

8. Now include volunteer 4; they will step in as an additional staff member who comes to the situation.
   - Let volunteer 3 (first staff person) know they no longer need to act in a negative manner but should feel support by the arrival of (name volunteer 4).
   - Inform volunteer 1 to comply if reasonable limits are set by staff.
   - Let volunteer 2 reduce their signs of Anxiety if a staff member is Supportive.

9. Allow the situation to continue for approximately 5 minutes until the added staff member has used effective skills to defuse the situation. Then have the volunteers pause, and discuss the following question with the whole group:
   - Who was the team leader in this situation and why? Call on individuals for answers; most likely it is the second staff member because they will have more confidence in the situation. If necessary, turn to pages 80–83 and review the Team Intervention section.

10. If time permits, have volunteer 5 come up. Let them know that they are going to be an additional individual in care at the facility. They do not like volunteer 1. Add them to the scene with the intention of re-escalating that individual.

11. Allow the scene to play out for about 5 minutes, allowing the two staff members to interact and intervene with the three individuals in their care.
12. End the scenario and engage the large group in debriefing.

- Feedback should be focused on behaviors and interventions observed.
- Discuss how concepts from Part 1 have been applied during the activity by asking each row/table about what they observed based on the area of focus that they were given at the beginning of the activity.
- Talk about what took place and why, as well as the feelings and reactions of the observers.
- Discuss the individual in their care that was in a state of anxiety, and how staff members addressed the situation.
- Allow the volunteers to discuss their perspective and experience.

13. To close this activity, have participants pair up with one or two others. Ask them to consider the scenario and list two skills they learned during Part 1 of the training which they think they would use in a similar situation in their workplace.

So far in the program, different behaviors can be perceived as different levels of risk, and you have a professional and legal obligation to use a reasonable and proportionate response. If individuals engage in risk behavior, the disengagements taught in the next unit follow basic principles. This allows you to adapt to different situations when escape and/or evasion are the safest alternatives available (Turn to Units 8 and 9).
Units 8 and 9: Physical Interventions

**Unit 8: Physical Interventions - Disengagement Skills**

Please see Unit 8: Physical Interventions - Disengagement Skills section starting on page 105.

**Unit 9: Physical Interventions - Holding Skills**

Please see Unit 9: Physical Interventions - Holding Skills section starting on page 127.
Unit 10: Postvention

Introduction

The final behavior level in a crisis situation is Tension Reduction. This can be a difficult stage. Some people may realize that their actions were wrong and may fear the consequences of those actions, particularly if harm or injury has occurred. Thoughts of retaliation, loss of personal freedom, or shame may be of great concern. In order to provide the best possible Care, Welfare, Safety, and SecuritySM, the staff attitude/approach of Therapeutic Rapport is utilized. This is a process of re-establishing communication with the individual, when active listening is essential.

All those directly involved in the crisis, and in particular those involved in a crisis that has included the use of physical interventions, must go through a debriefing process after the event. In addition, there may be a need to communicate with other stakeholders, including other staff members, bystanders, and peers or family members.

Instructional Objectives

1. Explore the final behavior level in the Crisis Development ModelSM and the appropriate staff response.

2. Help the individual experiencing Tension Reduction examine alternative, more appropriate behaviors.

3. Communicate with team members after the crisis intervention.


KEY POINTS

» Use the COPING ModelSM to explain the Postvention process. Each letter in the word COPING stands for a word that describes how to establish Therapeutic Rapport with an individual who is experiencing Tension Reduction.

» Discuss the COPING ModelSM twice—first as a process to be completed jointly by staff and the person they support, and then with the staff involved in the crisis as a debriefing process.

» Use a real-life example to follow the process from beginning to end.

TIP

If your participants went through Part 1 online, then they will have already covered Unit 10. During Part 2 for these individuals, feel free to have them go through the Postvention Activity listed on page 99.
Postvention provides an opportunity to work toward change and growth for individuals who have engaged in risk behavior, as well as for staff members. Without a Postvention process such as the one described below, crises are likely to occur over and over again.

The **COPING Model**

A model that guides you through the process of establishing Therapeutic Rapport with an individual after a crisis incident. The **COPING Model** can also be used to structure a staff debriefing.

<table>
<thead>
<tr>
<th>Individual</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>After the emotional—and often physical—outburst of the crisis, the energy level of the individual should drop. The individual will appear calmer and more rational.</td>
<td>Staff involved in managing or responding to a crisis as a team should meet after the event has occurred. During this meeting, staff can discuss the interventions and their own behaviors. Debriefing is not a complaint session or an opportunity to tell people what they may have done wrong, but instead is a constructive dialog between professionals on how to improve future crisis interventions. The process is similar to the one described for the individual.</td>
</tr>
</tbody>
</table>

- **Control**
  - Ensure that emotional and physical control is regained.  
  - Make sure that the person who was in crisis is back under emotional and physical control before the incident is discussed.  
  - Ensure that emotional and physical control is regained.  
  - Be sure that all staff members are back under emotional and physical control before discussing the incident.

- **Orient**
  - Orient yourself to the basic facts.  
  - Establish what happened and ensure you remain nonjudgmental. Listen to the perspective of the individual.  
  - Orient yourself to the basic facts.  
  - Establish the basic facts of the incident. Staff may have arrived at different points in the intervention and may have observed and heard events differently.
## Unit 10: Postvention

### WORKBOOK PAGE 33

<table>
<thead>
<tr>
<th>Patterns</th>
<th>Individual</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Look for patterns or triggers for the behavior. Look for any patterns in past behavior and the events preceding the crisis, and attempt to identify triggers for the behavior.</td>
<td>Look for patterns in staff responses to the behavior. Review the staff response to crisis situations. Are there patterns in the way the team responds? Did everyone know what to do? Did staff do anything that may have escalated the situation or the individual's behavior? If physical interventions were used, was this a necessary, reasonable, and last-resort option? Was the best possible Care, Welfare, Safety, and Security℠ provided to all who were involved?</td>
<td></td>
</tr>
</tbody>
</table>

| Investigate | Investigate alternatives to the behavior. Investigate alternatives to the behavior and resources that could be helpful in making behavioral changes. | Investigate ways to strengthen staff responses. Look for ways to strengthen individual and team responses to crisis situations. Explore ways to prevent similar situations in the future. Identify resources that may be helpful for staff members. Consider the need to review and/or practice any of the core knowledge and skills from the training. If the crisis was traumatic, are staff members in need of further debriefing or additional support from a trained counselor? |
## Unit 10: Postvention

<table>
<thead>
<tr>
<th></th>
<th>Individual</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N</strong></td>
<td>Negotiate future approaches, expectations, and behavior.</td>
<td>Negotiate changes that will improve future interventions.</td>
</tr>
<tr>
<td><strong>e</strong></td>
<td>Negotiate a contract with the individual. Make sure that the person</td>
<td>Agree to changes that will improve future interventions, and gain</td>
</tr>
<tr>
<td><strong>g</strong></td>
<td>understands what to do instead of displaying risk behavior. Ensure that</td>
<td>commitment from everyone to ensure that the improvements will be</td>
</tr>
<tr>
<td><strong>o</strong></td>
<td>the individual understands the consequences for positive and negative</td>
<td>implemented.</td>
</tr>
<tr>
<td><strong>g</strong></td>
<td>behavior in your contract.</td>
<td></td>
</tr>
<tr>
<td><strong>i</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>v</strong></td>
<td>Give control back; provide support and encouragement.</td>
<td>Give support and encouragement.</td>
</tr>
<tr>
<td><strong>e</strong></td>
<td>Give back the responsibility to control their own behavior, along with</td>
<td>Provide one another with support and encouragement. Express trust</td>
</tr>
<tr>
<td><strong>l</strong></td>
<td>your support and encouragement.</td>
<td>and confidence in fellow team members.</td>
</tr>
<tr>
<td><strong>i</strong></td>
<td>By giving the person respect and treating them with dignity, this can be</td>
<td></td>
</tr>
<tr>
<td><strong>n</strong></td>
<td>a time to build rapport and strengthen your relationship with the</td>
<td></td>
</tr>
<tr>
<td><strong>i</strong></td>
<td>individual.</td>
<td></td>
</tr>
</tbody>
</table>
Optional Postvention Activity

Learning Goal
This practice activity will allow you to experience a full range of crisis behaviors in a safe training environment and gain practice with intervention strategies. It is also an opportunity to practice using the COPI NG ModelSM to lead a debriefing discussion.

Participate
1. Divide the participants into roles. Based on class size, you may have one group or multiple groups of each role:
   a. **Staff**
      Explain to the participants who will be the staff team members that they will be responding to a crisis and that they should use the principles and skills that they have learned in the class to intervene. Give them relevant information such as who they are, where the crisis takes place, etc. Let them know that the individual may escalate to a level of risk behavior and they may be asked to use disengagement and/or holding skills as appropriate. (This last part is optional.)
   b. **Debriefing leaders** (1 for staff and 1 for individuals in crisis)
      Explain to the debriefing leaders that they will be leading a debriefing conversation using the COPI NG ModelSM after the role-play has completed. One person will debrief with staff and the other will debrief with the individuals in crisis. Ask them to observe the role-plays so that they can more accurately debrief afterwards.
   c. **Individuals in crisis**
      These participants will act as individuals served by your facility. Give them relevant information such as who they are, where the crisis takes place, etc. The individuals in crisis decide the level of behavior based on how the role-play is proceeding. If appropriate, instruct them to eventually escalate to risk behavior that causes staff to use disengagement and/or holding skills. Their goal is to create decision points where staff decide how to respond and make appropriate decisions. It is their responsibility to create learning opportunities, but to maintain safety for all.

2. Proceed with the activity. When the role-play reaches a natural conclusion (or at a point you choose to end it with your cue word), end the role-play activity and separate groups into staff and individuals in crisis.

3. Send each debriefing leader to their group and explain that they will now be leading this group through a debriefing discussion using the COPI NG ModelSM. One leads a debriefing with the group of staff, and another leads the debriefing with the group of individuals in crisis.

4. After an appropriate amount of time, end the activity and debrief with the group about the learning that took place.
Introduction

Post-tests are used to measure growth after instruction in order to determine if learning goals are met. They help you as a Certified Instructor assess how well key program concepts have been explained.

TIP

Allow adequate time for participants to complete the post-test. Review answers with participants. You can choose how to administer the post-test to your groups. More information about how to administer and grade post-tests can be found at crisisprevention.com.

KEY POINTS

» Each participant should also complete the evaluation form found near the back of their workbook.
» Evaluation forms can be of great assistance to you as a Certified Instructor and can enable you to provide feedback to participants, managers, or your organization. In addition, participant evaluations will give you information about your strengths in teaching the program, as well as areas that may need fine-tuning, improving, or adapting. Review these after class.
» Complete and distribute a Blue Card™ for each participant.

Conclusion of the Program

Thank your participants for attending and participating. You may also want to share information about expectations for ongoing training (e.g., frequency of refresher classes). Share your contact information and make yourself available for follow-up questions and support.

Refer back to the foundation of the program—the Crisis Development Model™. Each level of behavior and its matching staff attitude or approach has been explored. This program has shared and helped you practice valuable intervention strategies. Your final activity is to record this knowledge. Please turn to the post-test in your workbook.
1. Complete the *Crisis Development Model*℠.

<table>
<thead>
<tr>
<th>Crisis Development/Behavior Levels</th>
<th>Staff Attitudes/Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Anxiety</td>
<td>1. Supportive</td>
</tr>
<tr>
<td>2. Defensive</td>
<td>2. Directive</td>
</tr>
<tr>
<td>3. Risk Behavior</td>
<td>3. Physical Intervention</td>
</tr>
<tr>
<td>4. Tension Reduction</td>
<td>4. Therapeutic Rapport</td>
</tr>
</tbody>
</table>

2. What is the value of learning the four levels and corresponding staff attitudes?

Possible responses:
- Helps you intervene early and appropriately.
- Helps you avoid overreacting or underreacting.
- Helps you avert crises.

3. Complete the *Verbal Escalation Continuum℠*.

```
Intimidation          Release
 Refusal              Questioning
 Tension Reduction
```

4. Describe three reasons you should use the *Supportive Stance℠*.

Communicates respect, nonthreatening, safety

5. List two ways the Decision-Making Matrix model is used to consider risk.

Likelihood and severity

6. What are the values that underpin this course?

Care, welfare, safety, and security

7. Postvention is used for:

- Staff only.
- The individual in crisis only.
- **Staff and the individual in crisis.**
When teaching any physical intervention skills, keep in mind the following:

1. **Warm up.** Allow your participants to physically prepare before engaging in physical activity.

2. **Demonstrate first.** Participants need to see the classroom models before they can be expected to try to perform the skills.

3. **Use a step-by-step progression.** The physical intervention skills are taught step-by-step in order to give participants confidence and to allow them to gain skills at their own rates. Trying to teach too much at one time may inhibit confidence and lead to non-participation.

4. **Reinforce learning.** During the initial practice of physical intervention skills, be patient and provide positive reinforcement. To correct an inappropriate use of principles, emphasize what the person is doing right and gently correct the error. If participants hear that they are doing something wrong, they may be hesitant to continue practicing.

5. **Be aware of participant safety.** Careful supervision is necessary when teaching physical intervention. Do not allow the participants to begin practicing on their own. Make sure that the steps are initiated only on your command (see Due Care guidelines).

6. **Pair individuals according to size.** In the initial stages of teaching physical intervention skills, it is wise to pair individuals with others of equal body size and strength. Until the group becomes somewhat proficient in the skills, this will avoid having smaller and weaker individuals feel incompetent because they cannot control a larger, stronger individual.

7. **Do not force participation.** Some individuals feel extremely uncomfortable learning any type of motor skill. Certified Instructors should consider and be sensitive to participants’ needs, including those who have medical concerns and/or have experienced psychological trauma. Decide ahead of time how you will handle this type of situation(s), especially if participation in this training program is a job requirement.

8. **Demonstrate—do not participate.** When teaching physical intervention, it is imperative that the Instructor demonstrates, but does not participate in, the actual practice of the skills. It is impossible to adequately supervise the group if you are participating.

9. **Emphasize principles.** The goal of this portion of the program is to ensure everyone’s safety by following basic principles. Style is not an issue; safety is.

10. **Emphasize ongoing practice.** This is a starting point. Remind participants that the objective in the basic training course is to develop skills. Ongoing practice will improve use of the skills.
Unit 8: Physical Interventions - Disengagement Skills

**Introduction**

Remember CPI’s core values of Care, Welfare, Safety, and Security℠. Most people staff support who engage in risk behavior are also vulnerable and in need of safeguarding. As such, you have a professional obligation to act in everyone’s best interest.

The primary focus of this unit is to learn skills to keep yourselves and others safe from injury if you encounter someone engaging in risk behavior. The verbal interventions and staff approaches learned and practiced in previous units still apply.

**TIP**

This unit is not intended to teach participants self-defense skills and should not be treated as such. Your approach and attitude will have an impact on how your participants perceive this information.

**Instructional Objectives**

1. Identify a range of responses to risk behavior that may be encountered during a crisis.
2. Describe and apply the Principles of Disengagement.
3. Demonstrate and practice disengagement skills as they apply to lower-, medium-, and higher-level risk behaviors that may compromise safety.
4. Build the confidence of staff members in their ability to keep themselves and others safe in crisis situations.

**KEY POINTS**

» Begin this unit with the Key Principles discussion.
» It is necessary for participants to have the information in the lecture before beginning the practice sessions.
» Review Due Care guidelines for participants that were introduced at the start of the program.
» Allow participants to warm up and stretch prior to any physical activity.
» Demonstrate each of the physical intervention skills with participants in the group before asking people to try the skills themselves. Explain that you are demonstrating according to a CPI classroom model. (CPI classroom models are standardized ways of teaching skills to ensure that the basic principles are followed.)
» Change partners frequently. Give clear, consistent directions and cues.
» Remind participants to be considerate of their partners. Remember: Care, Welfare, Safety, and Security℠ applies to training sessions too.
Key Principles Discussion

Key principles for disengagement skills begin with concepts you have already practiced. Position, posture, and proximity are all used to maximize safety for all involved. You practiced these with the Supportive Stance™.

Position - Posture - Proximity

Biomechanical Benefit (Movement)

Understanding how the body moves (joints and muscles).

- **Hold and Stabilize** (limit aggressive range of motion).

- **Pull/Push** (move in opposite directions)
  
  Pulling away is a natural reaction, but it does not always work if the person holding you has a strong grip. Pulling and pushing at the same time in opposite directions weakens the person’s grip while minimizing any pain or injury.

  You can enhance Biomechanical Benefit by increasing your momentum (energy and speed) by ensuring that you pull and push simultaneously in opposite directions to the person’s thumb. This is usually the weakest part of the grip and often provides a natural means of release.

- **Lever**
  
  Combining momentum (energy and speed) with movement (rotation) around a single point (e.g., elbow, shoulders, and hips) creates linear and angular motion which is more effective and efficient than Pull/Push. If the person has a particularly strong grip or is using two hands, increase the momentum and rotation by creating whole body energy through the arms and/or legs to increase the effectiveness of the lever.

Be sure to continue to address interventions for risk behaviors. Think about how the skills and concepts you have learned so far can be applied if physical intervention is needed.

**TIP**

If your organization has chosen to omit Physical Interventions - Disengagement and/or Holding Skills, the next section you will facilitate is Unit 10.
Unit 8: Physical Interventions - Disengagement Skills

Set-Up/Classroom Management

- Create a framework for learning/developing skills by exploring what a lower-, medium-, and higher-level physical risk behavior might look like. For example, how might you compare a wrist grab by an elderly, medically fragile patient with a wrist grab by an otherwise healthy, intoxicated teenager? In these activities, you learn how to respond to risk behaviors using reasonable and proportionate responses based on the level of risk presented by the behavior.

- Use the Decision-Making Matrix to discuss which types of behaviors and/or individuals might present a:
  - Lower-level risk
  - Medium-level risk
  - Higher-level risk

- This will help set the framework for the levels of responses that will be practiced in the activities.

- Remind participants of the Due Care guidelines.
  - Optional flip charts may help you create a safer practice environment.
  - Establish clear cues to signal staff to begin/end practice.

- Organize participants into two lines with a partner as in Unit 2.

Optional Flip Charts

Refer to these during demonstrations and practice.

Role of Practice Partner
- Keep partner safe.
- Help partner learn.
- Provide partner feedback.

Safe Realism
- Safe enough to prevent harm.
- Real enough to promote learning.
Unit 8: Physical Interventions – Disengagement Skills

**CAUTION:** The physical interventions represented in this unit should only be learned and practiced under the supervision of a CPI Certified Instructor. The images of these interventions shown here are intended as a point of reference and represent only a snapshot of the process required to execute the skills and principles. Any attempt to learn these skills and principles from the images or descriptions, or use them without proper instruction, may result in injury.

**Strikes**

A weapon (body part or object) making contact with a target.

**Learning Goal**

Recognize and respond to a strike in a balanced and appropriate manner, utilizing one’s natural ability. (These points can be added to the flip chart.)

- Primal reflex
- Manage proximity
- Consider escape route

**Demonstrate**

- Designate the individual in crisis and staff.
- Staff assume a *Supportive Stance*™.
- Cue the individual in crisis to throw one punch at (or try to touch the shoulder of) the staff member.
- Using the principles of block and/or move, staff keep yourselves safe.
- The individual in crisis, you are directly responsible for building the skills of the staff members. Make sure your strike is measured to match their skill/ability. If you move too slowly, they will not build skills. If you move too fast, they will not build skills. Make sure that your punch or kick is measured to their skill/ability.

**Participate** *(Repeat each skill 3 to 5 times, then rotate partners and move to the next skill.)*

1. Single punch or touch the shoulder.
2. Two punches or touch the shoulder.
3. Right-hand punch, left-hand punch, or kick.
4. Right-hand punch, left-hand punch, kick, or choke.

**TEACHABLE MOMENT**

» Reinforce success (avoid “telling” participants how to move).
» There isn’t one best way to avoid a strike. You may want to encourage some of the following if and when appropriate during your drills:
  - Blocking with open hands rather than fists.
  - Moving away in different directions (left, right, behind partner).
» Fade out verbal instructions to nonverbal instructions so that the staff are directly responding to their partner’s behavior. Ask the staff to engage their partner in a discussion (e.g., make a request or give an instruction). Remind the staff to make use of all the skills used in the previous units. As the staff are engaged in the discussion with their partner, give a nonverbal cue to see how quickly staff are able to respond to their partner’s behavior.
Unit 8: Physical Interventions - Disengagement Skills

Grabs/Holds
Maintaining physical contact without consent.

Sample Scripting

- In addition to the principles of position, posture, and proximity, staff will use three simple principles when an individual is holding them. These principles are referenced on the Key Principles for Disengagement Skills poster.
  - Hold and Stabilize
  - Pull/Push
  - Lever

- CPI has enhanced how it teaches disengagement strategies, previously known as Principles of Personal Safety, in order to simplify the learning process and broaden the application.

- If you have participated in the earlier Nonviolent Crisis Intervention® program, you will recognize previously learned classroom models when you begin applying the principle of leverage.

- The additional strategies will provide staff with a greater breadth of response, allowing for a reasonable and proportionate response to the behavior of the individual in crisis, including being physically supportive to those who need support.

TEACHABLE MOMENT

» Look for several ways the principles are being applied and coach as necessary.
» If you can’t get out, use position, posture, and proximity to get to a safer position.
» Avoid individual intervention when possible. Use a team approach.
Wrist/Arm

Learning Goal
Apply the key Principles of Disengagement to a wrist or arm hold so as to minimize risk to staff, minimize risk to the individual in crisis, and safely manage the behavior.

Demonstrate
• Ask a participant to assist you.
• Place your arms in front of you and ask the participant to take hold of your wrist.

Lower-Level Risk
• Ask the class to imagine that your participant has a hold of your arm but is presenting little to no additional risk.
  » You may want to help the class by framing this as a frail or fragile individual who is at risk of falling, skin tears, bruising, joint damage, etc.
• Explore your options in a lower-risk grab (reference poster: A Verbal and Nonverbal Response).
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).

Medium-Level Risk
• Ask the class to now imagine that your partner is presenting a medium-level risk.
  » Maybe by holding tighter or pulling.
• Ask or tell your class how you might respond.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).
  » Pull/Push (creating movement simultaneously in opposite directions).

Higher-Level Risk
• Ask the class to now imagine that your partner is presenting high-risk behavior.
  » Maybe by holding even tighter, pulling, or maybe even trying to punch you.
• Ask or tell your class how you might respond.
  » Lever (applying energy and movement around a single point).
• You may still use the Hold and Stabilize principle and the Pull/ Push principle, but they are not required.
Unit 8: Physical Interventions – Disengagement Skills

**Participate/Practice** *(repeat each level skill 3 to 5 times, rotating partners after each level)*

**Lower-level risk to staff**
- Remind participants that their practice partner is presenting a low-risk behavior using an appropriate example from the workplace.

**Medium-level risk to staff**
- Encourage the practice partner to increase the level of intensity, simulating a medium-level risk and utilizing safe realism (refer to optional flip chart).

**Higher-level risk to staff**
- Encourage the practice partner to increase the level of intensity, simulating a higher-level risk and utilizing safe realism.

**Varying levels of risk to staff** *(Instructors are encouraged to assess the performance and capabilities of the staff before including this level of complexity in the learning experience.)*
- Cue the individual in crisis to hold using varying levels of intensity and utilizing safe realism.
  - Lower-, medium-, and higher-level risk.
  - The individual in crisis holding in different, realistic ways.
  - Holding and pulling.
  - Holding and punching or kicking.
  - Higher-level risk to staff from medically fragile individual.

---

**TEACHABLE MOMENT**

Reference:
» Physical Skills Review Framework
» Decision-Making Matrix

**TIP**
Changing partners frequently enhances learning.
Unit 8: Physical Interventions – Disengagement Skills

Clothing

Learning Goal
Apply the key Principles of Disengagement to a clothing grab so as to minimize risk to staff, minimize risk to the individual in crisis, and safely manage the behavior.

Demonstrate
- Ask a participant to assist you.
- Ask the participant to gently take hold of your clothing.

Lower-Level Risk
- Ask the class to imagine that your participant has a hold of your shirt but is presenting little to no additional risk.
  » You may want to help the class by framing this as a frail or fragile individual who is at risk of falling, skin tears, bruising, joint damage, etc.
- Explore your options in a lower-risk hold.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).

Medium-Level Risk
- Ask the class to now imagine that your partner is presenting a medium-level risk.
  » Maybe by holding tighter or pulling.
- Ask or tell your class how you might respond.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).
  » Pull/Push (creating movement simultaneously in opposite directions).

Higher-Level Risk
- Ask the class to now imagine that your partner is presenting high-risk behavior.
  » Maybe by holding even tighter, pulling, or maybe even trying to punch you.
- Ask or tell your class how you might respond.
  » Lever (applying momentum and movement around a single point).
- You may still use the Hold and Stabilize principle and the Pull/Push principle, but they are not required.
Unit 8: Physical Interventions – Disengagement Skills

**Participate/Practice** *(repeat each level skill 3 to 5 times, rotating partners after each level)*

**Lower-level risk to staff**
- Remind participants that their practice partner is presenting a low-risk behavior using an appropriate example from the workplace.

**Medium-level risk to staff**
- Encourage the practice partner to increase the level of intensity, simulating a medium-level risk and utilizing safe realism.

**Higher-level risk to staff**
- Encourage the practice partner to increase the level of intensity, simulating a higher-level risk and utilizing safe realism.

**Varying levels of risk to staff** *(Instructors are encouraged to assess the performance and capabilities of the staff before including this level of complexity in the learning experience.)*
- Cue the individual in crisis to hold using varying levels of intensity and utilizing safe realism. Options include:
  - Lower-, medium-, and higher-level risk.
  - The individual in crisis holding in different, realistic ways.
  - The individual in crisis holding and pulling.
  - The individual in crisis holding, pulling, and striking.
  - Higher-level risk to staff from medically fragile individual.

### TEACHABLE MOMENT
Consider clothing such as ties or hoodies, and how to apply principles to release.

### TIP
As you observe practice, watch participants for signs of fatigue. Periodically, ask how they are doing. You can take a break from practice and ask participants to record any learning points and thoughts in their workbooks. You may also choose to introduce the Physical Skills Framework and/or the RESPONSE Continuum™ while taking a break from physical activity.
Hair

Learning Goal
Apply the key Principles of Disengagement to a hair pull so as to minimize risk to staff, minimize risk to the individual in crisis, and safely manage the behavior.

Demonstrate
- Ask a participant to assist you.
- Ask the participant to gently take hold of your hair.

Lower-Level Risk
- Ask the class to imagine that your participant has a hold of your hair but is presenting little to no additional risk.
  » You may want to help the class by framing this as a frail or fragile individual who is at risk of falling, skin tears, bruising, joint damage, etc.
- Explore your options in a lower-risk hold.
  » Talk to the individual (relax and downplay; explain or ask).
  » **Hold and Stabilize** (prompt or gesture).

Medium-Level Risk
- Ask the class to now imagine that your partner is presenting a medium-level risk.
  » Maybe by holding tighter or pulling.
- Ask or tell your class how you might respond.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).
  » **Pull/Push** (creating movement simultaneously in opposite directions).

Higher-Level Risk
- Ask the class to now imagine that your partner is presenting high-risk behavior.
  » Maybe by holding even tighter, pulling, or maybe even trying to punch you.
- Ask or tell your class how you might respond.
  » **Lever** (applying momentum and movement around a single point).
- You may still use the Hold and Stabilize principle and the Pull/Push principle, but they are not required.
Unit 8: Physical Interventions - Disengagement Skills

**Participate/Practice** *(repeat each level skill 3 to 5 times, rotating partners after each level)*

**Lower-level risk to staff**
- Remind participants that their practice partner is presenting a low-risk behavior using an appropriate example from the workplace.

**Medium-level risk to staff**
- Encourage the practice partner to increase the level of intensity, simulating a medium-level risk and utilizing safe realism.

**Higher-level risk to staff**
- Encourage the practice partner to increase the level of intensity, simulating a higher-level risk and utilizing safe realism.

**Varying levels of risk to staff** *(Instructors are encouraged to assess the performance and capabilities of the staff before including this level of complexity in the learning experience.)*
- Cue the individual in crisis to hold using varying levels of intensity and utilizing safe realism. Options include:
  - Lower-, medium-, and higher-level risk.
  - The individual in crisis holding in different, realistic ways.
  - The individual in crisis holding and pulling.
  - The individual in crisis holding, pulling, and striking.
  - Higher-level risk to staff from medically fragile individual.

---

**TEACHABLE MOMENT**

» Apply principles to earrings or ear grab.
» Apply principles to long or short hair and grabs from behind.
Unit 8: Physical Interventions – Disengagement Skills

Neck

Learning Goal
Apply the key Principles of Disengagement to a neck hold so as to minimize risk to staff, minimize risk to the individual in crisis, and safely manage the behavior.

Demonstrate
- Ask a participant to assist you.
- Ask the participant to gently place their hands around your neck.

Lower-Level Risk
- Ask the class to imagine that your participant has a hold of your neck but is presenting little to no additional risk.
  » You may want to help the class by framing this as a frail or fragile individual who is at risk of falling, skin tears, bruising, joint damage, etc.
- Explore your options in a lower-risk hold.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).

Medium-Level Risk
- Ask the class to now imagine that your partner is presenting a medium-level risk.
  » Maybe by holding tighter or pulling.
- Ask or tell your class how you might respond.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).
  » Pull/Push (creating movement simultaneously in opposite directions).

Higher-Level Risk
- Ask the class to now imagine that your partner is presenting high-risk behavior.
  » Maybe by holding even tighter, pulling, or maybe even trying to punch you.
- Ask or tell your class how you might respond.
  » Lever (applying momentum and movement around a single point).
- You may still use the Hold and Stabilize principle and the Pull/Push principle, but they are not required.
Unit 8: Physical Interventions - Disengagement Skills

Participate/Practice (repeat each level skill 3 to 5 times, rotating partners after each level)

Lower-level risk to staff
- Remind participants that their practice partner is presenting a low-risk behavior using an appropriate example from the workplace.

Medium-level risk to staff
- Encourage the practice partner to increase the level of intensity, simulating a medium-level risk and utilizing safe realism.

Higher-level risk to staff
- Encourage the practice partner to increase the level of intensity, simulating a higher-level risk and utilizing safe realism.

Varying levels of risk to staff (Instructors are encouraged to assess the performance and capabilities of the staff before including this level of complexity in the learning experience.)
- Cue the individual in crisis to hold using varying levels of intensity and utilizing safe realism. Options include:
  - Lower-, medium-, and higher-level risk.
  - The individual in crisis holding in different, realistic ways.
  - Higher-level risk to staff from medically fragile individual.

TEACHABLE MOMENT
- Ensure staff is continuing to stabilize the individual in crisis while releasing.
- Ensure you maintain visual of the individual in crisis while releasing.
Unit 8: Physical Interventions – Disengagement Skills

Body

Learning Goal
Apply the key Principles of Disengagement to a body hug to minimize risk to staff, minimize risk to the individual in crisis, and safely manage the behavior.

Demonstrate
- Ask a participant to assist you.
- Ask the participant to gently wrap their arms around your waist from behind.

Lower-Level Risk
- Ask the class to imagine that your participant has a hold of your body but is presenting little to no additional risk.
  » You may want to help the class by framing this as a frail or fragile individual who is at risk of falling, skin tears, bruising, joint damage, etc.
- Explore your options in a lower-risk hold.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).

Medium-Level Risk
- Ask the class to now imagine that your partner is presenting a medium-level risk.
  » Maybe by holding tighter or pulling.
- Ask or tell your class how you might respond.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).
  » Pull/Push (creating movement simultaneously in opposite directions).

Higher-Level Risk
- Ask the participant to now gently wrap around your body and trap your arms.
- Ask the class to now imagine that your partner is presenting a higher-level risk because the individual has your arms trapped.
- Ask or tell your class how you might respond.
  » Lever (applying momentum and movement around a single point).
- You may still use the Hold and Stabilize principle and the Pull/Push principle, but they are not required.
**Unit 8: Physical Interventions - Disengagement Skills**

**Participate/Practice** *(repeat each level skill 3 to 5 times, rotating partners after each level)*

**Lower-level risk to staff**
- Remind participants that their practice partner is presenting a low-risk behavior using an appropriate example from the workplace.

**Medium-level risk to staff**
- Encourage the practice partner to increase the level of intensity, simulating a medium-level risk and utilizing safe realism.

**Higher-level risk to staff**
- Encourage the practice partner to increase the level of intensity, simulating a higher-level risk and utilizing safe realism.

**Varying levels of risk to staff** *(Instructors are encouraged to assess the performance and capabilities of the staff before including this level of complexity in the learning experience.)*
- Cue the individual in crisis to hold using varying levels of intensity and utilizing safe realism.
  - Lower-, medium-, and higher-level risk.
  - The individual in crisis holding in different, realistic ways.
  - Higher-level risk to staff from medically fragile individual.

**TEACHABLE MOMENT**

» Be aware of different body types and sizes in considering how to apply the principles.
» Consider use of additional staff.
Unit 8: Physical Interventions – Disengagement Skills

Bite

Learning Goal
Apply the key Principles of Disengagement to a bite so as to minimize risk to staff, minimize risk to the individual in crisis, and safely manage the behavior.

Demonstrate
• Ask a participant to assist you.
• Ask the participant to place their hand on your forearm and place their chin on their hand.

Lower-Level Risk
• Ask the class to imagine that your participant is biting your arm but is presenting little to no additional risk.
  » You may want to help the class by framing this as a frail or fragile individual who is at risk of falling, skin tears, bruising, joint damage, etc.
• Explore your options in a lower-risk grab.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).

Medium- and Higher-Level Risk
• Ask the class to now imagine that your partner is presenting a medium/higher-level risk.
• Ask or tell your class how you might respond.
  » Talk to the individual (relax and downplay; explain or ask).
  » Hold and Stabilize (prompt or gesture).
  » Pull/Push. Pull the person toward you and push your body in close so that the individual is trapped. This will minimize further harm and should make the person feel that they want to release and get free. Ensure they have released the bite before you allow them to move away.
Unit 8: Physical Interventions – Disengagement Skills

**Participate/Practice** *(repeat each level skill 3 to 5 times, rotating partners after each level)*

**Lower-level risk to staff**
- Remind participants that their practice partner is presenting a low-risk behavior using an appropriate example from the workplace.

**Medium- to higher-level risk to staff**
- Encourage the practice partner to increase the level of intensity, simulating a medium/higher-level risk and utilizing safe realism.

**Varying levels of risk to staff** *(Instructors are encouraged to assess the performance and capabilities of the staff before including this level of complexity in the learning experience.)*
- Cue the individual in crisis to hold using varying levels of intensity utilizing safe realism. Options include:
  - Lower-, medium-, and higher-level risk.
  - The individual in crisis biting in different, realistic ways.
  - Higher-level risk to staff from medically fragile individual.

You’ve completed your practice of disengagement skills. The Physical Skills Review Framework and the RESPONSE Continuum™ have been developed to help you reflect on the appropriateness of each physical intervention in order to reduce the risk of harm using four key considerations. (Refer to the Physical Skills Review poster.)

Please return to your seats for a discussion about this framework and how these considerations can help maximize safety when using physical interventions.
Unit 8: Physical Interventions – Disengagement Skills

Physical Skills Review Framework

In keeping with the program values of Care, Welfare, Safety, and Security, all the physical interventions within the program have been independently risk assessed. As a result of the risk assessment, none of the physical skills in the program have been identified as high risk to the individual in crisis and/or staff. However, no physical intervention is risk-free, and this assessment cannot take into account the dynamic nature of risk behavior and/or the specific physical and psychological factors of each individual involved in an incident (the individual in crisis and staff). This framework can help you reflect on the appropriateness of each physical intervention in order to reduce risk of harm using four key considerations.

**Safe:** What makes these skills safe?

Think about how safe the physical interventions are in relation to the specific risk behavior and the individual presenting the behavior. If the person has any known physiological and psychological vulnerabilities, consider any reasonable adjustments you can make to the physical interventions in order to reduce the intervention compromising the individual's welfare, while, at the same time, taking into account the level of risk associated with the behavior. Equally, consider the staff involved and ensure they are able to use the physical intervention without compromising their welfare. Physical interventions are not risk-free, but every effort should be made to minimize the risk of injury to all.

**Effective:** What makes it an effective strategy?

The aim of a physical intervention is to enable staff to respond to and manage risk behavior in order to reduce harm in crisis situations in which the individual has lost rational control. As such, it is important that the specific physical intervention is effective in enabling staff to meet this aim. This requires staff to make continuous assessments of the individual and the behavior within the context of risk, and to ensure the specific intervention supports staff in the risk management of the behavior until the individual regains rational control and achieves Tension Reduction.

**Acceptable:** Would this be viewed as an acceptable response to risk behavior?

Given the wide range of people and services, it is important that any physical intervention is legal and professionally acceptable and falls within any national or regulatory guidance. Additionally, any physical interventions used by staff should not breach the human rights of any individual and, at no time, should be used to gain compliance, enforce rules, or as a punishment. Staff should reflect on the service setting, organizational policy, and regulatory requirements, as well as the individual's age, gender, disability, cultural background, and any other factor that may determine which physical interventions are (or are not) appropriate.

**Transferable:** Is this skill transferable?

The physical skills are taught as classroom models and are underpinned by core principles that can be applied to any situation or individual in the management of risk behavior. As you learn the skills, it is important that you think about the range of people you work with, the range of risk behaviors you typically might need to manage, and how the skills can be transferred back into the workplace. Whenever possible, each individual who may be subject to physical interventions should have an individual plan that approves and authorizes which interventions are appropriate and which are not.
Unit 8: Physical Interventions - Disengagement Skills

The RESPONSE Continuum<sup>SM</sup>

The Crisis Development Model<sup>SM</sup> helps you recognize a multitude of experiences when witnessing and responding to crisis behavior. Throughout the program, participants have examined behaviors at each level of the Crisis Development Model<sup>SM</sup> and connected to this common frame of reference. You have gained the skills and practiced a range of nonverbal, verbal, and paraverbal strategies designed to decelerate and de-escalate potential risk behavior. It is important to ensure that these strategies remain part of staff interventions as you explore the principles for responding to risk behavior.

The RESPONSE Continuum<sup>SM</sup> gives you a framework of what to think about, say, and do as you decelerate, de-escalate, and intervene with risk behavior so that your reactions remain productive. Given that CPI's core values remain constant throughout staff responses, and Therapeutic Rapport is central to all interactions in terms of promoting Tension Reduction, you need to consider how your responses can help individuals recognize you are there to provide for their care and safety.

The RESPONSE Continuum<sup>SM</sup> allows you to review skills you have already practiced in Supportive and Directive approaches, to demonstrate respect and consideration. It also reminds you of factors to consider when deciding your response to risk behavior.

| R | Relax and Downplay. By relaxing and staying in control, you are able to downplay an individual's behavior and promote deceleration and Tension Reduction. Relax and Downplay does not mean to ignore or pretend the behavior is not happening. Instead it helps you to avoid overreacting and to focus on positive outcomes. It allows you to communicate important messages which can be used even when an individual presents risk behavior.  
For example: Someone you work with might take hold of your hand or arm and pull you near. (The person may be trying to communicate that they want you to go with them or that they need something.) Use Hold and Stabilize so that you feel in control and then move with the individual. If the behavior is low risk and you know what the person wants, downplaying the behavior and focusing on their needs is all you need to do, and this often results in them letting go. |
|---|---|
| E | Explain or Ask. Demonstrate respect and consideration to others. Often people cooperate when you explain the situation or ask them to do something. Use simple and clear directives and limit-setting approaches (e.g., Interrupt and Redirect, When and Then, or If and Then) to explain potential outcomes for choices. When an individual escalates in risk behavior, your verbal directives are aimed at gaining even small steps of compliance. Use these approaches in the simplest way possible.  
For example: When the person takes hold of your hand or arm, you may say, “Please let go; your grip is uncomfortable.” The directive is short and simple and emphasizes the impact of the behavior: the grip is uncomfortable. You can also use a limit-setting strategy such as If and Then: “If you let go of my arm, then I can help you.” |
### Unit 8: Physical Interventions – Disengagement Skills

| S | State or Tell. Use this when an individual has not responded positively to your request, is losing rationality, or has lost control. Within the Crisis Development Model, the person may be at the Anxiety or Defensive Behavior Level and may be using challenging questions, shouting, or threatening. At the Risk Behavior Level, an individual may strike out physically or hold you in a way that may be harmful. Responding to what the individual is saying or providing too much information may add to the chaos of the moment. The goal of your intervention is to maintain self-control, continue to be respectful, and regain Therapeutic Rapport.

For example: If a person takes hold of your hand or arm, you may tell the person to “let go” or “open your hand.” This directive is very short and clear and is focused on the behavior you want the person to do. |
|---|---|
| P | Prompt, Gesture, or Sign. When verbal or physical behavior is escalating, the ability to listen and comprehend is often lost in irrational thinking. Nonverbal prompts or gestures can help convey the intended message more clearly than verbal content alone.

For example: If a person takes hold of your hand or arm, you might touch the person’s hand as a prompt when saying, “let go.” |
| O | Option to Use Physical Interventions. As a situation escalates and the person engages in risk behavior, you may want to consider physical intervention as an intervention based on an immediate appraisal of risk (Decision-Making Matrix). It is important to remember that physical intervention is not an ultimate goal in responding to risk behavior and should only be considered when the risk of harm is imminent or immediate.

Even if the individual has a known pattern of risk behaviors, you still have to make a decision based on the immediate circumstances. You may determine that the option to use physical interventions is not the safest given the environment or need for additional staff assistance. You might back away, you may use more proximity control, or remove an audience. The decision to use physical intervention should be a balanced and considered judgment when there is no safer or more reasonable alternative.

For example: If a person takes hold of your hand or arm, and any of the previous interventions have been unsuccessful, you may use one of the disengagement principles to gain a release (e.g., Pull/Push or Lever). |
### Unit 8: Physical Interventions - Disengagement Skills

**N**

**Nurture Recovery.** Whether an individual has lost control rationally, verbally, or physically, staff are always considering ways to nurture recovery and prompt Tension Reduction in order to regain Therapeutic Rapport. Paying attention to nonverbal cues such as muscle relaxation or verbal cues such as asking information-seeking questions provides you with an opportunity to help the individual entering Tension Reduction.

*For example:* As the person lets go of your arm or you gain a release from the hold, you might say, “Thank you. Now how can I help you?”

---

**S**

**Support.** Following any crisis, people involved often benefit from post-crisis support (both physical and emotional). Offering those involved in the crisis impartial and nonjudgmental help and support is important. It helps people feel respected and valued. It may help to reduce the emotional trauma associated with crisis events. Encourage people to think about what can be done to keep the crisis event from happening again.

*For example:* A person who has been involved in a crisis event wants to talk to someone about what happened. Debriefing may be a way of providing informal and nonjudgmental support. Directing the person to Human Resources for more formal support or counseling from trained professionals may be another way to help.

---

**E**

**Engage and Learn.** Following a crisis, everyone involved has the opportunity to engage and learn from the event in order to reflect on what happened. There are opportunities to identify any potential triggers or patterns of behavior and to establish what did or didn’t work well so that successful approaches can continue, and alternative approaches that may prevent the crisis in the future can be developed.

*For example:* It is important that the individuals involved feel empowered to reflect and make choices about their own learning and any changes to practice they may wish to implement.

---

**TIP**

Throughout review of the areas outlined in the RESPONSE Continuum℠, ask participants for examples of skills they have already learned and practiced. Help them connect those approaches as they review disengagement skills and as they practice holding skills in Unit 9.
Introduction

All of the interventions taught within this program are based on the concept that a team approach is used in order to maximize the Care, Welfare, Safety, and SecuritySM of everyone when aggressive or violent individuals are held using physical interventions. With the exception of disengagement and personal safety situations, CPI advocates that, wherever possible, a minimum of two staff are involved in the use of physical interventions in order to capitalize on staff knowledge, skills, experiences, and communication skills. This also ensures that vulnerable people (who are often subject to physical interventions) are safeguarded from the potential misuse or abuse of such approaches.

Instructional Objectives

1. Identify touch zones that are permissible to contact during physical holding.
2. Identify the potential risks that can arise from the use of physical holding and strategies for minimizing risks.
3. Describe the Principles of Holding.
4. Demonstrate and practice holding skills as a team approach to avoid injury to both staff and individuals who engage in risk behaviors that compromise safety.
5. Build the confidence of staff members in their ability to keep themselves and others safe in crisis situations.
6. Holding skills are to be used only as a last resort.

KEY POINTS

» As you begin this unit, re-emphasize that physical intervention should be used only as a last resort when an individual is a danger to self or others.
» Keep control of the group at all times. Remind the group that this is not a time to show off, engage in horseplay, or harm others.
» Watch for participant fatigue during physical intervention training. Try to accommodate the physical abilities of group members by taking breaks. You can also use the lectures as natural breaks in the physical activity portion of the program.
» Keep in mind the following goals:
  – Avoid injury to staff.
  – Control and restrain the individual demonstrating risk behavior as quickly as possible.
  – De-emphasize style–focus on principles.
Touch Zones Key Principles Discussion

Before you practice holding skills, refer to your workbooks. Identify parts of the body where people generally tend to feel uncomfortable touching or where people prefer not to be touched. (All individuals abide by cultural and social rules regarding touch.)

As you begin this unit, emphasize that physical interventions should be used only as a last resort when an individual engages in a behavior that is a danger to self or others. Responses to these risk behaviors are all based on the key principles, so it is necessary for participants to have the information in the discussion before beginning the practice sessions.
Unit 9: Physical Interventions – Holding Skills

Would anyone like to share which areas you identified and your reasons? (You may want to write these on a flip chart to show that there is a commonality within the group, which is based on key themes.)

This discussion shows that generally, you do not allow others to touch you without your consent, and willingness to provide consent is based on the situation, the status of the person touching, and your relationship with them. As such, it is likely that a person engaging in risk behavior will not want to be held. It is important that you hold people in such a way as to avoid the parts of the body that are likely to cause harm or lead to complaint due to the social and cultural rules regarding touch.

Risks of Restraints

Consider the types of injury or harm you might expect to arise as a result of restrictive physical interventions. Review participants’ answers and then categorize them in the following way:

- Psychosocial injury
- Soft-Tissue injury
- Articular or Bony injury
- Respiratory Restriction
- Cardiovascular Compromise

These are ranked in terms of likelihood. Refer participants to Appendix 2 in their workbooks.

Review the definition of physical interventions and bridge back to Unit 7. Holding skills can be described as a range of physical positions (seated or standing) that can be applied and maintained in order to manage the prevailing risk associated with the individual’s behavior.

Review the three Ps (position, posture, and proximity) and ask participants to define each term (refer them to Unit 2 of their workbooks). The three Ps are very important in relation to the use of physical skills, and these are easily achieved by adopting the Supportive StanceSM.
Key Principles Discussion

Position: Approach the person from the side whenever possible.
Posture: Ensure you remain balanced and nonthreatening.
Proximity: Move as close as possible to the person.

Introduce the principle of Biomechanical Benefit in relation to holding, and provide a definition and example.

Biomechanical Benefit: Understanding how the body moves (joints and muscles).

- **Outside/inside principle**: Placing something on the outside and something on the inside of the limbs and/or body.
  
  Example:
  - Upper arms—place something on the outside of the elbow and something on the inside of the arm.
  - Upper body—place something on the outside of the shoulders.
  - Lower body—place something where possible alongside the hips, thighs, and knees.

- **Limit the range of motion**: Limiting or restricting the person’s movement (lower-, medium-, or higher-level restriction) in order to manage the person’s dynamic movement and prevailing risk.

  Example:
  - Use the three Ps and the Outside/Inside principle to apply an appropriate level of restriction. The more restrictive you need to be, the more you need to apply the principles collectively.

Consider the individual, behavior, and risk.

Consider the level of restriction and ensure you are as least restrictive as possible.

Decision-Making Matrix

<table>
<thead>
<tr>
<th>SEVERITY</th>
<th>LIKELIHOOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Risk</td>
<td>Last resort; reasonable; least restrictive; proportionate to the level of risk behavior.</td>
</tr>
<tr>
<td>Higher Risk</td>
<td></td>
</tr>
</tbody>
</table>
Unit 9: Physical Interventions – Holding Skills

Set-Up/Classroom Management

• Create a framework for learning/developing holding skills to keep everyone safe when the individual in crisis is engaged in risk behavior. In these activities, participants learn how to engage in reasonable and proportionate holding strategies based on the level of risk presented by the behavior.

• Use the Decision-Making Matrix in the workbook to discuss which types of behaviors individuals might present:
  – Lower-level risk
  – Medium-level risk
  – Higher-level risk

• This will help set the framework for the levels of responses that will be practiced in the activities.

• Remind participants of the Due Care guidelines.
  – Optional flip charts below may help you create a safe practice environment.

• Form groups of three or four participants.

• Place three chairs side-by-side for each group.

• Designate roles.
  – The center chair is for the individual in crisis; the two outside chairs are for staff.

Optional Flip Charts

Role of Practice Partner
• Keep partner safe.
• Help partner learn.
• Provide partner feedback.

Safe Realism
• Safe enough to prevent harm.
• Real enough to promote learning.
CAUTION: The physical interventions represented in this unit should only be learned and practiced under the supervision of a CPI Certified Instructor. The images of these interventions shown here are intended as a point of reference and represent only a snapshot of the process required to execute the skills and principles. Any attempt to learn these skills and principles from the images or descriptions, or use them without proper instruction, may result in injury.

Lower-Level Holding in a Seated Position

Learning Goal
To physically hold an individual in crisis in a reasonable and proportionate manner based on their actions or risk behavior.

These points can be used as a consistent introduction for each holding skill.

- Position, posture, and proximity will now be applied to holding strategies.
- Introduce the Outside/Inside principle.
- These strategies may be utilized in support of someone who is at risk and/or when behavior poses a risk to self or others.
- As the individual in crisis, you are directly responsible for building the skills of the staff member. Therefore, during initial learning you should be cooperative. However, as you build skills, you will be asked to increase your behavior in a measured way to improve the skills/abilities of the staff/participants.

Demonstrate
- Ask two participants to assist you.
- Designate one as a staff member and the other as the individual in crisis (seated).
- Ask the class to imagine that the individual in crisis is engaging in limited risk behavior.
  - The individual in crisis may be a frail or fragile individual who is at risk of falling, skin tears, bruising, joint damage, etc.
  - The individual in crisis may be in need of supportive touch to decelerate.
  - On your cue, direct the staff member to mirror your entry into the Lower-Level Seated Holding Position.
  - Prompt the individual in crisis through the Lower-Level Holding Arm Movements.
Unit 9: Physical Interventions - Holding Skills

**Participate**

1. Enter into a Lower-Level Seated Holding Position.
2. Outside/Inside principle.
3. Lower-Level Seated Holding Arm Movement.
   - The individual in crisis touches their nose.
   - The individual in crisis reaches across their body to either staff member.
   - The individual in crisis attempts to elbow/off-balance either staff member.
4. Disengage.
5. Rotate roles within the group, allowing each person to experience each staff member’s role (left/right) and the role of the individual in crisis.

**TEACHABLE MOMENT**

» Reinforce success.
» Prompt the individual in crisis to engage in specific actions that will allow the participants to feel how the Outside/Inside principle creates a Biomechanical Benefit.
» Encourage staff to maintain good posture.
» Lower-level holding can be used at the early stages of risk behavior, ending stages of risk behavior, or to provide physical support for the individual in crisis.
» Use the descriptors of the principles as you demonstrate. For example:
   - Position: “Approach from the side.”
   - Posture: “Remain balanced and nonthreatening.”
   - Proximity: “Move close.”
   - Outside/Inside: “Place something on the outside of the elbow and something on the inside of the arm.”
Unit 9: Physical Interventions – Holding Skills

Medium-Level Holding in a Seated Position

Learning Goal

To physically hold the individual in crisis in a reasonable and proportionate manner based on their actions or risk behavior.

These points can be used as a consistent introduction for each holding skill.

- Position, posture, and proximity will now be applied to holding strategies.
- Introduce the Outside/Inside principle.
- These strategies may be utilized in support of someone who is at risk and/or when behavior poses a risk to self or others.
- As the individual in crisis, you are directly responsible for building the skills of the staff member. Therefore, during initial learning you should be cooperative. However, as you build skills, you will be asked to increase your behavior in a measured way to improve the skills/abilities of the staff/participants.

Demonstrate

- Ask for two participants to assist you.
- Designate one as a staff member and the other as the individual in crisis (seated).
- Beginning from a Lower-Level Seated Holding Position, ask the class to imagine that the individual in crisis is engaging in riskier behavior.
  - The individual in crisis may be in need of supportive touch to decelerate.
  - On your cue, direct the staff member to mirror your transition into the Medium-Level Seated Holding Position.
  - Prompt the individual in crisis through the Medium-Level Holding Arm Movements.
Unit 9: Physical Interventions - Holding Skills

Participate

1. Transition from a Lower-Level Seated Holding Position to a Medium-Level Seated Holding Position.
2. Outside/Inside principle.
3. Medium-Level Seated Holding Arm Movement.
   - The individual in crisis touches their nose.
   - The individual in crisis reaches across their body to either staff member.
   - The individual in crisis attempts to elbow/off-balance either staff member.
4. Transition from a Medium-Level Seated Holding Position to a Lower-Level Seated Holding Position.
5. Rotate roles within the group, allowing each person to experience each staff member’s role (left/right) and the role of the individual in crisis.

TEACHABLE MOMENT

» Reinforce success.
» Prompt the individual in crisis to engage in specific actions that will allow the participants to feel how the Outside/Inside principle creates a Biomechanical Benefit.
» Encourage staff to maintain good posture.
» Medium-level holding can be used to moderately manage (not completely restrict) movement associated with risk behavior and/or provide physical support for the individual in crisis.
» Remember the purpose of the transition from low-level restriction to medium-level restriction. The level of risk behavior presented by the individual has increased thereby justifying your decision to become more restrictive.
Unit 9: Physical Interventions – Holding Skills

Higher-Level Holding in a Seated Position

Learning Goal

To physically hold the individual in crisis in a reasonable and proportionate manner based on their actions or risk behavior.

These points can be used as a consistent introduction for each holding skill.

- Position, posture, and proximity will now be applied to holding strategies.
- Introduce the Outside/Inside principle.
- These strategies may be utilized in support of someone who is at risk and/or when behavior poses a risk to self or others.
- As the individual in crisis, you are directly responsible for building the skills of the staff member. Therefore, during initial learning you should be cooperative. However, as you build skills, you will be asked to increase your behavior in a measured way to improve the skills/abilities of the staff/participants.

Demonstrate

- Ask two participants to assist you.
- Designate one as a staff member and the other as the individual in crisis (seated).
- Beginning from a Medium-Level Seated Holding Position, ask the class to imagine that the individual in crisis is engaging in high-risk behavior.
  - The individual in crisis may be in need of supportive touch to decelerate.
  - On your cue, direct the staff member to mirror your transition into the Higher-Level Seated Holding Position.
  - Prompt the individual in crisis through the Higher-Level Holding Movements.
Unit 9: Physical Interventions - Holding Skills

Participate

1. Transition from a Lower-Level Seated Holding Position to a Medium-Level Seated Holding Position to a Higher-Level Seated Holding Position.
2. Outside/Inside principle.
3. Higher-Level Seated Holding Movement.
   - The individual in crisis attempts to elbow/off-balance either staff member.
   - The individual in crisis attempts to head-butt or bite either staff member.
   - The individual in crisis attempts to kick either staff member.
4. Transition from a Higher-Level Seated Holding Position to a Medium-Level Seated Holding Position to a Lower-Level Seated Holding Position.
5. Rotate roles within the group, allowing each person to experience each staff member’s role (left/right) and the role of the individual in crisis.

TEACHABLE MOMENT

» Apply these principles to people who use wheelchairs, are seated in vehicles, and situations when only one staff person is available.

» Higher-level holding can be used for greater management (not complete restriction) of movement associated with risk behavior and/or provide physical support for the individual in crisis.

» In order to gain a high level of restriction, staff should apply all the principles ensuring they remain as close as possible. If the person is presenting with a high-risk behavior, then staff have to ensure that they are as restrictive as needed in order to minimize harm.
Lower-Level Holding in a Standing Position

Learning Goal

To physically hold the individual in crisis in a reasonable and proportionate manner based on actions or risk behavior.

These points can be used as a consistent introduction for each holding skill.

- Position, posture, and proximity will now be applied to holding strategies.
- Apply the Outside/Inside principle.
- These strategies may be utilized in support of someone who is at risk and/or when behavior poses a risk to self or others.
- As the individual in crisis, you are directly responsible for building the skills of the staff member. Therefore, during initial learning you should be cooperative. However, as you build skills, you will be asked to increase your behavior in a measured way to improve the skills/abilities of the staff/participants.

Demonstrate

- Ask one participant (the individual in crisis) to assist you.
- Ask the class to imagine that the individual in crisis is engaging in limited risk behavior.
  - The individual in crisis may be a frail or fragile individual who is at risk of falling, skin tears, bruising, joint damage, etc.
  - The individual in crisis may be in need of supportive touch to decelerate.
  - Demonstrate the Lower-Level Standing Holding Position.
Unit 9: Physical Interventions - Holding Skills

Participate

1. Enter into a Lower-Level Standing Holding Position.
2. Outside/Inside principle.
3. Lower-Level Standing Holding Arm Movement.
   - The individual in crisis touches their nose.
   - The individual in crisis reaches across their body to either staff member.
   - The individual in crisis attempts to elbow/off-balance either staff member.
4. Disengage.
5. Rotate roles within the group, allowing each person to experience each staff member’s role (left/right) and the role of the individual in crisis.

TEACHABLE MOMENT

» Lower-level holding can be used at the early stages of risk behavior, ending stages of risk behavior, or to provide physical support for the individual in crisis.
» Consider how to move/transport the individual.
» Consider application of principles for different height and sizes.
Unit 9: Physical Interventions – Holding Skills

Medium-Level Holding in a Standing Position

Learning Goal
To physically hold the individual in crisis in a reasonable and proportionate manner based on actions or risk behavior.

These points can be used as a consistent introduction for each holding skill.

- Position, posture, and proximity will now be applied to holding strategies.
- Apply the Outside/Inside principle.
- These strategies may be utilized in support of someone who is at risk and/or when the behavior poses a risk to self or others.
- As the individual in crisis, you are directly responsible for building the skills of the staff member. Therefore, during initial learning you should be cooperative. However, as you build skills, you will be asked to increase your behavior in a measured way to improve the skills/abilities of the staff/participants.

Demonstrate
- Ask two participants to assist you.
- Designate one as a staff member and the other as the individual in crisis.
- Beginning from a Lower-Level Standing Holding Position, ask the class to imagine that the individual in crisis is engaging in riskier behavior.
  - The individual in crisis may be in need of supportive touch to decelerate.
  - On your cue, direct the staff member to mirror your transition into the Medium-Level Standing Holding Position.
  - Prompt the individual in crisis through the Medium-Level Holding Arm Movements.
Unit 9: Physical Interventions - Holding Skills

Participate

1. Transition from a Lower-Level Standing Holding Position to a Medium-Level Standing Holding Position.
2. Outside/Inside principle.
   - The individual in crisis touches their nose.
   - The individual in crisis reaches across their body to either staff member.
   - The individual in crisis attempts to elbow/off-balance either staff member.
4. Give the individual in crisis an instruction to walk across the room to another area.
5. Position the individual in crisis to have a seat with staff and transition from a standing to a seated position.
6. Transition from a Medium-Level Standing Holding Position to a Lower-Level Standing Holding Position.
7. Rotate roles within the group, allowing each person to experience each staff member’s role (left/right) and the role of the individual in crisis.

TEACHABLE MOMENT

» Medium-level holding can be used to moderately manage (not completely restrict) movement associated with risk behavior and/or provide physical support for the individual in crisis.
» Consider how to move/transport the individual.
» Consider application of principles for different height and sizes.
Higher-Level Holding in a Standing Position

Learning Goal
To physically hold the individual in crisis in a reasonable and proportionate manner based on their actions or risk behavior.

These points can be used as a consistent introduction for each holding skill.

- Position, posture, and proximity will now be applied to holding strategies.
- Apply the Outside/Inside principle.
- These strategies may be utilized in support of someone who is at risk and/or when the behavior poses a risk to self or others.
- As the individual in crisis, you are directly responsible for building the skills of the staff member. Therefore, during initial learning you should be cooperative. However, as you build skills, you will be asked to increase your behavior in a measured way to improve the skills/abilities of the staff/participants.

Demonstrate

- Ask for two participants to assist you.
- Designate one as a staff member and the other as the individual in crisis.
- Beginning from a Medium-Level Standing Holding Position, ask the class to imagine that the individual in crisis is engaging in riskier behavior.
  - The individual in crisis may be in need of supportive touch to decelerate.
  - On your cue, direct the staff member to mirror your transition into the Higher-Level Standing Holding Position.
  - Prompt the individual in crisis through the Higher-Level Holding Movements.
Unit 9: Physical Interventions – Holding Skills

Participate

1. Transition from a Lower-Level Standing Holding Position to a Medium-Level Standing Holding Position to a Higher-Level Standing Holding Position.
2. Outside/Inside principle.
3. Higher-Level Standing Holding Movement.
   - The individual in crisis attempts to elbow/off-balance either staff member.
   - The individual in crisis attempts to drive forward.
4. Give the individual in crisis an instruction to walk across the room to another area.
5. Position the individual in crisis to have a seat with staff and transition from a standing to a seated position.
6. Transition from a Higher-Level Standing Holding Position to a Medium-Level Standing Holding Position to a Lower-Level Standing Holding Position.
7. Rotate roles within the group, allowing each person to experience each staff member’s role (left/right) and the role of the individual in crisis.

TEACHABLE MOMENT

» Higher-level holding can be used for greater management (not complete restriction) of movement associated with risk behavior and/or provide physical support for the individual in crisis.

» In order to gain a high level of restriction, staff should apply all the principles ensuring they remain as close as possible. If the person is presenting with a high-risk behavior then staff have to ensure that they are as restrictive as needed in order to minimize harm.

» Consider how to move/transport the individual.

» Consider application of principles for different height and sizes.
Unit 9: Physical Interventions – Holding Skills

Higher-Level Holding – Standing Position
Team Control Position℠

Key Principles
Position – Posture – Proximity
Biomechanical Benefit
- Outside/Inside
- Limit the range of motion

Control Dynamics
Manage the arms.
Reduce upper-body strength.

Manage the incline.
Reduce lower-body strength.

Manage mobility.
Through close body contact.
Unit 9: Physical Interventions – Holding Skills

Higher-Level Holding – Standing Position
Children’s Control Position℠

The Children’s Control Position℠ is designed to be used with children. Consider using this position only with individuals considerably smaller than yourself.

Physical Skills Review

Safe: What makes these skills safe?

Effective: What makes it an effective strategy?

Acceptable: Would this be viewed as an acceptable response to risk behavior?

Transferable: Is this skill transferable?

You have now completed your skills practice using disengagement and holding skills. Please remember that these are intended to be used as a last resort and that not every crisis situation will result in the use of physical intervention. If you look at the Crisis Development Mode℠, Tension Reduction can occur after any level of behavior. Unit 10 will discuss this behavior level and the staff attitude or approach of Therapeutic Rapport in more detail. (Return to Unit 10.)
Glossary of Terms

Anxiety—A noticeable increase or change in behavior. A nondirected expenditure of energy; e.g., pacing, finger drumming, wringing of the hands, or staring. It is the first level in the Crisis Development Model®.

Challenge Position—a body position in which one individual is face-to-face, toe-to-toe, and eye-to-eye in relation to another individual. This position is often perceived as a challenge and tends to escalate a crisis situation.

Classroom Model—demonstrating physical interventions in order to show the application of basic principles.

COPING Model®—a model that staff members can use to guide them through the process of establishing Therapeutic Rapport with an individual after a crisis incident. The COPING Mode® can also be used to structure a staff debriefing.

Crisis Development Model®—a series of recognizable behavior levels an individual may go through in a crisis, and corresponding staff attitudes/approaches used for crisis intervention.

Decision-Making Matrix—a tool that can help staff reach objective critical decisions about risk.

Defensive Level—the beginning stage of loss of rationality. At this stage, an individual often becomes belligerent and challenges authority. It is the second level in the Crisis Development Model®.

Directive Staff Attitude/Approach—an approach in which a staff member takes control of a potentially escalating situation. It is the recommended staff attitude/approach to an individual at the Defensive level.

Disengagement—the use of a physical intervention to gain a release from any holding situation while minimizing risk of pain or injury in situations in which the behavior has been assessed as a lower, medium, or higher risk to self or others.

Empathic Listening—an active process to discern what a person is saying.

Grab/Hold—a situation in which another person maintains physical contact without consent and there is the intentional or unintentional risk of harm to a part of one’s body.

Haptics—communication through touch; a form of nonverbal communication.

Higher-Level Holding—physical intervention necessary to restrict a person’s range of movement in relation to high-risk behavior as determined by a behavioral risk assessment. Higher-level holding is designed to restrict a person’s ability to move away from staff and prevent the person being held from causing significant harm to self or others.

Integrative Experience—the concept that behaviors and attitudes of staff impact behaviors and attitudes of those in their care and vice versa.

Kinesics—the nonverbal behavior that communicates messages to others via body position, posture, and movement.

Likelihood—the chance that an event or behavior may occur.

Limit Setting—a verbal intervention skill in which a person is offered choices and consequences. Limits should be clear, simple, reasonable, and enforceable.

Lower-Level Holding—physical intervention necessary to use as a guide or physical prompt or to provide minimal physical support to limit the person’s range of movement in relation to low-risk behavior as determined by a behavioral risk assessment. Lower-level holding does not limit a person’s choice to move away from staff.

Medium-Level Holding—physical intervention necessary to limit the person’s range of movement in relation to medium-risk behavior as determined by a behavioral risk assessment. Medium-level holding is designed to limit the person’s ability to move away from staff and cause harm to self or others.

Opt-Out Sequence®—an algorithm designed to assist staff in the assessment of risk behavior and decision making required during the use of physical interventions. The Opt-Out Sequence® enables staff to reduce the duration of physical interventions, minimize the potential adverse outcomes (risk) associated with such approaches, and re-establish Therapeutic Rapport.

Paraverbal Communication—the vocal part of speech, excluding the actual words one uses. Three key components are tone, volume, and cadence of speech.

Physical Intervention—a safe, nonharmful, and last-resort response to a person in crisis displaying risk behavior posing a threat to self or others. Physical interventions include disengagement and/or holding skills that are reasonable and proportionate to the level of risk behavior presented.

Position—where you are in relation to others—your orientation.

Posture—how you hold and move your body.

Precipitating Factors—the internal or external causes of behavior over which staff have little or no control.

Proxemics—personal space. An area surrounding the body, approximately 1.5 to 3 feet in range that is considered an extension of self.

Proximity—distance between individuals.

Rational Detachment—the ability to stay in control of one’s own behavior and not take behavior of others personally.

RESPONSE Continuum®—a verbal and nonverbal communication framework designed to help someone consider an appropriate intervention. It helps ensure that physical interventions are used as a last resort and as part of existing communication strategies. This is especially important in situations in which the person does not intend to cause injury (e.g., a person with an intellectual disability or an older person with dementia).

Restraint—A measure or condition that keeps someone or something under control or within limits that may include environmental and/or physical ways to manage a prevailing or perceived risk. Any physical hold or restraint utilized must be used as a last resort, and only when the specific danger that behavior/condition poses to self and/or others outweighs the risks of the hold or restraint. Staff should choose the least restrictive approach appropriate for the situation and constantly assess for the earliest safe opportunity to disengage.

Restraint-Related Positional Asphyxia—a fatal condition that occurs when the position of a person’s body interferes with respiration, and results in asphyxia or suffocation.
Risk Behavior—the total loss of control, which may result in physical behavior that presents a risk to self or others. It is the third behavior level in the Crisis Development Model™ and the point at which physical interventions may be considered to minimize harm.

Severity—the level of harm if the event or behavior does occur.

Strike—a weapon (body part or object) making contact with a target.

Supportive Staff Attitude/Approach—an empathic, nonjudgmental approach attempting to alleviate anxiety. It is the recommended staff attitude/approach to an individual at the Anxiety level.

Supportive Stance™—the suggested body position for a staff member to maintain when intervening with a potentially out-of-control individual. The Supportive Stance™ is maintained by keeping a distance of one leg-length from the person and by remaining at an angle.

Tension Reduction—a decrease in physical and emotional energy that occurs after a person has escalated, characterized by the regaining of rationality. It is the fourth level in the Crisis Development Model™.

Therapeutic Rapport—an approach used to re-establish communication with an individual who is experiencing Tension Reduction. Characterized by a decrease in emotional and physical energy.

Transition—the time during a crisis when staff may be switching between seated; standing; and higher-, medium-, or lower-level holding positions. Transitioning between various holds is determined by the level of risk a person in crisis is displaying at any given moment.

Verbal Escalation Continuum™—a model demonstrating a variety of defensive behaviors that are often seen when individuals are in the Defensive level of the Crisis Development Model™. This model includes suggested staff interventions for each behavior.
Nonviolent Crisis Intervention® Training Program
A CPI collaboration for the Management of Actual or Potential Aggression

Introduction

The ability to prevent and/or positively manage disruptive, challenging, or aggressive behavior is essential in professions where staff work with vulnerable individuals who may present a range of risk behaviors. Professionals working in education settings, health care, behavioral health, residential treatment, and other human services are often in situations that require balancing responsibilities for providing care with obligations for maintaining a safe environment. Professional values, public expectations, and regulatory frameworks add to the complexity of decision making in these types of situations. Therefore, it is essential that staff teams have core knowledge and skills, supported by policies and procedures, that provide a consistent framework for decision making and problem solving to prevent or intervene safely in crisis situations.

The Significance of the Nonviolent Crisis Intervention® Training Process

Without training to learn strategies and build skills, staff who encounter risk behavior are more likely to react from a fear instinct rather than respond in a manner that minimizes risks. Instinctive responses are more likely to escalate a situation, less likely to be rooted in professional values, and may not be legally or professionally defensible if subject to scrutiny or challenge. CPI’s Nonviolent Crisis Intervention® training provides the framework for learning necessary skills and team strategies rooted in a philosophy that prioritizes Care, Welfare, Safety, and Security™. The program does not provide a script or recipe for staff to follow in evolving crisis situations. The CPI program design and Training Process promote a person-centered approach for staff decision making, using problem-solving principles to prevent, defuse, or manage risk behaviors.

Principles and Priorities

The Nonviolent Crisis Intervention® training program was developed to build staff capabilities in managing challenging situations and behaviors in ways that prioritize care and minimize risks. The program offers intervention options to manage a wide range of complex behaviors but also prioritizes creating a culture of care. Complexity can be present in all types of behavior—from anxious to the most acute behavioral disturbances. The Nonviolent Crisis Intervention® program sets forth a philosophy and principles applicable to all people in all environments. The principles surround a values base concerned with ensuring that the rights of people are maintained and that physical interventions are used to protect and not used in any way that could be viewed as degrading or abusive. These principles are:

1. The use of physical interventions must be integrated into an overall behavior management protocol, which provides staff with a range of positive, proactive, and nonphysical approaches before considering the use of any physical intervention.

2. If staff are trained to use physical interventions, they must be trained in approaches that enable them to prevent, decelerate, or manage behavior safely to avoid more restrictive physical intervention. Training should provide information and skills to help staff:

   • Recognize and respond effectively to varied levels of behavior.
   • Understand the cause and function of behavior and the range of Precipitating Factors that influence behavior.
   • Utilize effective interpersonal skills, incorporating nonverbal, verbal, and paraverbal communication, as well as Empathic Listening skills.
   • Consider legal, professional, and ethical issues associated with the use of physical interventions.
   • Understand elements of behavioral risk assessment.
   • Use a consistent framework for decision making for responding to risk behavior.
   • Understand the risks and adverse consequences of physical interventions, how to identify warning signs, and how to respond with corrective actions to minimize harm during the use of physical interventions.
3. The extent of any physical intervention must be proportionate to the assessed risk of harm to the individual or others. Physical intervention must be consistently effective in achieving the aim of temporarily restricting the individual’s movement, thereby protecting them and others from harm. As such, physical interventions are a risk-management strategy and must never be used to enforce rules or gain compliance.

4. Any physical intervention is assessed to consider its safety and acceptability. The assessment should include the extent to which the risks inherent in the use of physical interventions are exacerbated by the intrinsic factors unique to the individual being held, the evidence base in relation to the known risks or adverse consequences of restraint, and the likely margin of error that may occur if interventions are executed incorrectly during application.

5. There must be a clear emphasis within the training program and within the organizational policy that the Care, Welfare, Safety, and SecuritySM of the individual being held remains at the forefront of decisions relating to the use of physical interventions.

Two Forms of Aggressive Behavior

Regardless of what a person actually does in a crisis situation, typically this can be categorized into two forms of aggressive and violent behavior: verbal and physical. Clarification of this point is a critical key to intervening and allows staff to begin to formulate concrete guidelines regarding the approaches taken during crisis situations. Often staff confuse these two types of behavior and consequently assess and react to each in the same way. Doing so can prompt staff to intervene using inappropriate actions for each behavior.

For example, let’s assume that a person becomes agitated to a point of shouting, swearing, and screaming. In situations where staff assess the level of risk of verbal behavior as they would for physical behavior, there is a danger that they will overreact and attempt to use a physical intervention strategy in an effort to calm the individual. Adversely, the use of a physical intervention for this type of behavior is likely to precipitate a physical response from the individual and therefore increase the level of risk to the individual and/or others. By using a physical approach, staff may accelerate the individual’s behavior rather than decelerate it (somewhat like throwing gasoline on a bonfire in an attempt to put it out). Using a physical approach for verbal behavior does not work and invariably makes matters more difficult to manage and resolve.

At the opposite end of the spectrum are the situations in which staff attempt to use verbal intervention skills to decelerate situations where individuals are engaged in physical risk behavior. At this point, while an individual may be hitting, kicking, or physically harming others, it is likely that verbal interventions would be ineffective. In many cases, the individual’s auditory channels shut down so they are often unresponsive at the crisis point of physical risk behavior.

It is important to avoid both overreaction as well as underreaction. Therefore, a goal of the training program is to organize thinking about different levels of behavior and the best staff response at each level. Building proficiency in this helps ensure that staff use effective verbal skills to decelerate verbal behavior so that the use of any physical skills can be avoided. Physical interventions are used only to manage physical risk behavior and only when all other nonphysical approaches have been exhausted. This approach reinforces the perspective that physical interventions should only be used as a risk-management strategy to keep people safe and minimize harm.

Two Types of Aggressive Behavior

| Verbal Behavior | Verbal Intervention |
| Risk Behavior | Physical Intervention |

The Crisis Development Model is an extremely valuable tool that can be utilized to determine a person’s behavior level during an escalation process. Granted, human behavior does not follow an orderly 1–4 progression. Yet, determining the behavior level of a potentially violent individual can help professionals determine how to respond to the different stages of escalation and, as a result, improve deceleration and de-escalation efforts.
The Crisis Development Model℠: Four Levels of Crisis Development

The CPI Crisis Development Model℠ is the primary framework upon which all skills and strategies in the program are associated. The Crisis Development Model℠ outlines four distinct and identifiable behavior levels and corresponding staff responses. The Crisis Development Model℠ is not meant to oversimplify the complexities of the behavioral process, but rather to function as a workable and reflective model to enable staff to develop positive interventions in any crisis situation. The model serves to help staff reflect on the person’s behavior at each of the four levels in order to consider appropriate responses and attitudes.

Anxiety Behavior Level

The Anxiety Behavior Level is the first level within the model and is defined as a noticeable increase or change in behavior. Not to be confused with a medical or psychiatric definition, the Anxiety Behavior Level is the first point at which staff may observe changes in the person’s behavior that may be considered not typical, and that may alert staff to the idea that something internally or externally is adversely impacting the person. Although the behavior observed at this level will be unique to each person, examples of Anxiety-level behavior may include changes in body language, facial expression, and eye contact. Although staff may not know what internal or external factors are affecting the individual, they will notice that something is different about the person’s behavior.

Supportive Staff Attitude and Approach

The staff response at the Anxiety level is to adopt a Supportive attitude and approach. An empathic, nonjudgmental approach communicates support and can encourage an individual in distress to convey concerns and work toward resolution in a rational manner. If not addressed, Anxiety can stimulate irrational thinking. By adopting a Supportive attitude and approach, staff can decelerate potential crisis events proactively, thereby avoiding risk behavior. A Supportive response also reinforces a level of trust and rapport, which is key to reducing the likelihood of risk behavior.

Defensive Behavior Level

There will obviously be times in which staff are not present to respond to the Anxious behavior exhibited, or staff may inadvertently respond in a manner that accelerates behavior. There will also be times in which the individual is unable to accept the staff support. Perhaps they do not have the capacity or the necessary coping skills to manage influences on their behavior. In these circumstances, despite staff’s best efforts to decelerate the situation, the person’s behavior may escalate to the next level within the Crisis Development Model℠.

The Defensive Behavior Level is defined as the beginning stages of a loss of rationality. At this point, in addition to the nonverbal changes in behavior observed at the Anxiety Behavior Level, the person begins to demonstrate verbal behavior that indicates that they are beginning to lose control. This is a potentially volatile behavior level and usually includes verbal belligerence, shouting, swearing, sexually or racially offensive language, personal insults, hostility, and verbal threats. Typically the person will challenge staff, their authority, and the facility. They may avoid, distort, or generalize issues, or attempt to intimidate or distract staff. At this level, as the person continues to lose rationality and control, they may also lose the ability to respond to the context of staff requests or instructions, and may be more in tune with staff’s paraverbal communication (volume, tone, and cadence) as well as nonverbal behavior (body position, posture, and proximity).

This is an extremely critical point during a crisis event, and staff responses can easily escalate behavior if they do not recognize that irrational thinking is fueling behavior and the individual is not processing information easily. It is not uncommon for staff to engage in a power struggle or debate when they don’t understand the intricacies of this level. If staff lose control and professionalism, they too can become irrational and part of the problem. If the person at the Defensive Behavior Level senses that staff are not in control of their own behavior, there is a danger that the whole situation will escalate and the risk of harm will increase.
Directive Staff Attitude and Approach
During the Defensive Behavior Level, the best approach for staff to take is the Directive attitude and approach, giving a simple, clear directive to gain some type of compliance. This is often only a fraction of what may have been an initial request which prompted the Defensive behavior. The irrational person won’t process complex instructions. To reintroduce rationality, staff should consider what simple directive the individual may comply with. For example, although the initial request was for the person to leave an area and complete some task, if the person has escalated to an irrational state, the staff directive may be “sit in this chair so we can talk” or “stop shouting.” Any “yes”—demonstrated through compliance—can stimulate return of rational thinking. If the individual does not comply with a simple directive, staff will need to set limits.

There are several important considerations when setting behavioral limits. First, it is important that staff ensure that the limits are clear. Staff should not assume that the person will listen or understand what the behavioral limit is or why it is being issued. Therefore, staff should use words that the person will understand (signs, symbols, and other augmentative methods of communication can also be used with people who have additional communication difficulties) and ensure that the limit set is described in behavioral terms. Second, staff should keep the limit simple and avoid complex statements or instructions that involve too many options or choices. When a person is at the Defensive Behavior Level, they will have lost some of their rationality and control, and are therefore more likely to respond to one or two options rather than five or six. Third, it is essential that any behavioral limit is considered objective and reasonable and is delivered by staff in a considerate manner. This is important, not only in terms of staff modeling appropriate behavior that is nonthreatening and respectful, but also to enable the person to realize that the impact and consequences of their behavior are within their control. A behavioral limit should be win–win. Finally, staff should always ensure that any behavioral limit is enforceable, since most people at the Defensive Behavior Level will test any limits that are imposed.

When using a behavioral limit, it is important that, wherever possible, it is constructive and delivered with a focus on a positive behavioral outcome rather than via ultimatum or threat. Behavioral limit setting is a skill that requires practice as well as a confident, calm, and professional approach. A behavioral limit-setting statement should let the person know which specific behavior they are engaging in and the impact their behavior is having. It should also include the desired alternative behavior and positive consequence that will result when the person engages in the desired behavior. At the point of crisis, when the person is in the Defensive Behavior Level using aggressive, derogatory, and hostile language, staff often find themselves stressed, and therefore find it difficult to use positive behavioral limit-setting statements. Instead, they may use a challenging statement, which will accelerate the situation. A way of helping staff avoid challenging statements is to practice structuring statements so they can respond intuitively and positively to the situation, the person, and the behavior.

Risk Behavior Level
In any situation, staff may not be able to decelerate the situation using Supportive and/or Directive approaches, as they may inadvertently use an acceleratory intervention. Alternatively, if the person concerned does not possess the necessary coping skills to manage the internal or external influences on behavior, or refuses, or is unable to accept staff support, then despite staff’s best efforts to decelerate the situation, the person’s behavior may escalate to the next level within the Crisis Development Model: the Risk Behavior Level. This level is defined as a total loss of control, which results in a violent action. The person is no longer able to maintain self-control, so the verbal behavior turns to physical risk behavior. At this point, the person may attempt self-harm and/or may attempt to assault staff and other onlookers or bystanders.

Physical Intervention
Physical intervention should be absolutely avoided at all times unless there is no safer alternative and the risks of not intervening are greater than the risks of physical intervention. There are many legal, professional, and regulatory implications associated with the use of physical interventions,
as well as the important issue of human rights. Physical intervention is not without risk, so it is important that organizations authorize and approve the specific physical interventions that can be used, and ensure that staff are well trained and competent.

It is essential that physical intervention is used only as a last resort to manage risk behavior when all other reasonable, nonphysical approaches have been exhausted and failed to prevent the situation from escalating. If the person is no longer responding to reason and presents a risk to self and others, staff have a legal, professional, and moral duty of care to intervene to prevent or minimize harm. Physical interventions should never be used to enforce rules or as a punishment, and should not rely on pain-inducing principles. People who are subject to physical interventions are often vulnerable, so organizations should ensure that appropriate policies are in place, which safeguard vulnerable people from the misuse or abuse of such interventions.

When using physical interventions, staff must remember that losing one’s control and being held by others is a frightening and unpleasant experience. It is likely that at this point in the crisis the person will shout, swear, and scream, as well as frantically fight and struggle in an attempt to get free from staff. It may be difficult to keep this behavior in perspective, as it will sound and look like risk behavior, and will feel like the person is attempting to harm staff. As such, staff must remember that the purpose of physical intervention is to reduce the risk of harm and should quickly look at ways in which they can begin to de-escalate the situation, let go, and return control to the person. While in some situations people may use physical risk behavior with the intent to cause harm to others, in many human service settings such behavior is not premeditated, but is simply a response to the internal and external triggers that impact those individuals who are often vulnerable and who often lack the coping skills to prevent their behavior from escalating.

**Tension Reduction Behavior Level**
The Tension Reduction Behavior Level is the final level in the Crisis Development Model®. During the Risk Behavior Level, the individual in crisis expends an enormous amount of physical and emotional energy that eventually reduces. During a physical intervention, staff will actually feel the Tension Reduction in the muscles, and the hostile and aggressive verbal behavior subsides, often leaving the person emotionally drained, withdrawn, or even remorseful.

It is important to remember that the Tension Reduction Behavior Level is the point at which the person begins to regain self-control and rationality. A person going through the Tension Reduction Level following a physical intervention has been through a potentially frightening and traumatic experience, and may not be able to remember all of it. As such, the person may be emotionally vulnerable.

**Therapeutic Rapport Attitude and Approach**
The final response by staff is Therapeutic Rapport, in which all attempts should be made to re-establish a positive relationship. This is a good time to explain to the person what will happen next. Staff should begin to offer the person a range of safe choices as the person regains self-control, and staff should recognize that the person may be seeking emotional support and reassurance.

The Crisis Development Model® shown above is an extremely valuable tool that can be utilized to determine a person’s behavior level during an escalation process. Granted, human behavior does not follow an orderly 1-4 progression. Yet, determining the behavior level of a potentially violent individual can help professionals determine how to respond to the different stages of escalation and, as a result, improve deceleration and de-escalation efforts.
Behavioral Interventions: A Continuous Learning Process

A fundamental purpose of this CPI program is to help everyone understand that all behavior has a function. At times, however, particularly in relation to challenging, aggressive, and violent behavior or acute behavioral disturbance, it can feel like this type of behavior is intentionally motivated with the sole goal of harming staff. In situations where individual staff members are targeted, it can feel like the person’s behavior is very personally motivated and directed toward staff, which can leave staff feeling isolated, vulnerable, or even angry.

When staff intervene in an attempt to defuse, decelerate, or manage behavior, they must be aware that their attitude and behavior have a significant impact on the person they are attempting to manage. In most cases, the subsequent escalation or de-escalation of the person’s behavior may depend entirely upon how staff react. The Nonviolent Crisis Intervention® program stresses that all behavior is continually shaped by internal and external factors, and that the recognition and management of a crisis event is an Integrated Experience between the staff and the other people involved. If staff allow themselves to become irrational, angry, vengeful, or unprofessional, it is likely that the intervention will not be focused on the Care, Welfare, Safety, and Security℠ of everyone, and there is a greater likelihood that physical interventions will be misused or abused.

The Crisis Development Model℠ teaches staff to recognize changes in behavior levels and to consider their attitude and approach to the person. Meeting anxiety with anxiety and defensiveness with defensiveness is likely to accelerate, rather than decelerate, the development of the crisis, and increase the chance of risk or harmful behavior.

In an effort to maximize the chance of avoiding a crisis situation and enabling the person to remain calm and in control, it is advantageous to balance or offset the person’s behavior with therapeutic and nonthreatening responses by staff. Even in the most extreme behavior or circumstances, staff have a clear professional and legal obligation to maintain a therapeutic relationship with the individual at all times. By using safe and nonharmful interventions taught within the program, staff are more likely to develop and maintain a therapeutic relationship at all times, regardless of the person’s behavior.
Understanding the Risks of Physical Restraints

Overview

The use of restraint remains contentious particularly due to the specific concerns and risks associated with such practice. As such, this resource is intended to support and promote positive practice and to ensure that physical interventions are used as part of our commitment to Care, Welfare, Safety, and Security SM. In accordance with current legislation and guidance, the circumstances that may justify the use of physical interventions include:

- When an individual poses a significant risk to self.
- When an individual poses a significant risk to others.
- When an individual causes damage to property that may result in significant risk of harm to self or others.

Despite any legal and professional justification, physical interventions are not free from risk, and as such professional staff have a duty of care to minimize the psychological and physiological adverse outcomes that are associated with such practice. When using physical interventions to manage the risks associated with an individual's behavior, staff face the dilemma that the specific intervention used may compromise the welfare and safety of those involved, and as such it is important that physical interventions are applied within a context of best practice in order to minimize harm.

Potential Risks Associated With the Use of Physical Interventions

In circumstances where it has been identified that physical interventions are an appropriate response to manage a prevailing risk associated with an individual's behavior, it is important that staff fully understand the adverse impact physical interventions may have. (See Figure 1.) While there is a need to reduce psychosocial impact and soft-tissue and articular/bony injuries, there is a clear priority that every effort should be made to ensure restraint-related deaths are avoided.

Figure 1: Restraint-Related Injury or Harm

<table>
<thead>
<tr>
<th>Psychosocial Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including post-traumatic stress disorder and damage to therapeutic relationships.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Soft-Tissue Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including injury to skin, muscles, ligaments, and tendons.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Articular or Bony Injury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including injury to joints and bones.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including compromise to airway, bellows mechanism, and gaseous exchange, which results in respiratory crisis or failure.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiovascular Compromise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Including compromise to the heart and the peripheral vascular system.</td>
</tr>
</tbody>
</table>
Understanding the Risks of Physical Restraints

Theories of Restraint-Related Deaths

There has been a growing body of opinion that highlights that specific interventions are associated with higher risks to the person being restrained. However, while this view remains dominant among practitioners, organizations, and legislators, the evidence shows that although physical restraint has the ability to impede or restrict life-maintaining physiological functions, the imposed impediment is not uniform between different restraint positions. In particular, the term “positional asphyxia” (Reay, et al. 1988), which is misunderstood and inconsistently used and interpreted, is often viewed as the mechanism for sudden restraint-related death and has become synonymous with prone restraint—a conclusion primarily based on opinion.

In 2011, the Independent Advisory Panel on Deaths in Custody commissioned a review of medical theories, case studies, and research and concluded that certain groups are more vulnerable to the risks of restraint as a result of specific bio-physiological, interpersonal, situational, or attitudinal factors. From this review, it is clear that certain individuals have personal characteristics that may make them more vulnerable to restraint-related adverse outcomes and, in particular, restraint-related death. More recently, Barnett, et al. (2012) published a 30-year review of all the scientific studies related to the physiological impact of restraint and raised attention to the fact that few scientific studies on the physiological impact of restraint have been undertaken with the findings from these not completely valid or generalizable to the real-life event. As a result of the recent published reviews, Figure 2 below illustrates an overview of the evidence from the literature, case studies, and experimental research and demonstrates there are a number of complex issues related to adverse outcomes of restraint suggesting that restraint-related death, in particular, is a multi-factorial phenomenon.

Figure 2: Restraint-Related Deaths - A Multi-Factorial Event

<table>
<thead>
<tr>
<th>Most Vulnerable Individuals</th>
<th>Contributing/Situational Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• People with serious mental illness.</td>
<td>1. People who have a pre-existing health condition that is compromised by physical restraint: Respiratory disease, cardiovascular disease, epilepsy, obesity.</td>
</tr>
<tr>
<td>• People with intellectual disabilities or cognitive impairment.</td>
<td>2. Stress-related cardiomyopathy: A weakening of the heart muscle triggered by high levels of emotional stress or anxiety resulting in high circulating levels of catecholamines (adrenaline and epinephrine).</td>
</tr>
<tr>
<td>• People from minority ethnic groups.</td>
<td>3. External respiratory restriction as a result of the restraint position: Positional asphyxia associated with prone, hog-tie, and flexed-seated restraint.</td>
</tr>
<tr>
<td>• People with a high body mass index.</td>
<td>4. Intoxication: An adverse physiological state produced by a poison or other toxic substance (especially cocaine), which results in erratic or violent behavior.</td>
</tr>
<tr>
<td>• Men aged 30–40 years.</td>
<td>5. Excited delirium: A combination of acute behavioral disturbance, agitation, severe anxiety, disorientation, and elevated body temperature; associated with severe mental illness and/or drug intoxication.</td>
</tr>
<tr>
<td>• Children and young people below the age of 20 years.</td>
<td>6. Respiratory acidosis: A decrease in respiratory ventilation resulting in a buildup of carbon dioxide leading to increased acidity in the blood and tissues.</td>
</tr>
<tr>
<td>• People who are held for prolonged periods of time.*</td>
<td>7. Thromboembolic disease: A cardiovascular condition involving the obstruction of blood flow to one or more arteries in the lungs.</td>
</tr>
<tr>
<td>* While some researchers, O’Halloran, et al. (2000) and Miller (2004), provide case-study evidence to suggest collapse can occur between 2 and 12 minutes, others such as Parkes (2000) argue that restraints involving prolonged, severe struggle are of greatest concern.</td>
<td>8. Use of prescribed psychotropic medication: Prescribed medication which may have an adverse effect on the person’s physiology resulting in hypotension, respiratory compromise, and, in extreme cases, neuroleptic malignant syndrome.</td>
</tr>
</tbody>
</table>
**Positional Asphyxia and Restraint Position**

Although there are a relatively small number of restraint-related deaths reported in health, educational, and social care environments occurring during and/or in close proximity to physical restraint (Independent Advisory Panel on Deaths in Custody, 2011), these are often perceived to have occurred as a result of positional asphyxia. This has led to some organizations advocating the unhelpful and largely unsupported view that prone restraint is the main risk and therefore should be abolished in favor of alternative positions (seated, standing, or supine), which are incorrectly perceived as less harmful.

As part of an overall approach to reduce risk, professional staff who are expected to manage behavior using physical restraint need to ensure that the training they receive provides sufficient information on restraint-related adverse outcomes so they know how such factors can be minimized in order to maintain everyone’s Care, Welfare, Safety, and SecuritySM. Figure 3 below highlights a range of best-practice indicators that should shape practice and enable organizations to reduce avoidable restraint, as well as minimize the risks of restraint when such measures are unavoidable.

**Figure 3: Best-Practice Indicators**

<table>
<thead>
<tr>
<th>Some Best-Practice Principles for the Use of Physical Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Physical interventions should be used within an organization as part of a wider restraint-reduction strategy to minimize avoidable restraint.</td>
</tr>
<tr>
<td>• As part of a restraint-reduction strategy, physical interventions should be used only when all other nonphysical interventions have failed to manage the prevailing risk. Physical interventions should never be used as a punishment, to force control, gain compliance, or enforce rules.</td>
</tr>
<tr>
<td>• People who are likely to be subject to the use of physical interventions should have an individual risk assessment completed in order to identify any specific contraindications associated with the person, including any known vulnerabilities that may increase the likelihood of an adverse consequence. Where possible, specific medical advice should be sought in order to fully assess the impact physical interventions may have on those individuals who are known to be in vulnerable groups.</td>
</tr>
<tr>
<td>• All physical interventions should be authorized and approved by the organization and written into an individual management plan. Where physical interventions are used reactively to manage an unforeseen risk, an individual assessment and management plan should be undertaken as soon as is reasonable and practical.</td>
</tr>
<tr>
<td>• Only staff who have received training should use physical intervention skills.</td>
</tr>
<tr>
<td>• Prolonged physical restraint increases the risk of restraint-related death. Whenever possible, all reasonable and alternative nonphysical interventions should be used if the duration of a physical restraint exceeds 10 minutes (NICE, 2015).</td>
</tr>
<tr>
<td>• Staff using physical interventions must be fully aware of the risk associated with each intervention. They must monitor the individual’s safety and well-being at all times, be able to identify signs of distress, and know how to respond to medical emergencies. (See Figure 5.)</td>
</tr>
<tr>
<td>• In order to maximize the Care, Welfare, Safety, and SecuritySM of everyone, physical interventions should be used within the context of the Opt-Out SequenceSM in order to promote early physical de-escalation.</td>
</tr>
<tr>
<td>• Staff who use physical interventions should also be trained in emergency first aid so they can respond to medical emergencies should they occur as a result of restraint.</td>
</tr>
<tr>
<td>• Physical interventions should be used only for the minimum amount of time, using the minimum amount of restriction on the basis of prevailing risk that staff are attempting to manage.</td>
</tr>
<tr>
<td>• In any emergency where an individual is held on the floor, a supine (face up) position should be used (Barnett et al, 2013; 2016).</td>
</tr>
</tbody>
</table>
Understanding the Risks of Physical Restraints

**Prolonged Physical Restraint**

Prolonged physical restraint increases the risk of harm to the individual and has been associated with restraint-related deaths. As such, all physical interventions must be the least restrictive and only maintained for the least amount of time possible.

The *Opt-Out Sequence*™ has been developed as an active decision-making framework to enable staff to assess the continued risks in order to minimize the duration of the restraint. In any situation where a physical restraint exceeds 10 minutes, staff must take all reasonable actions to end the restraint and seek an alternative nonphysical intervention (NICE, 2015).

**Figure 4: The Opt-Out Sequence™**

In order to ensure everyone’s *Care, Welfare, Safety, and Security*™ during restraint, a number of key observations must be maintained, as such events can quickly become medical emergencies. Figure 5 illustrates some of the observations, sounds, signs, and symptoms along a continuum of low concern (section A) to high concern (section C), and identifies the corrective actions staff must take to ensure the individual’s welfare is maintained and the risk of serious harm is reduced.
## Understanding the Risks of Physical Restraints

### Figure 5: Risks of Restraints: Warning Signs and Corrective Actions

<table>
<thead>
<tr>
<th>Warning Signs</th>
<th>Corrective Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>A  • Shouts and swears at staff to “let go.”</td>
<td>Treat as IMPORTANT. Manage the prevailing risk and follow the Opt-Out Sequence&lt;sup&gt;SM&lt;/sup&gt;. Consider letting go as soon as possible, or reduce the level of restriction and/or change the position of the person.</td>
</tr>
<tr>
<td>• Attempts to struggle free and/or injure self or others.</td>
<td></td>
</tr>
<tr>
<td>• Is hostile and aggressive to self or others.</td>
<td></td>
</tr>
<tr>
<td>B  • Complains of difficulty breathing.</td>
<td>Treat as URGENT. Immediately assess level of restriction and check to ensure you are not impeding or restricting breathing.</td>
</tr>
<tr>
<td>• Complains of feeling sick and/or vomits.</td>
<td>Check movement of limbs and signs of fracture/dislocation.</td>
</tr>
<tr>
<td>• Voids bladder and/or bowels.</td>
<td>Follow the Opt-Out Sequence&lt;sup&gt;SM&lt;/sup&gt; and consider letting go as soon as possible; reduce the level of restriction; and/or change the position of the person so they are seated upright, reclined (recumbent), or in a position that is not impeding or restricting breathing.</td>
</tr>
<tr>
<td>• Complains of pain or discomfort.</td>
<td>Encourage person to relax and to take sips of a cold drink—assess hydration needs.</td>
</tr>
<tr>
<td>• Limbs positioned awkwardly; not moving within normal range of motion; and/or sounds of crepitus.</td>
<td>Call for help—an independent person not involved in the physical restraint is often best to assess what is happening and what action needs to be taken.</td>
</tr>
<tr>
<td>• Becomes distressed and/or cries.</td>
<td>Refer person to medical practitioner as soon as possible for further assessment.</td>
</tr>
<tr>
<td>• Continually struggles; becomes increasingly hot/flushed/sweaty.</td>
<td></td>
</tr>
<tr>
<td>C  • Unresponsive to requests or instructions.</td>
<td>Treat as a MEDICAL EMERGENCY.</td>
</tr>
<tr>
<td>• Loss of or reduced consciousness.</td>
<td>The term Medical Emergency&lt;sup&gt;1&lt;/sup&gt; should be used as a verbal prompt for staff to stop the restraint immediately and:</td>
</tr>
<tr>
<td>• Abruptly/unexpectedly stops struggling or suddenly calms down.</td>
<td>• Call for emergency medical assistance.</td>
</tr>
<tr>
<td>• Sudden change in breathing pattern.</td>
<td>• Follow the basic life support (BLS) algorithm as outlined in national and international resuscitation guidelines.</td>
</tr>
<tr>
<td>• Has a seizure of epileptic or non-epileptic origin.</td>
<td></td>
</tr>
<tr>
<td>• Blueness of lips/fingernails/ear lobes (cyanosis).</td>
<td></td>
</tr>
<tr>
<td>• Tiny pinpoint red dots/bruises (called petechia) on the skin, particularly on the upper chest, neck, face, and around the eyes.</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup>At any time, if any staff member is concerned about the individual’s welfare and safety, they should clearly state “medical emergency.” The term “medical emergency” is an instruction for everyone involved in the restraint to immediately let go of the individual and begin the necessary emergency aid.


Joint Commission. (2009). The 2009 Joint Commission comprehensive accreditation manual for hospitals, PC.03.05.01.


Additional Resources and References


Siegel, D. J. (1999). The developing mind: How relationships and the brain interact to shape who we are. New York: Guilford Press.


The staff of CPI thank you for your participation in our program. If we can be of any other assistance to you, your facility, or your colleagues, please do not hesitate to contact our office.