Show slide 4.3 Short-term options

Trainer led discussion

It is important that all staff be aware that a range of options exist when faced with aggressive or violent individuals. These responses will depend on a number of factors including the nature and severity of the event, whether it is a patient, visitor or intruder and the skills, experience and confidence of the staff members involved. This may include calling for back-up, security or local police. This section is a summary of the content completed in the earlier parts of this session and in the previous eLearning modules and should be facilitated to reinforce previous concepts.

- Issue a verbal warning.
- Use communication skills.
- Decide to stay or leave.
- Medication management.
- Duress response options and calling for back-up.
- Defending self.

Link to Participant Manual

Refer participants to content in Participant Manual (pages 25–26) and link to Zero Tolerance policy during the discussion.

Trainer led discussion

Short-term response options

Some short-term options for dealing with aggression may include the following; the order in which they are used or the appropriateness of the strategy depends on the specific situation.

Issue a verbal warning

In the face of verbally aggressive or abusive behaviour, it may be appropriate to issue a warning. If the staff member feels unable to do this, or is not appropriate to the situation, or that it will further inflame the situation, back-up should be sought. If the situation does warrant issuing a warning, this should be done in a calm, respectful, 'informative' manner, for example, 'You are shouting and I am feeling threatened, I would like to help you but I need you to stop yelling.'

Use communication skills

Staff should remain calm, listen to the individual's concerns in an empathetic, non-confronting manner, emphasise your desire to help, try and make the individual more comfortable and utilise accompanying friends/relatives if appropriate. For example, 'If you cannot talk to me calmly I will need to get help so others don't feel threatened.'

Decide to stay or leave
If the individual fails to respond to verbal warnings or the situation escalates, staff should seek back-up and/or retreat if necessary. If staff feel unsafe at any time, they should call for back-up. You should always go and get help if you retreat. Remember that you still need to consider the safety of others.

Medication management
If the aggressive person is a patient and the aggression is deemed to be the result of a clinical condition, it may be considered appropriate to administer medication to this person. Oral medication should be initially offered if appropriate and if this is declined, then intramuscular or intravenous medication may be given. It is not acceptable to use or threaten to use chemical restraint in response to non-compliance with instructions or as a punishment.

Duress response options and calling for back-up
Depending on the level of perceived threat, imminence or actuality of violence, effects of the behaviour on others, availability of support and local protocols, back-up may include:

- Calling on a more senior staff member or clinician – in some circumstances, this may be enough to calm an aggressive patient and also allow for a clinical assessment if warranted.
- Contacting security staff – the presence of security staff may act as a deterrent and/or assist in the protection of staff and visitors.
- Using the duress alarm or initiating the duress response.
- Calling police or other external security services.
- Withdrawing to a safer location.

Defending self
Staff are entitled by law to protect themselves or another from a threat of attack or injury. The protection afforded by the law is however limited to situations where there is an immediate or imminent threat or attack.

Show slide 4.4 Long-term options

Trainer led discussion
Emphasise that long-term response options are focused on the problem behaviours being displayed, not the illness. They will also vary depending on whether the source of aggression is a patient, visitor or intruder:

- Written warnings.
- Conditional treatment agreements.
- Conditional visiting rights.
- Exclusion from visits.
- Flagging and patient alerts.
- Individual patient care plans.
- Inability to treat.

- Apprehended violence orders (AVO).
- Laying charges.

Link to Participant Manual
Refer participants to content in Participant Manual (pages 27–30) and link to Zero Tolerance policy during the discussion.

Trainer led discussion
Written warnings
Depending on the circumstances, it may be appropriate to issue a letter of warning to a patient or visitor who has exhibited repeated aggressive or violent behaviour and where verbal discussion with the patient has failed to resolve the situation. A number of factors will need to be considered in determining whether a letter is appropriate, or whether it is necessary to utilise other risk control strategies e.g. a conditional treatment agreement. These factors may include:

- Frequency, nature and severity of the behaviour.
- Circumstances surrounding the behaviour.
- Extent of exposure of staff, visitors and others to the behaviour.
- Level of threat or risk the behaviour presents to others.
- Patient's or visitor's ability to comprehend the issues associated with their behaviour.
- Patient's or visitor's capacity or ability to modify his/her behaviour.
- Patient's or visitor's ability to read and understand English.

The document must have the signature of the unit manager, facility manager or area health service chief executive officer as most appropriate.

Conditional treatment agreements
In some circumstances it may be necessary to establish a conditional treatment agreement with the patient. Such circumstances may include where the patient has a history of repeatedly:

- Presenting for treatment under the influence of alcohol or other drugs, leading to aggressive, violent or disruptive behaviour.
- Being accompanied by groups of friends/relatives significantly disrupting the treating environment.
- Being accompanied by persons with a history of aggressive behaviour towards staff or others.
- Presenting in an aggressive manner late at night or at change of shift times and disrupting the treating environment.
- Regularly threatening, attempting or perpetrating violence against staff or other patients.

Depending on the individual circumstances, the following conditions may be considered for inclusion when developing conditional treatment agreements:

- Clearly articulated behavioural requirements (the patient and those accompanying him/her need to understand what behaviour is required).
- Stated results of the patient's failure to comply e.g. treatment may need to be provided in different ways/times, visitors may not be permitted, etc.
- Where the treatment will be provided e.g. at what facility and at what location within that facility.
- Specified time/s.
- Who will accompany the patient e.g. a friend/relative with a calming influence.
- Who will not accompany the patient e.g. friend/relative who is regularly threatening or aggressive towards staff, other patients.
- The condition of the patient and those accompanying the patient e.g. not under the influence of alcohol.

The conditional treatment agreement should:

- Be developed in consultation with the patient and other relevant stakeholders e.g. guardian, relatives, treating staff, security, etc.
- Not be discriminatory e.g. focuses on behaviour, not condition, race etc.
- Be regularly reviewed according to an agreed timetable (from both a clinical and practical perspective).
- Be reviewed when there are changes in the patient's circumstances e.g. moves to a different residential location, condition/behaviour improves etc.
- Focus on the ability to provide meaningful treatment in an appropriate facility and a safe environment.
- Include an appeals mechanism.

Conditional treatment agreements should be negotiated with patients as far as possible. They should form part of broader risk control strategies aimed at protecting staff, patients and visitors from violence, while at the same time, as far as possible, allowing for appropriate treatment to be administered in a therapeutic environment.

Conditional visiting rights
These usually apply to relatives or other visitors to a health facility and may be considered as a long-term option for repeated problem behaviours.

Exclusion from visits
These usually apply to relatives or other visitors to a health facility and may be considered as a long-term option for repeated problem behaviours.

File flagging and patient alerts
File flagging and patient alerts may be used to identify patients who pose a risk to the health and safety of staff and other patients. They enable staff to be aware of the patient's tendency to become violent.

The criteria to meet the need for a flag needs to be linked to violence and safety issues because of the person's behaviour, not simply because of the person's medical diagnosis. The flagging of a file may result in the person being provided with services in a different manner than other patients. This may even, in extraordinary cases, include an inability to supply the service in certain circumstances.

Individual patient care plans
These will set out who is treating the patient, what the crisis care strategies are, identified goals and methods for achieving these goals. These plans are often used for suicidal patients.

Inability to treat
Despite the options available for managing violent patients, there may be, on rare occasions, and usually as a temporary measure, a situation where it is almost impossible to treat a patient without significant, unacceptable risks to those involved.

Depending on the circumstances surrounding this situation, options may include:

- Deferring treatment where possible (if not life threatening) to a time when the risks are better able to be managed e.g. when more suitably skilled and experienced staff are available, or when the patient is more settled.
- Arranging for treatment to be carried out in a different, more secure location.
- The option not to treat (at that time or at that location) would only arise after all of the above mechanisms have been investigated to their full capacity, and should always be a last resort unless immediate escape from a violent event is necessary.

Apprehended violence orders (AVO)
Where a staff member fears that there may be future violence, harassment or intimidation from someone they have been exposed to in the workplace or in the course of their work, regardless of whether charges of assault are being laid against the person, the staff member may seek to take out an apprehended violence order (AVO). An AVO is an

order made by the court to protect people from abuse, violence or threats of violence. They can also be applied if someone is being stalked, intimidated or harassed, or has reason to fear that they may be in the future.

The AVO is an agreement between the defendant and the court that the defendant will not engage in certain behaviours. It usually states that the defendant cannot assault, harass, threaten, stalk or intimidate the person seeking the order (the complainant), or go within a certain distance of their home or workplace. Other orders can be included if necessary.

Laying charges
All significant violent incidents should be reported to the police. Recent changes to the Crimes Act now mean that the occupation of the victim of an assault will be considered in determining an appropriate sentence. These changes are designed to allow tougher penalties to be imposed on those who assault health staff in the course of their work.

MORNING TEA
20 MINUTES

110 MINS **SESSION 5 Communication and de-escalation skills**

Purpose: This session is intended to provide participants with an understanding of different communication methods and strategies to improve the communication process when confronted by an escalating person. The participant will have an opportunity to apply practical verbal intervention skills using role play and scenarios.

Show slide 5.1 – Session 5 Introduction

Research
In order to effectively facilitate this session, trainers should read the following article and familiarise themselves with the approach, objectives, guidelines and domains that will be used in this session for verbal de-escalation.

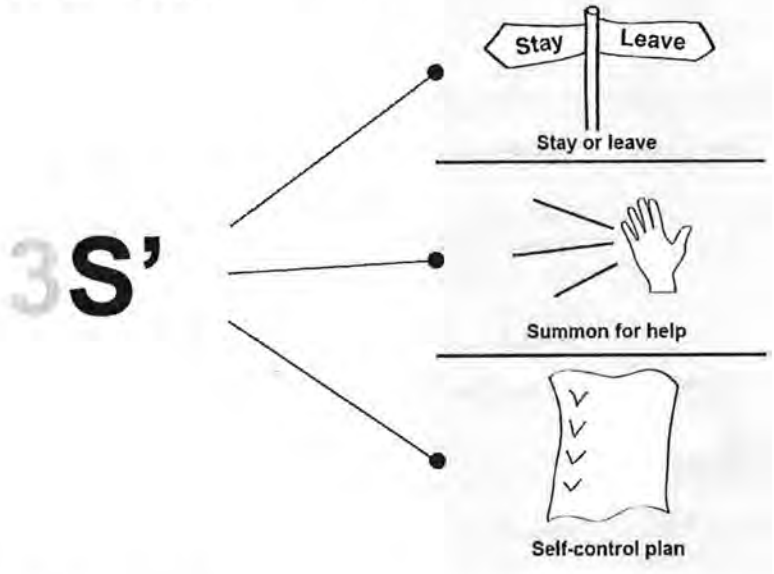
Richmond, J et al. 2012, Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup, West J Emerg Med. 2012 February; 13(1): 17–25. Retrieved from: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3298202/

Show slide 5.2 – Principles of personal protection

Trainer led discussion

- Know your environment.
- Always be aware of the potential for violence when dealing with patients.
- Make yourself aware of your patient's known risks.
- Be aware of your exits.
- Ensure staff know your whereabouts.
- Never knowingly place yourself or others in danger.
- Never approach an aggressive patient alone.
- Wear appropriate attire; dress for work.
- Develop a rapport with patients.
- Respectful communication.

Show slide 5.3 – The 3 Ss of Safety
Staff can use the 3 'S' approach to the management of aggressive and/or violent behaviour.



Trainer led discussion
Stay or leave
Make the decision; if you think you should leave and you can, leave.
You should leave the situation when:

- You feel you cannot control the situation or the situation is getting out of control.
- You endanger yourself or others by staying.
- When you are alone with an aggressive person.

Summon for help
Be aware of duress response in your LHD/SN.
Remind participants that they can use their voice to call for assistance!

Question
Ask participants to describe duress activation in their workplace and what other options they have when a situation is high risk.

Self-control plan
Our response can often further escalate the situation. Be aware of your personal response to aggression. Ask participants to think about our natural reaction as human beings to aggression. Many people when confronted with an aggressive or violent situation respond with 'fight, flight or freeze'.

Question
Ask participants if they are aware of how they 'appear' when confronted with an aggressive person.

Common symptoms of increased adrenaline include:

- An increase in heart rate and/or blood pressure.
- Dry mouth.
- Shaky knees or hands.
- Quivering voice.
- Narrowing of peripheral field of vision.
- Auditory exclusion.

Sometimes this increase of adrenaline into the body can manifest in other ways. One such way will be demonstrated with this exercise by nearly all participants. Most if not all will begin to smile or grin broadly and may giggle or laugh out loud as they perform the exercise. This is a typical response and staff should be aware of how this may adversely affect the de-escalation process.

The first step in prevention is awareness so if staff are aware that this is a natural response to a highly charged situation, they may be able to take steps to control this behaviour.

Adrenaline response activity
Trainers may want to use this exercise to prompt discussion regarding awareness of adrenaline response.

Form 2 lines of 6 people facing each other several metres apart (line A and line B), so that every person has a partner facing them from the other line. Tell line B to remain in their positions. Ask line A to be the aggressor first by placing an angry expression on their faces and remain locked into a hostile stare with the other person in line B. Now ask line A, to purposefully move towards their partner at a steady stride, stopping only inches from the face of their partner getting into the other's personal space.

As it is a training simulation and staff may feel comfortable with their partners, a response may not occur, but most of the time a reaction of some sort will occur. Make participants aware of this response. Reverse the situation with line B being the aggressors.

Discussion
What is your individual self-control plan?
Ask the class what their individual self-control plan is:

- Breathe.
- Inner dialogue.
- Empathy.
- Listen and hear what the patient is saying.
- Respond, don't react.

What does aggression look like?
Ask the class to describe what aggression looks like. Responses may include:

- Pacing.
- Fists clenched.
- Kicking objects.
- Loud voice.
- Staring.
- Tense facial expressions.
- Threatening demeanour.
- Silence.
- Ignoring requests.

Show slide – 5.4 Communication

Trainer led discussion
Communication is often spoken of as a 2-way street. Despite this, when dealing with aggressive persons, a common approach is to focus on what WE should or shouldn't SAY. Often the 'silent' half is forgotten ... LISTENING SKILLS.

We have one mouth and two ears; we should learn to use them in that proportion.

Listening requires us to give the other person our undivided attention. This in itself engenders positive feelings of being heard or understood. Listening is also a great way to learn the 'who, what, when, how and why' essential to problem-solving and negotiation.

Throughout this session, we will focus on communication and de-escalation skills, and should remember that listening is a key component of these skills.

Show slide 5.5 Active listening

Trainer led discussion

'Active listening' means, as its name suggests, actively listening. That is, fully concentrating on what is being said rather than just passively 'hearing' the message of the speaker.

Active listening does not just mean listening and hearing; it involves trying to understand the meaning of the words being used by the person and the context from which they originate.

Show slide 5.6 – Core values and skills

Trainer led discussion

Paterson and Leadbetter (1999) suggest the following core values and skills that staff need to possess when managing aggressive behaviour:

- Consistency in showing respect for the values and dignity of the individual.
- Empathetic, non-judgmental approach.
- Honesty.
- Self-awareness.
- Effective communication skills.

Emphasise respect and politeness. Good social skills are highly effective in preventing and minimising aggression. De-escalation communication skills are really basic common sense:

- Be honest – don't pretend you know what is going on if you do not.
- Tell the truth but do it in a way that is sensitive – be truthful but not brutal.

To enhance relationships:

- Treat the person as an individual.
- Listen to others and make them feel comfortable about their problems.
- Enable others to have input into decisions.
- Spend time to help establish needs (patients and others).
- Provide choices.
- Provide reasons for decisions.
- Assist with needs other than medical treatment.

Link to eLearning modules
Link this session back to customer service content in the eLearning module Awareness to summarise core values and skills.

Show slide 5.7 – What is de-escalation?

Trainer led discussion
A non-coercive approach:

- The person is verbally engaged.
- A collaborative relationship is established.
- The person is verbally de-escalated out of an agitated state.

The act of verbally de-escalating a patient 'is a form of treatment in which the patient is enabled to rapidly develop their own internal locus of control' (Richmond et al. 2012).

Show slide 5.8 – Goals for de-escalation

Trainer led discussion
The goals for de-escalation:

- Understand the person's expectations.
- Communicate back to them that you understand.
- Encourage the other person to think about and re-focus on solving the problem.
- Help negotiate a solution.
- Keep everyone safe.

These objectives are not without challenges. For example, in your high risk workplace environment you may have encountered any of the following situations:

- Patients who are irrational in their thinking.
- Clinic with large patient load.
- Premature use of medications.

Question
Ask the group if they can think of some of other challenges. The class may explore:

- Inconsistency in staff.
- Frequently visiting patients.
- Not following through with plans.
- Not having a management plan.

Show slide 5.9 – De-escalation domains

Trainer led discussion

Display the 10 domains of de-escalation PowerPoint slide and use the following slides and trainer notes to discuss the specific skills of de-escalation. Trainers should demonstrate and give examples of de-escalation skills where appropriate throughout this session. Trainers may also use video resources throughout this session to demonstrate the use of communication and de-escalation skills.

Link to Participant Manual

Refer the participant to (pages 33–44) of their manual to record notes of the discussion. The questions in the Participant Manual may be used to facilitate small group discussion with feedback to the larger group after the activity if preferred.

Show slide 5.10 – De-escalation domain no. 1: Personal space

Activity

Ask participants to describe or show you how we should stand if approached by an aggressive person or, if we need to approach an agitated person?

Or ask for a volunteer and demonstrate how much personal space participants think is appropriate with an agitated/aggressive person:

- Stand slightly side on.
- Shift your weight to your toes.
- Maintain an open stance.
- Remain in safe zone – not the danger zone.
- Stand slightly to the side of the person.
- Ensure you face the person so you can observe them.

Question

How much distance would you put between yourself and an agitated/violent individual?

- Maintain a step and a kick or punch distance greater, depending on the risk.
- Step back if the person asks you.

What are some considerations when respecting personal space?

- Culture.
- Religion.
- Have sufficient space to allow you to move out of the way.
- Increase space if needed to feel safe and know where the exits

are.

- If the patient tells you to move, do so.
- Tell patients and staff where you are going.

Be aware of:

- An individual's sensitivity to belongings.
- Past trauma and experiences.
- Sense of vulnerability for example: being undressed and past sexual abuse.
- Sex of both parties.
- Culture.

Show slide 5.11 – Positive positioning
This slide is to reiterate and consolidate the discussion from the previous slide.

Positive positioning is placing oneself in the optimal position for safety and readiness. This means being aware of the environment e.g. where the exits are, who is in the immediate area, and placing yourself positively in response to this knowledge.

Positive positioning also allows staff to maintain communication with an aggressive individual whilst maintaining a safe distance. It also incorporates how staff position themselves to safely approach an aggressor and when disengaging from an aggressive person.

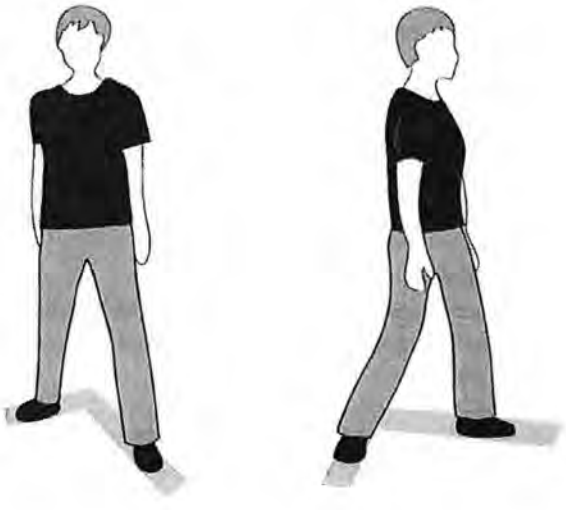
Some of the principles of positive positioning are (demonstrate to group as you discuss):

- Stand half side on.
- Shift your weight to your toes.
- Maintain an open stance.

- Ensure knees are not locked in an upright position i.e. knees very slightly bent.
- Place your hands in front of you in an open position.
- Ensure you face them so you observe them clearly.
- Remain in far safe zone – not the danger zone.
- Be mindful of exits, layout and other people in the immediate area.
- Be mindful of potential weapons in the environment.

Energiser activity
Ask participants to demonstrate 'L Shape Safety Stance':

- Step back with the foot on the side of danger.
- Placing this rear foot at a right angle to the front foot.
- The front foot should remain pointing towards the aggressor.
- Feet form an 'L' stance and should be about shoulder width apart.
- Hands should be kept in front in a useful/protective position.



Show slide 5.12 – Safe and danger zones

Trainer led discussion

Discuss one's 'personal space'. This zone will change depending on a number of factors e.g. culture, gender and psychological distress and you should take care to observe signs which indicate that you may be intruding, such as:

- The person begins to lean back from you or steps backwards.
- The person begins to raise their hands in front of them.
- The person purposefully looks away or to the side.

Question

Ask participants to think about precursors to physical aggression. Ask participants to think about how someone may look before they kick, punch or lunge.

Most people require a shift in weight and a wind up motion of some sort in order to launch a strike or attack.

Activity

Demonstrate a punch. Ask participants to describe what your body looked like prior to the punch:

- Drawing back of elbow behind shoulder.
- Clenching of fist.
- Changing of stance.

Prior to a kick:

- Changing of stance.
- Kick foot back before swinging leg.
- Hands down to counter balance lifting of the leg.

Emphasise that maintaining a safe distance and utilising observation skills are a major protective factor for staff.

Danger zone

- If you are close enough to the aggressive person to be struck, then you are in the danger zone.
- Danger zone is determined by the distance the aggressor requires to make a **step and punch or a kick.**

Safe zone

- A FAR safe zone.
- A NEAR safe zone.

Far safe zone

By keeping a safe distance from the person, you will be in the 'far safe zone'. It is easier for an aggressive person to lunge or move straight ahead than for them to move to the side or backwards, therefore the ideal position to stand is out of the danger zone and slightly to one side of the aggressive person.

We will explain and demonstrate the near safe zone in the evasive techniques.

How should we look?

Discuss body language – particularly the importance of congruency between what we are saying and how we look. Demonstrate an example of incongruence in verbal and non-verbal communication and discuss impacts on an escalating situation or one where risk factors for aggression already exist.

Show slide 5.13 – De-escalation domain no. 2: Do not be provocative

Trainer led discussion

The staff member must:

- Use open body language.
- Demonstrate congruency between verbal and non-verbal communication.
- Ensure others do not provoke.
- Not humiliate or threaten the person.
- Not use non-blaming language.

Question

Ask the participants what is the appropriate body language you should display when dealing with an agitated or violent individual:

- Avoid concealed hands.
- Avoid facing patient directly.

- Stand at an angle.
- Exhibit a calm demeanour and facial expression.
- Do not stare.
- Do not humiliate.
- Use integrity.
- The body language must be congruent with the conversation.
- Do not touch without permission.
- Be respectful at all times.

The clinician must demonstrate by body language that he/she will not harm the patient, that he/she wants to listen, and that he/she wants everyone to be safe. Hands should be visible and not clenched. Knees should be slightly bent. The clinician should avoid directly facing the agitated patient and should stand at an angle to the patient so as not to appear confrontational.

A calm demeanour and facial expression are important. Excessive, direct eye contact, especially staring, can be interpreted as an aggressive act. Closed body language, such as arm folding or turning away, can communicate lack of interest. It is most important that the clinician's body language be congruent with what he/she is saying.

Show slide 5.14 – Engagement skills

Trainer led discussion

DO:

- Show respect, honesty and empathy.
- Be culturally sensitive.
- Be attentive with a calm voice and manner.
- Clarify your role and purpose.

DON'T:

- Take it personally.
- Say 'I understand…'
- Appear too calm.
- Lose focus – interpret their communication cues.

Show slide 5.15 – De-escalation domain no. 3: Establish verbal contact

Trainer led discussion

Staff should consider the following before establishing verbal contact:

- Consider who is leading the process.
- Introduce self, be polite and reassuring.
- Acknowledge feelings e.g. distress, fear, frustration.

- Seeing: 'I see that...', 'You look like...'
- Hearing: 'I hear that...', 'You sound...'
- Doing: 'Are you trying to...?'

The first person to make contact with the patient should be the person designated to de-escalate the patient. If that person is not trained or is otherwise unable to take on this role, another person should be designated immediately.

Multiple people verbally interacting can confuse the patient and result in further escalation. While the designated person is working with the patient, another team member should alert staff to the encounter, while removing innocent bystanders.

Show slide 5.16 – Verbal skills

Trainer led discussion

DO:

- Acknowledge feelings.
- Listen actively – clarify, paraphrase and sum up.
- Speak slowly, clearly and be aware of tone.
- Give clear and accurate responses to questions.

DON'T:

- Agree to anything unrealistic.
- Say 'calm down'.
- Raise your voice or speak over someone.
- Give long explanations.

Show slide 5.17 – Non-verbal skills

Trainer led discussion

DO:

- Maintain intermittent eye contact.
- Give more personal space.
- Hold hands in front and open.
- Adopt an open stance.

DON'T:

- Stare.
- Fold your arms.
- Place hands behind you or in pockets.
- Turn away.
- Copy/mimic aggressive behaviour.

- Smile.

Question
Ask the participants should only one person verbally interact with the patient to de-escalate? Provide rationale.

- Yes, only one person verbally interacts with the patient to reduce confusion and prevent further escalation.

Ask the participants what strategies would you recommend to establish verbal contact when engaging with an agitated individual?

- Introduce yourself.
- Provide orientation and reassurance.
- Be polite.
- Ask the patient what they want to be called.
- Acknowledge the agitation and ask what may reduce it.

Show slide 5.18 – De-escalation domain no. 4: Be concise

Trainer led discussion

- Be prepared to repeat your question or statement

(but not more loudly or slowly, which may seem patronising).

- Keep message simple.
- Agree with person's position whenever possible.

Since agitated patients may be impaired in their ability to process verbal information, use short sentences and a simple vocabulary.

More complex verbalisations can increase confusion and can lead to escalation. Give the patient time to process what has been said to them and to respond before providing additional information. This involves persistently repeating your message to the patient until it is heard.

Question
Ask the participants, what strategies can you put in place when communicating with agitated individuals who have impaired verbal processing?

- Remain objective and non-judgmental.
- Use short sentences and very simple language.
- Be patient and take your time.
- Repeat your message.
- Use language/picture cards.
- Offer to write things down.
- Utilise interpreters, family members and friends.

- Find out individuals' expectations.

Show slide 5.19 – De-escalation domain no. 5: Identify wants and feelings

Trainer led discussion

- What do you want/hope for…?
- Focus on empathy for their position or viewpoint.
- Have the confidence NOT to defend your position or that of the service – just listen to what is being said.

A sad person wants something he has given up hope of having. A patient who is fearful wants to avoid being hurt. The aggressive patient has specific wants also, and identifying these wants is important for the management of the patient.

Ask the participants why it is important to export the agitated individual's wants:

- Enhances empathy and desire to help.
- Uses free information.

Show slide 5.20 – De-escalation domain no. 6: Listen closely

Trainer led discussion

- Clarify information – check for understanding.
- Imagine what the person is saying is 'true' – do not dismiss their perception of the situation.
- Show genuine interest.
- Try to reduce adrenaline-induced 'tunnel vision' by asking about safe topics (re-engage with rational thoughts).

The clinician must convey through verbal acknowledgment, conversation, and body language that he/she is really paying attention to the patient and in what he is saying and feeling. As the listener, you should be able to repeat back to the patient what he has said to his satisfaction.

Such clarifying statements as, "Tell me if I have this right. . .' is a useful technique. This does not mean necessarily that you agree with the patient but, rather, that you understand what he is saying.

Ask the participants to define the term 'active listening' and provide a clinical example of how it de-escalated an agitated individual:

- Really paying attention.
- Clarification, verbal acknowledgment, conversation and body

language.

Example: Repeating back what the patient has stated, 'Tell me if I have this correct'

Show slide 5.21 – De-escalation domain no. 7: Agree or agree to disagree

Trainer led discussion

- Agree with the truth.
- Agree with the principle.
- Agree with the 'odds'.
- Acknowledge the person's experience even when you cannot relate.

There are 3 ways to agree with a patient. The first is agreeing with the truth. If the patient is agitated after 3 attempts to draw his/her blood, one might say, 'Yes, she has stuck you 3 times. Do you mind if I try?'

The second is agreeing in principle. For the agitated patient who is complaining that he/she has been disrespected by the police, you don't have to agree that he/she is correct but you can agree with him/her in principle by saying, 'I believe everyone should be treated respectfully.'

The third is to agree with the odds. If the patient is agitated because of the wait to see the doctor and states that anyone would be upset, an appropriate response would be, 'There probably are other patients who would be upset also.'

Using these techniques, it is usually easy to find a way of agreeing, and one should agree with the patient as much as possible. However, if there is no way to honestly agree with the patient, agree to disagree.

Question
Ask the participants to provide an example of how you have de-escalated an agitated patient by agreeing or partially agreeing with the statement they have made:

- Providing truth.
- Agreeing in principle.
- Agreeing with the odds.

Show slide 5.22 De-escalation domain no. 8: Set clear limits

Trainer led discussion

- Set limits on behaviour positively – remember tone of voice

e.g. 'Please come over here with me'.

- Request desired behaviour with brief rationale

e.g. 'Please stop shouting, I am having trouble understanding'.

It is critical that the patient be clearly informed about acceptable behaviours. Tell the patient that injury to him or others is unacceptable.

Set limits demonstrating your intent and desire to be of help but not to be abused by the patient. If the patient is causing the clinician to feel uncomfortable, this must be acknowledged.

Often telling the patient that his behaviour is frightening or provocative is helpful if it is matched with an empathetic statement that the desire to help can be interrupted or even derailed if the clinician feels angry, fearful, etc.

Question
Ask participants, how can you establish limit setting with an agitated individual?

- Engage first.
- Ensure the individual is aware of acceptable behaviours.
- Do not use threats.
- Be respectful and allow the patient their dignity.
- Acknowledgement to the individual if you feel uncomfortable.
- Use empathetic statements.
- Coach the patient in how to stay in control.

Show slide 5.23 – De-escalation domain no. 9: Offer choices and optimism

Trainer led discussion

- Offer realistic choices.
- Acts of kindness – water, food, magazines.
- Return to what is possible, rather than unrealistic options.
- Agree with person's aim for the problem to be solved.
- Offer medication assistance or review where appropriate.
- Make plans to implement agreed actions straight away.
- Explore what they can do to help that plan.
- Praise any effort to regain control or any self-calming behaviour.

For the patient who has nothing left but to fight or take flight, offering a choice can be a powerful tool. Choice is the only source of empowerment for a patient who believes physical violence is a necessary response.

In order to stop a spiralling aggression from turning into an assault, be assertive and quickly propose alternatives to violence. While offering choices, also offer things that will be perceived as acts of kindness, such as blankets, magazines, and access to a phone.

Be mindful that these choices must be realistic.

Question
Ask the participants to provide some examples of how you have offered choice and empowered individuals when they exhibited an agitated behaviour?

- Offer choice as source of empowerment.
- Be realistic.
- Never deceive.
- Provide hope and optimism.

Show slide 5.24 – De-escalation domain no. 10: Debrief the patient and staff

- This can be one of the most valuable learning opportunities for all involved.
- Clinicians should endeavour to review what happened with the patient themselves.
- Choose the right time, place and frame of mind for all concerned.
- Use non-blaming language to explore what led to the incident and consider alternatives.

After any involuntary intervention with an agitated patient, it is the responsibility of the clinician who ordered these interventions to restore the therapeutic relationship to alleviate the traumatic nature of the coercive intervention and to decrease the risk of additional violence.

Start by explaining why the intervention was necessary. Let the patient explain events from his perspective. Explore alternatives for managing aggression if the patient were to get agitated again. Finally, debrief the patient's family who witnessed the incident.

If restraint or force needs to be used, it is important that the staff be debriefed on the actions after the event. Staff should feel free to suggest both what went well during the episode, and what did not, and recommend improvements for the next episode.

Question
Describe a situation where debriefing has produced a positive outcome for you and the agitated individual:

- The participant may discuss an example of developing a therapeutic relationship.
- Learning through reflection.
- Doing something different next time, alternatives for managing violence in the workplace.
- Discuss what worked well.
- Ask, 'Are you ok?'

The answers above have been developed using the following source:
Richmond JS, Berlin JS, Fishkind AB, et al. (2011).Verbal de-escalation of the agitated patient: consensus statement of the American Association for

Emergency Psychiatry Project BETA De-escalation Workgroup. West J Emerg Med.

Show slide 5.25 De-escalation role plays

Activity

- Show slide with the 10 domains for participants to review and prompt the participants to use the 10 domains of de-escalation during this activity.
- Refer to pages 100-102 for de-escalation role play instructions, de-escalation activity observer sheet and role plays.
- Refer the participants to (pages 45) for de-escalation role play instructions.
- Try to provide context specific scenarios.
- Break the large group into small groups of 3.
- All 3 participants must play a role as the patient, clinician and observer.
- Following the role play all observers will feedback to the other parties.
- Large group discussion should occur at the end of this group activity to summarise and draw on the de-escalation domains.
- If time permits the participants and trainer could engage in discussions around treatment plans and the management of the patient from the scenario.

Tip

The trainer is provided with a variety of scenarios to choose from and can decide on the suitability for the participants. This will depend on time, class size and the participant's workplace and context.

The trainer can use LHD/SN and/or facility role play examples when providing this session. The trainer may add them to the bank of scenarios provided.

A de-escalation activity observer sheet is available with exercise instructions for the observer, patient and staff member in the Participant Manual, page 46.

Trainers should make copies of the role play scenarios they intend to use for this session to provide to participants. Role play scenario sheets can be laminated to be re-used.

Following the role plays, a short discussion should occur with all participants, to encourage everyone to state how they are feeling following this activity. Offer EAP if required.

Attachment
A copy of all resources for this activity is included on pages 100–106 of this manual.

LUNCH BREAK
30 MINUTES

20 MINS **SESSION 6 Introduction to evasive techniques**

Show slide 6.1 – Session 6 Introduction

Trainer led discussion – Evasive techniques

- 'A set of physical skills to help separate or break away from an aggressor in a safe manner that does not involve restraint' (NICE 2005).
- Is NOT a form of martial arts.
- Follow the concept of the use of reasonable force concept.
- Do not use pain.

Disarming weapons
This training does not teach participants to disarm weapons. NSW Health does not expect staff to attempt to disarm a patient of a weapon. Should any participant come across a scenario whereby a weapon is involved, further assistance is to be requested by calling '000'. The staff member should retreat to a safe environment until appropriate assistance arrives.

Show slide 6.2 – Safety principles

Trainer led discussion
Emphasise safety points for the second half of the day:

- Inform trainers of any medical concerns or injuries, psychological concerns or previous experience of trauma for participant (encourage participants to inform trainers either prior to or during the training, or after the workshop).
- Remove items from pockets, jewellery, scarves, and ties.
- Only practice techniques taught.
- Do not use resistance on your training partner. Trainers may use resistance throughout the training where they see a benefit to the learning outcomes.
- Be respectful of your training partner.
- When a trainer calls 'STOP' – participants to stop technique.

- Always stay on the mats during all practice sessions.
- Self-care during training.
- Report any injuries (even if they seem minor) immediately.
- Partake in warm up and warm down activities.

Revise content:

- Safety – 3 'S'.
- Positive positioning.
- Safe and danger zones.

Use this session to revise, clarify and reflect on the learning from the morning session.

Show slide 6.3 – Evasive techniques: Basic principles

Trainer led discussion
Prior to using any evasive technique the following should always be considered. Ask participants to always complete the 4 basic principles prior to using an evasive technique.

Evasive techniques: Basic principles

Principle	Teaching points
Assess level of risk presented.	Awareness of environment and the identified risks – acute vs. aged care. Risk posed by patient. Know where your exits are. What level of threat is present? Patient's body language/verbal threats/force of hold/level of severity of hold. Does the patient have a weapon? What obstacles are between you and the exit? Observe patient's movements; if possible step back before they take a hold of you. Have you got a rapport with the patient?
Side on stance.	Stand half side on. Shift your weight to your toes. Maintain an open stance and balance. Wide base. Knees slightly bent. Offer protection to face with spare hand.
Communication with patient.	Ask them to 'let go'. Initiate communication. Listen to what the patient is saying.
Summon assistance.	Assess level of risk and summon assistance where necessary – activate duress alarm, shout for help.

Show slide 6.4 – Safe disengagement basic principles

Trainer led discussion
Prior to safely disengaging from the patient the following should always be considered. Ask participants to always complete the basic principles prior to safely disengaging.

Safe disengagement – Basic principles

Trainer led discussion: The disengagement process for each of the various techniques will be explained and demonstrated as part of that process.
These are some general points to remember that are common to all disengagements.

Principle	Teaching points
Disengage from the patient in a safe manner.	When disengaging, move away from the patient swiftly. Do not turn your back on the patient. Maintain visual contact with the patient until in a far safe zone.
Maintain communication.	Ensure communication with the patient is maintained throughout. The aim of maintaining communication is to maintain negotiation to ensure the patient is made aware of all options and plan.

Question
Ask participants to consider the evasive techniques and safe disengagement – basic principles and discuss why they are important?

Participant health questionnaire
If participants have not already done so, ask them to complete the participant health questionnaire prior to moving into the practice sessions.

Activity – warm up
Ensure all participants take part to prevent injury and that movements are closely monitored to ensure correct techniques are used by all participants. Trainers should take note of any physical impairment participant's exhibit which may cause injury during the physical training requirements.

Link to manual
The warm up activity instructions are provided on pages 107–108 of this manual.

30 MINS **SESSION 7 Practice session 1**

Show slide 7.1 – Session 7 – Practice session 1

Show slide 7.2 – Practice session 1

Note: Throughout this guide S refers to staff member; and S1, S2, S3 etc. refers to additional staff members; P refers to the person being restrained.

Low level wrist release

Trainer led discussion: Introduce the concepts of assessing threat, communicating, increasing distance from the attacker's free hand (the 'side of danger'), locating and working against the thumb and increasing the distance or exiting after breaking a grip.

This wrist release is low level due to an assessment of the situation coming to the conclusion that the person is of low risk of being aggressive and that the response is low level, in that it uses a minimal approach to the release.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
Identify the weakest part of the link.	It is important to discuss where the weakest part of P's grab is, as this will determine the direction of the movement. Weakest part is between P's fingers and thumb of the hand that has grabbed S.	

Continued over page

Low level wrist release *(continued)*

Chunk technique	Teaching points	Trainer safety note
Same side grab: S grabs P's arm with their free hand in underhand grip. **Diagonal side grab:** S grabs P's arm with their free hand in overhand grip.	Almost like a 'handshake'. This fixes the arm.	
S steps towards the same side of P's grabbing hand. S and P's arms will meet elbow to elbow. S will be facing in the same direction as P.		
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

One-handed wrist release

Trainer led discussion: Discuss the concepts of assessing threat, communicating, increasing distance from the attacker's free hand (the 'side of danger'), locating and working against the thumb and increasing the distance or exiting after breaking a grip.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
Side on stance.	To increase leverage and stabilise S.	Do not lean into P.
Identify the weakest part of the link.	Important to discuss where the weakest part of P's hold is, as this will determine the direction of the movement. Weakest part is between P's fingers and thumb of the hand that has grabbed S.	
S makes a fist with hand that has been grabbed and pulls hand through weakest part of the link. Clenched hand comes towards own ear in a swift movement.	Make a fist to strengthen wrist. Almost like 'answering the phone'.	S to ensure they don't hit self in face or chest.
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Two-handed wrist release – One arm

Trainer led discussion: Discuss the concepts of assessing threat, communicating, increasing distance from the attacker's free hand (the 'side of danger'), locating and working against the thumb and increasing the distance or exiting after breaking a grip.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	Please ensure participants do not hold wrist securely for training purposes due to risk of discomfort to self.
Identify the weakest part of the link.	It is important to discuss where the weakest part of P's grab is, as this will determine the direction of the movement. Weakest part is between P's fingers and thumb of the hand that has grabbed S.	
Side on stance.	To increase leverage and stabilise S.	Do not lean into P – reduces risk of banging heads with P.
S makes a fist with hand that has been grabbed and reaches over with their spare hand and grabs own fist.	Make a fist to strengthen wrist.	Do not lean into P – reduces risk of banging heads with P. S must ensure they make a fist to hold on to with other hand – risk of breaking fingers if not in a fist.
S pulls hand through weakest part of the link. Clenched hand comes towards own ear in a swift movement.	Almost like 'answering the phone'.	S to ensure they don't hit self in face or chest.
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Two-handed wrist release – Two arms

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
Identify the weakest part of the link.	Important to discuss where the weakest part of P's grab is, as this will determine the direction of the movement. Weakest part is between P's fingers and thumb of the hand that has grabbed S.	
If P is pulling S, S needs to go with this movement initially. Once S decides to attempt the evasive technique they must step forward and move into a side on stance.	To increase leverage and stabilise S.	
S claps hands together and maintains this hold. As soon as the hands are clasped S leans in slightly to gain leverage and swiftly pulls their hands through the weakest part of the link up towards the side of S's body.		S to ensure they do not interlock fingers due to discomfort to self. S to ensure they don't hit themselves in face, chest or groin.
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Clothing grab release

Trainer led discussion: Introduce the concepts of fixing P's hand firmly against S's body, 'make it your own' and responding to P in a calm manner when the threat is heightened.
Discuss the need to wear appropriate clothes to work.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
S places hand of their protective arm to secure P's hand against their body. S's forearm is used to protect their face.	Use the term 'Make it your own' – this implies S is taking control of the hold and fixing the hand in place against S's body.	
S's other hand reaches up close to where P has grabbed S's clothing and takes a grab of their own clothing and swiftly pulls the clothing out of P's grasp.	The pulling movement must be swift and forceful.	
S releases the hold on P's hand.		

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

30 MINS **SESSION 8 Practice session 2**

Show slide 8.1 Session 8 – Practice session 2

Show slide 8.2 – Practice session 2

Bites

Trainer led discussion: Introduce the concepts of minimising damage to self and to apply pressure in the direction of the bite rather than trying to pull away.
The release from a bite is one of the few techniques taught that will have an effect of localised discomfort to the patient. The purpose of instilling this discomfort is in no way punitive but simply to cause an alteration in body position and/or distance as a means to affect release. The effect is immediate and long-term pain or injury should not occur as a result of these techniques.
If a patient is known to bite this should be clearly documented in the patient's care planning documentation.

Chunk technique	Teaching points	Trainer safety note
	Ask participants, for the purpose of training, to simulate a bite, by placing their own hand on partner's arm and placing their mouth on their own hand.	
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
S places the palm of their hand on the back of P's hand to fix P's head.	Make it your own – although it is natural instinct, do not pull away as it may cause more damage.	S is attempting to minimise any further damage from this point on.

Continued over page

Bites *(continued)*

Chunk technique	Teaching points	Trainer safety note
S also pushes their body part into the bite; this will open P's jaw (e.g. if P is biting S's arm, S moves arm into the bite rather than pulling back).	By pushing into the bite this helps loosen P's jaw which minimises the risk of further damage. Remind participants to remain in this position until help arrives.	
When assistance arrives S2 approaches P from behind in a 45 degree angle. S2 presses index finger on the submandibular on either side of P's jaw (below ear, under jaw bone).	Ask participants to do this on themselves to feel this sensation and only simulate the action when practising the technique.	This may cause P some discomfort.
Safe disengagement – both S and S2.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Scratches

Trainer led discussion: Reinforce the concepts of minimising damage to self by applying pressure down onto the back of the scratching hand, keeping the scratching hand in position and moving the body part in the direction of the scratch.
If a patient is known to scratch this should be clearly documented in the patient's care planning documentation and ensure nails are kept short.

Chunk technique	Teaching points	Trainer safety note
	Ask participants, for the purpose of training, to simulate a scratch, make a fist against S's body.	
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
S places their palm(s) over the hand of P that is scratching and secures P's hand against their body.	Make it your own – although it is natural instinct, do not pull away as it may cause more damage.	S is attempting to minimise any further damage from this point on.
S must assess the direction in which P is scratching and swiftly moves in the direction of P's fingernails. S continues to hold P's hand.	Lessen the damage by moving in the direction of the scratch and 'unhook' the scratch.	
S releases the hold of P's hand and safely disengages.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Hair grabs – from the front

Trainer led discussion: Emphasise minimisation of hair loss by pushing the patient's hand down onto your head. There will be situations that will require assistance from other staff.
In most circumstances there will be some hair loss, however, the aim is to minimise loss.
If a patient is known to grab hair this should be clearly documented in the patient's care planning documentation.
Discuss where staff have long hair they must consider dressing for the environment and placing their hair in a 'bun' or 'pony tail'.

Chunk technique	Teaching points	Trainer safety note
	Ask participants, for the purpose of training, to simulate a hair grab, place a closed fist on top of the head.	
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	This technique should only be used as a last resort where S has been unable to disengage from P's hold in the forward position.
S places both hands over the top of P's hand, fixing hand by pushing down against S's head.	Make it your own – although it is natural instinct, do not pull away as it may cause more damage. Pushing down widens the grip making it looser. P may loosen the grip at this point and S may safely disengage or disengage with the assistance of a colleague.	S is attempting to minimise any further damage from this point on. S can block their face with their forearms to reduce the risk of being hit with P's free hand.

Continued over page

Hair grabs – from the front *(continued)*

Chunk technique	Teaching points	Trainer safety note
S swiftly walks under P's arm and through to the back of P. S stands and disengages from P's grip.		This part of the technique should only be used as a last resort where S has been unable to disengage from P's hold in the forward position.
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Hair grabs – from behind

Chunk technique	Teaching points	Trainer safety note
	Ask participants, for the purpose of training, to simulate a hair grab, place a closed fist on top of the head.	
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	This technique should only be used as a last resort where S has been unable to disengage from P's hold in the forward position.
S places both hands over the top of P's hand, fixing hand by pushing down against S's head.	Make it your own – although it is natural instinct, do not pull away as it may cause more damage. Pushing down widens the grip making it looser. P may loosen the grip at this point and S may safely disengage or disengage with the assistance of a colleague.	S is attempting to minimise any further damage from this point on.
S uses one of their hands to locate P's thumb.	Locating the side on which the thumb is located will determine which side S exits from i.e. if thumb is located on the left side of S's head, S steps through on the right side of P's body.	This part of the technique should only be used as a last resort where S has been unable to disengage from P's hold in the forward position.

Continued over page

Hair grabs – from behind *(continued)*

Chunk technique	Teaching points	Trainer safety note
S bends at the waist and brings body weight forward. S swiftly walks under P's arm and through to the back of P. S stands and ensures P's arm is straightened and disengages from P's grip.		This part of the technique should only be used as a last resort where S has been unable to disengage from P's hold in the forward position.
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

AFTERNOON TEA
15 MINUTES

30 MINS **SESSION 9 Practice session 3**

Show slide 9.1 – Session 9 – Practice session 3

Show slide 9.2 – Practice session 3

Strangles

Trainer led discussion: If a patient has managed to strangle a staff member, they are attempting to minimise any damage from this point on. Emphasise immediate protection of airway and duress activation. Discuss the importance of positioning yourself in the environment where there is a reduced risk of a patient approaching quickly and undetected.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication – this may not always be possible. Summon assistance.	
P approaches S indicating attempt to strangle: S sweeps their arm in an exaggerated 'windmill' motion making contact with P's arms.	A swift movement is required.	
Safe disengagement.	Revision of the safe disengagement basic principles.	
P is strangling S: S places both hands on P's hands and pulls down in an attempt to get a breath. S sweeps their arm in an exaggerated 'windmill' motion making contact with P's hands whilst moving in the direction of their exit.	Emphasise immediate and ongoing protection of airway and duress activation. A swift movement is required.	S is attempting to minimise any further damage from this point on.
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Headlock from behind

Trainer led discussion: If a patient has managed to place you in a headlock, you are attempting to minimise any damage from this point on. Emphasise immediate protection of airway and duress activation.
Discuss the importance of positioning yourself in the environment where there is a reduced risk of a patient approaching quickly and undetected.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
S places both their hands onto the forearm of P and pulls down in an attempt to get a breath. S can maintain their airway by tucking in their chin.	Emphasise immediate and ongoing protection of airway and duress activation.	S is attempting to minimise any further damage from this point on. Maintaining S's airway is the most important chunk of this technique.
S drops their body weight by bending knees and widening their base.	P may be trying to pull S back, dropping body weight gives S more control.	
S's hand nearest P's wrist remains in place and the other hand finds P's elbow and 'cups' it with S's palm.		
If P is using their second arm to lock the wrist S must 'pop' their shoulder up from under P's hold.	This movement creates more space for S to move out of the hold.	

Continued over page

Headlock from behind *(continued)*

Chunk technique	Teaching points	Trainer safety note
S lifts P's elbow in an upwards movement and maintains the hold around P's wrist. S swiftly walks under P's arm and through to the back of P continuing to lift the shoulder and bringing P's wrist through in the natural movement of the arm. S stands and ensures P's arm is straightened and disengages from P's grip.		
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Headlock from the side

Trainer led discussion: Revision – if a patient has managed to place you in a headlock, you are attempting to minimise any damage from this point on. Emphasise immediate protection of airway and duress activation. Discuss the importance of positioning yourself in the environment where there is a reduced risk of a patient approaching quickly and undetected.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
S places their outside hand onto the forearm of P and pulls down in an attempt to getting a breath.	Emphasise immediate and ongoing protection of airway and duress activation.	S is attempting to minimise any further damage from this point on.
S turns head away from P's elbow and tucks chin into the flank of P.	By tucking in the chin this can maintain S's airway.	Maintaining S's airway is the most important chunk of this technique.
S takes a hold with their inside hand on P's trouser waistband at the hip. S places their other hand, using a 'caring C' to hook round the back of P's knee.	P's hand should be kept resting against the back of P's knee.	
In one swift movement S pulls back with the hand holding P's trouser waistband and pushes with the hand against the back of P's knee.	P will fall to the ground.	You may want to have participants to practice this technique on trainers who are aware of how to land safely.
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Bear hugs from behind – arms free

Trainer led discussion: The release from a bear hug is one of the few techniques taught that will have an effect of localised discomfort. The purpose of instilling this discomfort is in no way punitive but simply to cause an alteration in body position and/or distance as a means to affect release. The effect is immediate and long-term discomfort or injury should not occur as a result of these techniques.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
S places both hands over P's wrists.		
Opening the jar: S places palm on top of P's hand, with thumb on the little finger side of P's hand and fingers gripping across index finger and twisting like 'opening a jar'.	Where the hold is unable to be released S's other hand can be used to assist with leverage.	
Thumb sweep: S places the palm of one hand on top of P's hand. S places their thumb over P's thumb and sweeps P's thumb across their palm.		
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Bear hugs from behind – arms trapped

Trainer led discussion: The release from a bear hug is one of the few techniques taught that will have an effect of localised discomfort. The purpose of instilling this discomfort is in no way punitive but simply to cause an alteration in body position and/or distance as a means to affect release. The effect is immediate and long-term discomfort or injury should not occur as a result of these techniques.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	
S takes a big breath and lifts their shoulders in to expand the chest.		
S exhales and bends at the waist pushing their buttocks in a forceful backwards motion. Simultaneously S throws their arms in a down and outward motion.		Participants who are role playing P must stand to the side with their hip against S's buttocks to ensure when S bends forward they don't get winded.
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants
Practice: Ask participants to work with a partner to practice this technique.

45 MINS **SESSION 10 Practice session 4**

Show slide 10.1 – Session 10 – Practice session 4

Show slide 10.2 – Practice session 4

Near safe zone

Trainer led discussion: This technique is used when staff are unable to maintain the far safe zone and the patient has moved into the danger zone and there is a threat of imminent or actual assault. Remind participants to activate their duress alarm in this situation or yell loudly for assistance.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	Emphasise the need for S to activate their duress alarm or yell loudly for assistance.
Where P attempts to or is punching or kicking S, S takes a big step in towards P ensuring they are in the side on stance and lead with their leg.		
S comes in as close to P as possible maintaining the side on stance. S wraps their arms around P's body attempting to trap P's arms.	If S has been unable to trap arm(s) they must maintain close contact and re-attempt to trap P's arms.	
S must grip own hands at the back of P or hold on to P's trouser waistband.		
S tucks head in against P's body.	S must stay in this position until additional staff arrive.	It is important to discuss that S could potentially sustain injuries to the back of the head and back, but this is preferable to the front of body.

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

Bull bars

Trainer led discussion: This technique is used when staff are unable to maintain the far safe zone and the patient has moved into the danger zone and there is a threat of imminent or actual assault. Remind participants to activate their duress alarm in this situation or yell loudly for assistance.

Chunk technique	Teaching points	Trainer safety note
Evasive techniques basic principles initiated.	Assess level of risk. Side on stance. Communication. Summon assistance.	Emphasise the need for S to activate their duress alarm or yell loudly for assistance.
Where P attempts to or is punching or kicking S, S moves towards the side of P where the punch is coming from.		
S keeps their head low and raises both hands up above head with fists clenched and forearms in front of their face.	When arms brought up, must leave space for S to see where they are going. Arms are used to deflect punches.	
S moves towards P and using their forearms aims to make contact with P's shoulder joint and upper arm to rotate the shoulder joint out of the way.		
S is able to continue moving through and safely exiting from behind P.	Demonstrate to the participants how flexible the shoulder joint is by getting them to use the palm of one hand to gently push against their other arm's shoulder.	

Bull bars *(continued)*

Chunk technique	Teaching points	Trainer safety note
Safe disengagement.	Revision of the safe disengagement basic principles.	

Demonstration: Trainers demonstrate move to participants.
Practice: Ask participants to work with a partner to practice this technique.

15 MINS **SESSION 11 Final practice session and warm down**

The purpose of this session is to allow participants to practice the techniques which have been covered throughout the afternoon.

Show slide 11.1 – Session 11 Final practice session

Activity
Ask participants to stand in a circle on the mat, and trainers will ask one participant at a time to demonstrate a particular evasive technique.

Use a round robin technique to ensure that all participants have the opportunity to engage in practice and that all moves are reviewed again for the group.

Tip
During practical drills and scenario activities, trainers should consider using the activity as an opportunity to take note of appropriate engagement and completion of the activity by all participants for later recording in the Training Completion Record.

Activity
Warm down – ensure all participants take part to prevent injury. Take notice if any participant shows signs of stiffness or soreness following the day's activities and address needs accordingly.

The warm down activity instructions are provided on pages 107–108 of this manual.

10 MINS **SESSION 12 Conclusion**

Show slide 12.1 – Session

Show slide 12.2 – Conclusion

Reflective activity
Conclude the program with a short overview of the performance outcomes and content covered during the day. The emphasis should be on the need to transform the lessons learned into actions as soon as possible.

Encourage participants to express their thoughts on the workshop.

Feedback
Conduct evaluation activities (a simple evaluation activity and evaluation form are provided in the master documents section of this manual pages 114–117).

CLOSE – 16:30

SECTION 4 TRAINER RESOURCES

References
NSW Health Policies, Guidelines and Resources
De-escalation role play instructions
De-escalation activity observer sheet
Role plays
Warm up/warm down activity
Medical history questionnaire
Completion requirements
Short evaluation templates
Notes

References

Bailey, D & Brennan, G 2008, De-escalation Workbook, Berkshire Healthcare NHS Foundation Trust.

Cowen, L, Davies, R, Graham, E, Berlin, T, Fitzgerald, M, & Hoot, S, 2003, De-escalating aggression and violence in the mental health setting, International *Journal of Mental Health Nursing*,12.64–73.

DelBel, J 2003, De-escalating workplace aggression, *Nursing Management*, September 2003; 34, 9.

Holloman, GH, Jr, Zeller, SL 2012, Overview of Project BETA: best practices in evaluation and treatment of agitation, 13(1), 1–2 *Western Journal of Emergency Medicine*.

Johnson, M, Delaney, K 2007, Keeping the Unit Safe: The anatomy of escalation. *Journal of the American Psychiatric Nurses Association*. 12:42.

Nordstrom, K, Zun, LS, Wilson, MP, et al. 2011, Medical evaluation and triage of the agitated patient: consensus statement of the American Association for Emergency Psychiatry Project BETA Medical Evaluation Workgroup, *Western Journal of Emergency Medicine*, 13(1), 3–10.

NSW Mental Health Act 2007.

Paterson, B, Leadbetter, D 1999, De-escalation in the management of aggression and violence: towards evidence-based practice. In Turnbull J, Paterson B eds, *Aggression and violence: approaches to effective management* (pp. 95–123), Basingstoke: Macmillan.

Price, O, Baker, J 2012, Key components of de-escalation techniques: A thematic synthesis. *International Journal of Mental Health Nursing,* 21, pp. 310–319.

Richmond, J et al. 2012, Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workgroup, *Western Journal of Emergency Medicine*, 13(1): pp.17–25.

Scheck, A 2011, Project BETA stresses verbal de-escalation for agitated ED patients, *Emergency Medicine News*, XXXIII (2), 19-20.

The Australian & New Zealand College of Psychiatrists, Position Statement 61: Minimising the use of seclusion and restraint in people with mental illness.

NSW Health Policies, Guidelines and Resources

NSW Health PD2012_035 Aggression, Seclusion & Restraint in Mental Health Facilities in NSW.

NSW Health PD2012_008 Violence Prevention Training Framework for the NSW Public Health System.

NSW Health PD2005_315 Zero Tolerance Response to Violence in the NSW Health Workplace.

NSW Health PD2009_039 Risk Management Enterprise-Wide Policy and Framework.

NSW Health PD2013_005 Work Health and Safety: Better Practice Procedures.

NSW Health PD2014_004 Incident Management Policy.

NSW Health GL2012_005 Aggression, Seclusion & Restraint in Mental Health Facilities – Guideline Focused on Older People.

NSW Health Training Manual: A safer place to work – preventing and managing violent behaviour in the Health workplace (2003).

Hunter New England Local Health District Training Manual: PMVA (2005).

Northern Sydney Local Health District: Violence Prevention and Management Training (module 2).

Western NSW Local Health District Training Manual: Aggression Minimisation in High Risk Environments (2012).