



THE AEGIS SYSTEM™
CRISIS PREVENTION AND DE-ESCALATION

PARTICIPANT HANDOUT



www.theaegissystem.com

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Welcome to Aegis!

Dear Participant,

Let me be the first to welcome you to TheAegis System™. The Aegis team holds frontline professionals in high esteem and appreciates your investment in learning the Aegis approach. We are here to further empower you along your professional journey. You will be embarking on a deep dive into tertiary strategies that are proven to prevent, de-escalate, and best mitigate incidents of crisis.

Our team believes, very strongly, in the value of our model and we are humbled by the gravity of our client engagements. Thousands of professionals, nationally and abroad, lean on Aegis to maintain the safety climate of their workplace. Each member of the Aegis team is painstakingly aware of what is at stake when crisis occurs. Aegis instructors carry this weight with them into every professional endeavor.

Our training program was developed with unrelenting focus on the experience of staff that are called on to perform in high-risk situations. Professionals with considerable experience de-escalating crisis and safely executing physical interventions have made great contributions to the system. Our hope is that this experience base will be evident in what is presented to you.

We place emphasis on practical tools that professionals can pull out of their back pocket in stressful moments. The techniques you will learn are intended to be applied immediately after training and on a daily basis; this puts Aegis into motion before crisis occurs. This proactive approach is how a positive impact is achieved.

At Aegis, we profoundly believe that the work you do is incredibly valuable. We hope that our training program is a contribution to your professional success and well-being.

Thank you for the work you do,

A handwritten signature in black ink, appearing to read 'M Smith', written in a cursive style.

Matt Smith, Aegis Training Director

TABLE OF CONTENTS

INTRODUCTION

i.	System Overview	.....	Pg. 1
ii.	What Will I Be Learning?	.....	Pg. 2
iii.	Aegis De-escalation Model	.....	Pg. 3
iv.	Core Aegis Principles	.....	Pg. 4
v.	Putting Out a Fire . . .	.....	Pg. 5
vi.	Social Survival	.....	Pg. 6
vii.	The Jockey & the Horse	.....	Pg. 7

SECTION 1. STAFF EMPOWERMENT

1.0	Towards Empowerment	.....	Pg. 9
1.1	Stress Inoculation	.....	Pg. 10
1.2	Cognitive Techniques	.....	Pg. 10
1.3	Perspective Taking	.....	Pg. 12
1.4	TRUST Model	.....	Pg. 12

SECTION 2. NONVERBAL COMMUNICATION

2.0	Nonverbal Acuity	.....	Pg. 15
2.1	Body Language Clusters	.....	Pg. 16
2.2	Paraverbal Acuity	.....	Pg. 17
2.3	The De-escalation Cluster	.....	Pg. 18

SECTION 3. VERBAL INTERVENTION

3.0	Rapport & Applied Empathy	.....	Pg. 19
3.1	Step 1 Communication	.....	Pg. 21
3.2	Positive Responses	.....	Pg. 22
3.3	The ABC's of DE-escalation	.....	Pg. 24
3.4	The Crisis 2-Step	.....	Pg. 26

SECTION 4. THE PROTECTIVE USE OF PHYSICAL INTERVENTION

4.0	Introduction	.....	Pg. 32
4.1	The Risk of Restraint	.....	Pg. 38
4.2	Safety Briefing	.....	Pg. 42
4.3	Moving to Physical Intervention	.....	Pg. 48

Appendix I: Aegis References

Introduction

THE AEGIS SYSTEM™

Aegis Introduction Learning Objectives:

1. Apply a 2-step approach to reduce or maintain infrequent incidents of crisis.
2. Assess how Aegis program philosophy aligns with workplace philosophy.
3. Identify core approaches to reducing incidents of crisis, including Applied Empathy.
4. Develop skills in establishing, building, and utilizing rapport.
5. Distinguish the three key components of a crisis situation.

i. SYSTEM OVERVIEW

The Aegis System™ is a nonviolent crisis intervention training program. Aegis solutions are composed of tertiary strategies that prevent, de-escalate, and mitigate the process of crisis escalation. The word *intervention* is used to describe any positive response to escalated behavior. *Crisis* refers to any situation where a person's escalated behavior presents a safety concern. The choice to integrate The Aegis System™ is a strong primary action taken to prevent the occurrence of workplace violence.

The clear focus of The Aegis System™ is on nonphysical de-escalation techniques that prevent the need for physical intervention. Aegis is committed to making a positive impact in this regard. This positive impact is measured by decreased incidents of restraint, increased staff retention, minimized injuries, and better mitigation of crisis incidents.

The Aegis System™ makes this positive impact by encouraging prevention, promoting early intervention, and providing solutions to crisis that are also relevant on a day-to-day basis. The Aegis System™ utilizes evidence-based practices, researched findings, and fills gaps with expert consensus. Each aspect of The Aegis System™ has also been placed through an experiential filter by professionals with considerable experience in crisis intervention.



MISSION STATEMENT

To protect and improve the safety climate of human service organizations.

ii. WHAT WILL I BE LEARNING?

The cornerstones of The Aegis System™ are staff empowerment, applied empathy, and rapport-based crisis de-escalation. Participants will be learning this proven approach, which empowers professionals with verbal and nonverbal intervention strategies to prevent and de-escalate the following:

Verbal aggression

Physical aggression

Self-injurious behavior



TRAINING GOALS

- ✓ **To reduce or further maintain infrequent incidents of crisis**
- ✓ **To improve workplace culture and atmospherics**
- ✓ **To increase staff tenure, performance, and job satisfaction**
- ✓ **To encourage empathy**
- ✓ **To stay ahead of best practices**
- ✓ **To create organization-wide consistency**



AEGIS PHILOSOPHY

Empowerment

Empathy

Rapport

Safety



AEGIS LANGUAGE

In Aegis, de-escalation is nonphysical. De-escalation refers to an intervening professional's best effort to prevent a situation from becoming physical. Aegis views crisis intervention along a continuum. De-escalation (sections 1–3) is relevant up to the point where there is an imminent safety threat. At this point, we are past de-escalation and a person's escalated behavior now warrants a situation-appropriate physical response (*egress* or *control*). The Aegis approach to this, for organizations that maintain certification in this option, is included in section 4, The Protective Use of Physical Intervention.

In the Aegis De-escalation Model, the client, patient, individual, consumer, student, etc., is simply referred to as the person in crisis. This person in crisis could be a youth or an adult under the care, supervision, or custody of an organization that has engaged The Aegis System™. In this context there is precedent that professionals within the organization have a duty to care and/or a duty to perform that is relevant to this training program. Employees are referred to as staff or as professionals throughout the curriculum.



TRAUMA-INFORMED

Due to the high prevalence of trauma in the populations served by organizations that use The Aegis System™, Aegis maintains strong alignment with trauma-informed principles. Although this training program is fully aligned with a trauma-informed approach, throughout this manual, the Aegis Ti icon will appear to identify specific trauma-informed concepts. These components of The Aegis System™ are not intended to stand alone as a comprehensive trauma-informed training but to provide select solutions to maintain a trauma-informed approach during crisis intervention. See the references in the TRUST Model (section 1.4) for a full list of resources.

iii. AEGIS DE-ESCALATION MODEL

The Aegis De-escalation Model is composed of sections 1–3 of The Aegis System™. This portion of Aegis training is entirely nonphysical. Included within the Aegis De-escalation Model are the following learning goals.

INTRODUCTION

Notes

SECTION 2. NONVERBAL ACUITY

Notes

SECTION 1. STAFF EMPOWERMENT

Notes

SECTION 3. VERBAL DE-ESCALATION & RAPPORT

Notes

iv. CORE AEGIS PRINCIPLES



FOCUS ON ACUTE CRISIS





Notes



APPLIED EMPATHY

Notes

Applied Empathy is:

-  Staying out of judgment
-  Taking another person's perspective
-  Recognizing emotion
-  Communicating all of this recognition



NONJUDGMENTAL APPROACH

Notes



STAFF OWNERSHIP

Notes



ENCOURAGING EARLY INTERVENTION

Notes



UTILIZING RAPPORT

Notes

The Crisis 2-Step



Step 1:
Earn Rapport



Step 2:
Use That Rapport



DE-ESCALATION IS EVERYBODY'S JOB

Notes



DE-ESCALATION SHOULD NOT REQUIRE SUBMISSION

Notes

V. PUTTING OUT A FIRE . . .

Notes

Escalated Behavior





ACTIVATING EVENT

Notes



BELIEF

Notes



CONSEQUENTIAL EMOTION (LEADING TO BEHAVIOR)

Notes



It's *not* a trigger or Activating Event that causes a person to escalate. It is a person's Belief (in the moment) about the Activating Event that causes them to escalate.

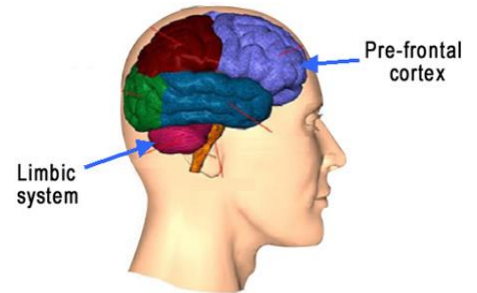
vi. SOCIAL SURVIVAL

Notes



The emotional brain serves as a survival guide that moves people away from danger and towards safety. Safety is most often represented by inclusion with other people.

Notes



TRAUMA SURVIVORS

Notes

vii. THE JOCKEY AND THE HORSE

Notes

IF THE THINKING BRAIN IS “THE JOCKEY,”

THEN THE EMOTIONAL BRAIN IS “THE HORSE.”



Never talk to the Jockey when you're dealing with the Horse.

Section 1

STAFF EMPOWERMENT

Section 1 Learning Objectives:

1. Discover the body's normal stress responses during acute crisis intervention.
2. Apply the Stress Inoculation Recipe to develop a calm and adaptive behavioral response during crisis incidents.
3. Apply positive self-talk strategies to help respond more appropriately during a crisis incident.
4. Implement Box Breathing techniques to calm the body's response to stress.
5. Discover and apply strategies to build empathic listening skills.
6. Apply elements of the TRUST model to build trauma-informed approaches to crisis intervention.

1.0 TOWARDS EMPOWERMENT



In light of the stressors present in crisis, professionals must maintain their critical thinking to achieve de-escalation and to make safety-oriented decisions. Professionals are accountable for their own mental state and to always respond (vs. react) to challenging behavior.

1.1 STRESS INOCULATION

The components of the body's stress response are:

Notes

▪ COGNITIVE

▪ PHYSIOLOGICAL

▪ BEHAVIORAL

BODY SENSATIONS OF THE STRESS
RESPONSE

-
-
-
-
-
-

STRESS INOCULATION RECIPE

$$\begin{array}{c}
 [\text{ }] \\
 + \\
 [\text{ }] \\
 = \\
 [\text{ }]
 \end{array}$$

1.2 COGNITIVE TECHNIQUES

Notes



MAKE THE DECISION TO ACT AHEAD OF TIME

Notes



APPLY POSITIVE SELF-TALK

Notes



ANTICIPATE TRIGGERS

[Reaction] = [_____]

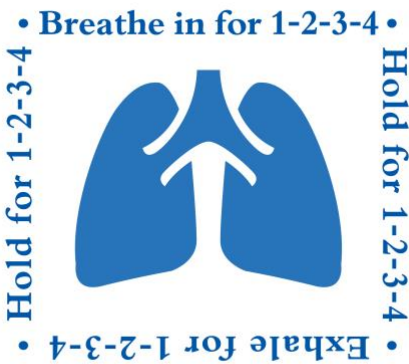
[Response] = [_____]

“Everything can be taken from a man but one thing: the last of the human freedoms—to choose one’s attitude in any given set of circumstances, to choose one’s own way.”

—Viktor E. Frankl








BOX BREATHING



1.3 PERSPECTIVE TAKING

Notes

Applied Empathy is:

-  Staying out of judgment
-   Taking another person's perspective
-  Recognizing emotion
-  Communicating all of this recognition



A fast track to a more empathic perspective is to replace what's "wrong" with someone with what's *happened* to them.

Notes

1.4 TRUST MODEL

The Aegis TRUST model helps to maintain a trauma-informed approach to people in crisis.



T -TRAUMA LENS
R -RESILIENCE
U -UNPREDICTABILITY
S -SAFETY
T -TIME



TRAUMA LENS

Notes



RESILIENCE

Notes



UNPREDICTABILITY

Notes



SAFETY

Notes



TIME

Notes

Section 2

NONVERBAL COMMUNICATION






Section 2 Learning Objectives:

1. Define elements of nonverbal communication and develop understanding of its critical role in crisis intervention.
2. Recognize how refractive affects individuals in crisis situations and how trauma affects behaviors.
3. Identify how to interpret behaviors through body language clusters.
4. Discover how messages are delivered through paraverbal communication.
5. Identify how to use a nonthreatening presentation in crisis.

2.0 NONVERBAL ACUITY

Notes

Applied Empathy is:

-  Staying out of judgment
-  Taking another person's perspective
-   Recognizing emotion
-  Communicating all of this recognition

NONVERBAL COMMUNICATION CONSISTS OF

-
-
-
-
-
-
-



In crisis, 100% of communication can be nonverbal.



MICRO-ESCALATIONS

Notes



UNDERSTANDING REFRACTION

Notes



When presenting to a person in crisis, an intervening professional will communicate one of two things before a word leaves their mouth: “Threat” or “No Threat.”



HYPERVIGILANCE IN TRAUMA SURVIVORS

Notes

2.1 BODY LANGUAGE CLUSTERS



FREEZE CLUSTER

Notes



FLIGHT CLUSTER

Notes



If the option for flight is taken away, the limbic system is more prone to a fight response.



AGGRESSION CLUSTER

Notes



PACIFIERS

Notes



HAND GESTURE PLANES

Grotesque Plane:

Notes

Trust Plane:

Notes

Excitement Plane:

Notes

2.2 PARAVERBAL ACUITY

Paraverbal communication: nonverbal communication that is constantly associated with spoken words. Paraverbal communication consists of *tone, tempo, cadence, rhythm, and volume*. When presenting to an escalated person, it's not what we say but how we say it that determines what the person hears.

Inattention to incongruent paraverbal communication is a common way that professionals unwittingly create barriers to achieving de-escalation. A far-too-common example of this would be telling someone to calm down while yelling at them (usually accompanied by other aggressive body language). The chosen words are to “calm down” while the nonverbal message is “get excited.”

Notes

2.3 THE DE-ESCALATION CLUSTER

Notes

- USE “NO-WEAPONS HANDS”
- AVOID HAND EVASION AND CLOSED FISTS
- AVOID THE POINTED FINGER
- MAINTAIN SAFE DISTANCING
- DON’T TOUCH!!!
- SIDESTEP
- BE CONGRUENT WITH PARAVERBAL COMMUNICATION
- AVOID TERRITORIAL GESTURES
- USE ENCOURAGING CUES
- STAY ON THE SAME LEVEL

Section 3

VERBAL INTERVENTION

Section 3 Learning Objectives:

1. Identify strategies to build rapport using applied empathy techniques.
2. Identify and avoid use of empathy-blocking strategies.
3. Apply reflective listening and other effective communication strategies.
4. Use positive responses to respond appropriately to anger and aggression.
5. Identify the difference between process language and static language.
6. Apply the Crisis 2-Step during intervention.
7. Demonstrate effective use of the **ABC DE**-escalation model in a crisis.

3.0 RAPPORT AND APPLIED EMPATHY

Notes

The Crisis 2-Step

  **Step 1:**
Earn Rapport

  **Step 2:**
Use That Rapport



Achieving de-escalation is all about timing. It is the rapport points earned in Step 1 that allow staff to have more of a verbal process in Step 2.



RAPPORT THROUGH A TRAUMA LENS

Notes



RAPPORT-BUILDING TIPS

Notes



EMPATHY BLOCKERS

-
-
-
-
-
-
-
-



AVOID THE “FIX-IT” URGE

Notes

3.1 STEP 1 COMMUNICATION



REFLECTIVE LISTENING

Notes

The Crisis 2-Step



Step 1:
Earn Rapport



TIPS FOR REFLECTIVE LISTENING

Notes

Applied Empathy is:



Staying out of judgment



Taking another person's perspective



Recognizing emotion



Communicating all of this recognition



ADDITIVE REFLECTION

Notes



OPEN-ENDED QUESTIONS

Notes



AN INSULATED APPROACH

Notes

▪ MISUSE OF THE FIRST-PERSON PERSPECTIVE

▪ DON'T STICK YOUR *BUT* IN AN ANGRY PERSON'S FACE

▪ USE PROGRAMMATIC LANGUAGE

▪ BODY POSITIONING

3.2 POSITIVE RESPONSES



RESPONDING TO VERBAL AGGRESSION

Notes



POWER STRUGGLES

Notes



In crisis, there is no such thing as “right” or “wrong”; there is only “safe” or “unsafe.”



PROCESS LANGUAGE VS. STATIC LANGUAGE

Notes



A fast-track to using and maintaining positive action language is to keep it in the moment.



POSITIVE ACTION LANGUAGE

Notes



PRESUPPOSITIONS

Notes

3.3 THE ABC'S OF DE-ESCALATION



ESCALATING BELIEFS

Notes



Step 2:
Use That Rapport

[Crisis] = [_____ to _____ Thinking]

Notes



Step 1:
Earn Rapport

Through applied empathy, the ABC's are acquired in Step 1 and reflected back to the escalated person.



Step 2:
Use That Rapport

The ABC's and rapport points earned in Step 1 allow DE-escalation to be achieved in Step 2.



SHATTERED BELIEFS

Notes



DISPUTING

Notes

6 ESCALATING BELIEFS RESULTING FROM ABSOLUTE DEMANDS

Notes

1. CONDEMNATION

2. I CAN'T!

3. I'M WORTHLESS

4. AWFULIZING

5. PERMANENCE

6. NO CHOICE



EFFECT

Notes

3.4 THE CRISIS 2-STEP

The Crisis 2-Step encapsulates the entire Aegis approach to achieving de-escalation. When intervening in crisis, Aegis never deviates from this 2-Step process. Each skill in The Aegis System™ fits into Step 1, Step 2, or both.

The Crisis 2-Step



Step 2 will use the rapport achieved in Step 1 to have a verbal process with a person in crisis. The intention is to positively influence an escalated person's Belief in the moment.

The goal is to come into alignment with a person's Horse in Step 1 and to then talk to the Jockey in Step 2.





STEP 1

- Remove the person in crisis from the audience, or the audience from the person, whenever possible.
- Maintain the De-escalation Cluster (nonthreatening nonverbal presentation).
- Lead in with a short and simple introduction that clearly offers support and a commitment to safety.
- Apply empathy to build rapport.
- Listen for hot language and reflect back the ABC elements. It's important for intervening professionals to root out and reflect escalating Beliefs in Step 1 and not yet attempt to repair them.
 - “What are you saying to yourself right now?”
 - “What are your thoughts about this?”
 - “What’s going through your mind right now?”
 - “How are you looking at this?”
 - “What does this say about you?”
- Describe, don’t diagnose:
 - “I hear that ____.”
 - “I can see that ____.”
 - “I can imagine feeling ____.”
 - “It makes sense to me that ____.”
 - Try not to “parrot” or use words like *I know* or *I understand*.
- Maintain an insulated approach and stick to open-ended questions in Step 1.
- Use clear and concise language. Don’t say it in ten words if you can say it in five.
- Don’t be hesitant to repeat yourself. Sometimes people in crisis need to hear something more than once to choose a safer option. When possible, give time to make a more positive choice.
- Apply positive responses as needed.



Step 1 must never be rushed. Often enough, a solid rapport is all that is needed for people to choose compliance and/or co-regulate to the point where they are not causing a safety concern. It is the rapport points earned in Step 1 that will allow for Step 2 to happen.

We never move to Step 2 until some level of rapport has been achieved and the ABC elements have been verbally reflected back to the person in crisis. This in-the-moment assessment is typically based on nonverbal cues. Navigating the decision to move from Step 1 to Step 2 is critical.



Intervening professionals are expected to make a situation-appropriate decision about moving to Step 2 based off a person's level of cognitive function and ability. For people that are nonverbal by choice, by disorder, or because of a chemical interruption, stick to Step 1 and do not go to Step 2.





STEP 2

- Engage DE-escalation by revisiting the escalating Belief, which is turning the volume up on a person's Consequential Emotion (leading to escalated behavior).
- Listen for absolute demands^(ad) in the form of musts, shoulds, and have-to's.
- Remember: [A + B] = [C]
- Disputing involves revisiting and weakening or reframing the escalated Belief.
- The rapport earned in Step 1 allows for an intervening professional to more directly Dispute the escalating Belief.
- Listen for the 6 Escalating Beliefs Resulting from Absolute Demands:
 - Condemnation
 - I Can't!
 - I'm Worthless
 - Awfulizing
 - Permanence
 - No Choice
- The intended Effect is for an escalated person to co-regulate (calm down) with intervening staff.



The Aegis De-escalation Model (sections 1–3) is relevant up to the point that there is an imminent safety threat.

At work, de-escalation is everybody's job, but *never* at the cost of personal safety.

When it is determined that there is an imminent safety threat, there are only two options:

EGRESS OR CONTROL

PLEASE READ TO THE LETTER

As a Certified Trainer in The Aegis System™, you and your participants will be learning and practicing physical intervention techniques. Practicing these techniques includes physical contact and risk of injury.

Participants in any Aegis training must understand that there is risk of injury in training. Participants are to be reminded of the Training Agreement and Training Safety Guidelines (section 4 of the Aegis Trainer Manual and accompanying Teaching Guide). Trainers, as leaders at their place of employment, are expected to model these safety measures at training and to review the Training Agreement and Safety Guidelines *before* practicing any physical skills.

Certification issued to staff by certified Aegis Trainers is per their judgment and assessment of staff participation. Organizations that utilize The Aegis System™ are ultimately responsible for meeting licensure requirements and maintaining compliance with oversight authority in all matters pertaining to staff training and certification.

Aegis Training Solutions, LLC, requires any organization utilizing The Aegis System™ to be in compliance with Aegis Operational Policy, which is subject to change. Aegis Operational Policy appears on the Standard Certification Page of the Aegis Client Portal (<https://www.theaegissystem.com>).

The Aegis System™ makes no warranty or assertion that the physical techniques included within the system comply with all local laws, regulations, and ordinances that may be directly relevant to persons and/or organizations utilizing The Aegis System™. The Aegis System™ should be used only in a way that is in accordance with local laws. It is the responsibility of each participating organization to operate in accordance with local laws. Aegis Training Solutions, LLC, assumes no liability for any bodily injury, loss, or damage caused by the illegal, incorrect, or inappropriate application of the techniques included in The Aegis System™, whether or not such injury, loss, or damage is foreseeable.

Certified Trainers in The Aegis System™ are not employees or agents (implied, apparent, or otherwise) of Aegis Training Solutions, LLC, and have no authority to act for or on behalf of Aegis Training Solutions, LLC.

Section 4

THE PROTECTIVE USE OF PHYSICAL INTERVENTION

Training Goals:

1. To safeguard against the possibility of a sentinel event.
2. To better mitigate incidents of crisis and minimize potential negative outcomes.
3. To stay ahead of best practice.
4. To positively impact all outcomes revolving around crisis.

Learning Objectives:

1. To educate learners on the risk factors of using a physical intervention to inform and support safety-oriented decision-making in crisis.
2. To learn physical safety techniques for egress (Aegis Escapes).
3. To learn physical safety techniques for control (Aegis Holds) as a last resort response to an imminent safety threat.
4. To learn procedures for after-incident mitigation.

4.0 INTRODUCTION

The Aegis philosophy for physical intervention is simple and direct: to *protect* is the only acceptable reason for the use of force. In The Aegis System™, use of force exclusively refers to the benevolent use of restraint and/or specific Aegis techniques for escaping unwanted contact in a professional capacity.



Any physical technique used during an intervention does carry risk. Benevolent restraint is only used when the risk of intervening clearly outweighs the risk of not intervening because of an imminent threat to safety.



The use of benevolent restraint is always a last resort.



CLARIFYING TERMS

In section 4 of The Aegis System™, the client, patient, individual, consumer, student, etc., is simply referred to as the person in crisis. This person in crisis could be a youth or an adult. The context for this is a person under the care, supervision, or custody of a professional organization that has agreed to the Aegis Terms of Use and formally engaged The Aegis System™. Within this context, there is precedent that professionals within the organization have a duty to care and/or a duty to perform that is relevant to this training program. Employees are simply referenced as professionals or staff throughout the curriculum.

US Government Accountability Office Definition of *Restraint* (1999):

“Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the patient’s (person’s) body that he/she cannot easily remove that restricts freedom of movement or normal access to one’s body.”

Aegis uses this definition of *restraint* with the addition of recognizing chemical restraints (psychotropic medications capable of affecting the mind, emotion, and behavior). The Aegis System™ certifies professionals in the use of (manual) physical benevolent restraints and does not include mechanical restraints, chemical restraints, or seclusion in its instruction. Seclusion is often referenced along with mention of restraint but is not included in the Aegis definition of restraint or in Aegis instruction.



EGRESS OR CONTROL

When a crisis event is past de-escalation (due to an imminent safety threat), *egress or control* refers to the two options for physical intervention. Egress is the action of expediently leaving a place. In this context, egress refers to escaping or evading unwanted contact and includes the step of calling for help or support.

Egress may also include a professional or intervention team making their best effort to egress other people in the orbit of an unsafe situation and/or to contain the situation. Control refers to the benevolent use of restraint used as a safety intervention to maximize the safety of an escalated person and/or others around them.



AEGIS USE OF THE WORD *BENEVOLENT*

Aegis certified staff and Trainers are expected not to use the word *restraint* by itself in documentation. The word *benevolent* is to be attached. The word *restraint*, in reality, is far too ambiguous. Each Aegis technique is designed to best mitigate risk of injury and offer clinical *utility* by allowing for the continuation of a therapeutic process (*utility, not value; restraints have no therapeutic value*).

Each technique is designed to best prevent injury when applied correctly. Potential incorrect application of the technique is reasonably anticipated/factored and addressed in training methodology. Avoidance of any bodily harm is the top priority; this defines the use of the word *benevolent*.



LEAST RESTRICTIVE OPTION

The Aegis System™ uses specific benevolent restraints (referred to as holds) that are arranged in tertiary levels to allow for staff to employ the least restrictive option. *Staff are expected to employ the*

least restrictive option at all times. The least restrictive option is the one that ensures a safe outcome without the use of excessive force. Additionally, a physical intervention should not be maintained longer than absolutely necessary to maximize a person's safety.

CWLA. (2002). *Best practice guidelines: Behavior management.* Child Welfare League of America.

CWLA. (2004). *Best practice guidelines: Behavior support and intervention training.* Child Welfare League of America.



SAFETY-ORIENTED DECISION-MAKING



Any physical intervention must never pose a greater risk than a person's escalated behavior.

As a situation escalates, the constant and persistent question must be: *Does the physical intervention pose a greater risk than the escalated behavior?* This question must be unrelentingly considered when making the choice to use benevolent restraint.



Additionally, the threat to safety must be imminent, meaning there is clear evidence that violence is about to happen.

The decision to use benevolent restraint is a safety intervention in response to escalated behavior—nothing less, nothing more. An Aegis Hold is to be used in the same fashion as CPR would be used during an emergency. This safety-oriented decision-making process must be revisited continuously during a physical intervention. Staff must maintain this commitment to safety despite any other factors.



COERCIVE USE OF RESTRAINT IS STRICTLY FORBIDDEN

The use of benevolent restraint is never a punishment. It is, exclusively and to the letter, *action taken only as a safety intervention*. Coercive intervention refers to physical intervention done for discipline, for convenience, or to achieve compliance. The coercive use of restraint is strictly prohibited by The Aegis System™ as well as many other standards and regulations.



Aegis expects each organization that utilizes benevolent restraint to publish a zero-tolerance policy forbidding coercive interventions. This policy should include immediate corrective action and be enforced to the letter.

Aegis Operational Policy is located in the Client Area at <https://www.theaegissystem.com>

In studies, as many as two thirds of an organization's incidents of restraint had no safety threat present; this is archaic and unacceptable. Coercive interventions carry extensive human cost and significant exposure to liability. In 1999, the Children's Health Act (P.L. 106-310) was passed by Congress. Section 3207 of this act provides that patients (*later applied through legislative best practices and accreditation standards to all people*) be free from restraints used for discipline or convenience.

Coercive interventions may also be in violation of the protections offered by Title II of the Americans with Disabilities Act (as determined in *Olmstead v. L.C.*) and CMS regulations, among other legal protections. Additional case references may be found in the appendix of this manual.

Day, D. (2008). Literature on the therapeutic effectiveness of physical restraints with children and youth. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 27–44). Child Welfare League of America.

Kennedy, S. (2008). Using restraint: The legal context of high-risk interventions. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 227–243). Child Welfare League of America.

Masters, K. (2008). Modernizing seclusion and restraint. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 45–66). Child Welfare League of America.

Paterson, B., & Tringham, C. (1999). Legal and ethical issues in the management of aggression and violence. In J. Turnbull & B. Paterson (Eds.), *Aggression and violence: Approaches to effective management* (pp. 52–78). Macmillan.

Steckley, L. & Kendrick, A. (2008). Young people's experiences of physical restraint in residential care: Subtlety and complexity in policy and practice. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 3–24). Child Welfare League of America.



LEVELS OF ACCEPTABILITY

Each Aegis benevolent restraint technique meets the following levels of acceptability:

1. EXPERIENCE BASED

The technique has been proven to be safe and effective in real conditions.

2. INTERVENTION GUIDELINES

The technique meets various state, federal, and private (accrediting body) guidelines.

3. BENEVOLENT INTENT

The technique is designed to best mitigate risk of injury and offer therapeutic *utility* by allowing for the continuation of the therapeutic process (*not value; restraints have no therapeutic value*). The technique is determined to be anatomically safe when applied correctly. Potential incorrect application of the technique is reasonably anticipated and addressed in training methodology. Avoidance of any bodily harm is the top priority; this defines the use of the word *benevolent*.

4. KINESIOLOGY REVIEW

The physical aspects of the technique have been reviewed by a team of medical doctors.



THE USE OF TIME-OUT

Time-out is a potentially ambiguous term with an alarming precedent in schools and in-patient facilities working with at-risk youth. Aegis encourages the use of cooldown-type interventions that utilize a stimulus-reduced space (as a potential alternative to restraint). Aegis discourages professionals from referring to this type of intervention as a time-out.

Aegis forbids any type of intervention, along these lines, that could be mistaken for the unsanctioned use of seclusion. Cooldown-type interventions are not to be utilized in a room or area that has any

physical or mechanical barriers that restrict voluntary movement. A cooldown-type intervention must be 100% supervised by staff.

4.1 THE RISK OF RESTRAINT

Many children and adults have died as a result of being restrained. Physical restraints are a big deal. All forms of restraint carry risk, some more than others. To support safety-oriented decision-making, professionals must demonstrate a baseline understanding of the physical, emotional, and social risks inherent in the use of benevolent restraint.



All professionals certified to use The Aegis System™ must receive training in the risk of restraint and the Aegis Safety Briefing. No Aegis certification is to be issued without a learning check for these components.

The goal of physical intervention is to ensure safety and reduce risk. Research indicates that many staff members may not be fully aware of the life-threatening risk of restraints. Staff may be called on to make high-risk choices under pressure and this must be factored as certified Aegis Trainers look to ensure that safety-oriented decision-making is maintained at all times.



RESTRAINT-ASSOCIATED OR POSITIONAL ASPHYXIA

This factor is paramount. Any technique or position that restricts free movement of the chest and/or diaphragm may restrict breathing and is strictly prohibited in The Aegis System™. If the free action of the diaphragm and/or intercostal muscles is compromised, it may cause hypoxia, disturbed heart rhythm, and death.



Prone and supine (floor) techniques significantly increase this risk factor. For this reason, The Aegis System™ does not use any type of prone or supine floor positioning. Aegis extends the definition of *prone* to any face-down position.

Any technique that may impede the movement of the chest or apply body weight to a person's torso also poses significant risk and is strictly forbidden in The Aegis System™. The Aegis Safety Position™ is used to mitigate this risk.



ADDITIONAL RISK FACTORS OF RESTRAINT

RISK FACTOR	AEGIS MITIGATION
<p>Associated Injury: The use of restraint creates potential risk of injury to the body. It is important to assess the person in crisis for any physical conditions that may contraindicate the use of restraint.</p>	<p>Application of the least restrictive option.</p>
<p>Trauma or Re-traumatization: The use of restraint can introduce or reintroduce trauma to all people involved.</p>	<p>Focus on techniques that offer dignity and an approach that minimizes the duration of incidents.</p>
<p>Restraint Dependency: Restraint may be experienced as positive reinforcement by some or forced as a maladaptive coping mechanism. This may lead to repeat cycles and abnormal frequency of restraint.</p>	<p>Individualize treatment and encourage self-regulating strategies.</p>
<p>Staff Turnover: Increased incidents of restraint are known to contribute to staff turnover.</p>	<p>Empower staff through training and take a supportive approach to incident debrief.</p>
<p>Staff Normalization of Restraint: Normalization is when something previously considered abnormal or unacceptable becomes treated as acceptable or normal. If frequent patterns of restraint become accepted or normal, then staff are not making their best effort to prevent them. Normalization has served as a significant contributor to workplace violence.</p>	<p>Addressing a zero-tolerance approach to normalization during training is the mitigating factor. Reinforcing the organization's stance with clear and direct policy is also needed. This messaging should come from the top down. In Aegis, restraints are always viewed as an anomaly (deviation from a baseline of cooperation and safety).</p>



SOURCES OF INJURY IN RESTRAINT

- Involvement of inadequate or excessive staff numbers in ratio to the escalated person.
- Complications from floor, most often head injuries.
- Staff engaging with hesitancy or “freezing up.”
- Staff coming in “too hot” and becoming counter-aggressive.
- Use of techniques learned elsewhere or applying unsanctioned techniques.
- Staff fatigue during longer physical interventions (techniques must minimize physical exertion).



PEOPLE HELD IN RESTRAINT REPORT

- Feeling intense sadness, frustration, anger, and embarrassment.
- The loss of dignity.
- Having hateful feelings and self-talk (towards staff and self).
- General notion of losing control (of behavior/emotions).
- Seeing or using restraint as a release or a way to vent anger.
- Having cathartic motivation for forcing staff to use a restraint.
- Feeling safe, feeling cared for, and using restraint to regulate emotion, “just needing a hug.”
- That it is harder to cope or calm down if the person felt like restraint was used too early or unfairly.
- People witnessing others restrained report having a very intense emotional reaction and feeling aligned against staff.
- People witnessing others restrained also report feeling aligned *with* staff, clearly seeing the need, feeling thankful towards staff, and having increased empathy as a result.

Allen, D. (2008). Risk and prone restraint. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 87–106). Child Welfare League of America.

CWLA. *Best practice guidelines: Behavior management*. (2002). Child Welfare League of America.

CWLA. *Best practice guidelines: Behavior support and intervention training*. (2004). Child Welfare League of America.

Holden, M. & Curry, D. (2008). Learning from research. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 107–123). Child Welfare League of America.

Masters, K. (2008). Modernizing seclusion and restraint. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 45–66). Child Welfare League of America.

Mohr, W. (2008). Physical restraints: Are they ever safe and how safe is safe enough? In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 69–86). Child Welfare League of America.

Nunno, M. A., Holden, M. J., & Tolar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child and Youth Services Review*, 25(4), 295–315.

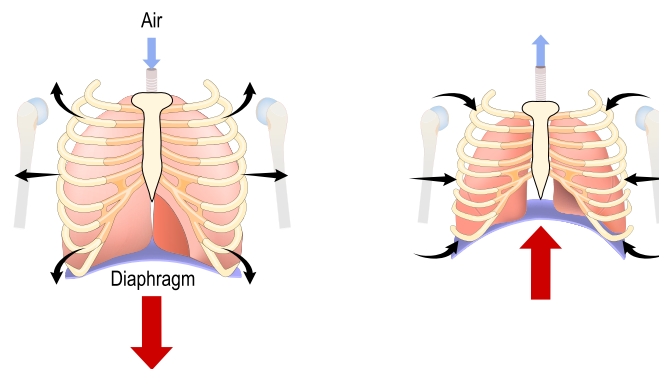
Paterson, B., & Leadbetter, D. (1999). De-escalation in the management of aggression and violence: towards evidence-based practice. In J. Turnbull & B. Paterson (Eds.), *Aggression and violence: Approaches to effective management* (pp. 95–123). Macmillan.

Paterson, B., & Leadbetter, D. (1999). Managing physical violence. In J. Turnbull & B. Paterson (Eds.), *Aggression and violence: Approaches to effective management* (pp. 124–147). Macmillan.

4.2 SAFETY BRIEFING

The most common cause of death during a restraint is asphyxia. For this reason, it's important to have an understanding of how breathing works to support safety-oriented decision-making. During the basic action of breathing, air is inhaled into the lungs, the diaphragm (muscle in chest cavity) contracts, and the rib cage is pulled upward and outward. This movement creates negative pressure, so that air can enter the lungs. When the diaphragm relaxes, the rib cage shrinks, the lungs contract, and air is exhaled.

BREATHING



Asphyxia occurs when there is a lack of oxygen to living cells. This is caused by anything that prevents adequate breathing. Causes include cardiac arrest, aspiration, airway obstruction, and abnormal positioning of the body that limits movement of the chest. In the prone position, a person's own weight puts pressure on their abdomen. This face-down position makes it harder for the diaphragm to contract and can affect a person's bellows action, which is needed to sufficiently breathe.

THE AEGIS SYSTEM™ DOES NOT USE ANY TYPE OF PRONE OR SUPINE POSITIONING

Aegis extends the definition of prone to any face-down position.



Commonly taught prone restraint techniques often result in weight being applied to a person's back by intervening professionals. This will compound the negative effects of being held in the prone position and makes it even harder for a person to breathe. If a person's head is in an awkward position, or their neck is bent, it can restrict the airway, making it even harder for a person to take in oxygen. Regardless of any other factor:

NEVER, FOR ANY REASON, IS ANY BODY WEIGHT APPLIED TO A PERSON'S TORSO.

In addition to medical review, twenty years of research into physical restraint deaths in a wide range of settings has shown that prone restraint is, by far, the most dangerous restraint position. In coroners' reports and incident reports regarding restraint deaths from the last twenty years, three words continually showed up as a person's final words:

“I CAN’T BREATHE.”

This is an evidence-based statement. NOT a political one.

In many cases, staff reported thinking that the fact that the person had enough air to say, “I can’t breathe,” meant that they were lying, and the restraint continued.

When breathing becomes labored, oxygen deficiency may occur, causing air hunger. The natural reaction is to struggle to get air. The struggle intensifies as the person held in restraint tries to breathe, and intervening staff may respond by increasing pressure to contain the child or adult. As a result, a vicious and deadly cycle leading to asphyxia can occur.

What was also evident in the vast majority of cases was that the staff performing the restraint did not have any malicious intent. In most cases staff did not come into work that day intent on ending another person’s life. Many incidents were in a caring setting, and staff were doing what they were trained to do: to help a person in crisis. In each case, there were, of course, details one could pick out regarding verbal skills that might have changed the outcome, but the recurring factor was the prone position.

Prone is not the only position that carries risk. In the supine position, there is increased risk of aspiration. This position puts weight from the heart onto the lungs. The seated position can be higher risk with small children, since their intercostal muscles are not fully developed, and the position itself can interfere with the ability of the diaphragm to move properly, especially if body weight is applied to a person’s back.



Always monitor a child or adult in restraint and terminate the restraint if there any indications of injury, difficulty breathing, or medical complication (see *The Eagle*, section 4.9).



Never ignore any of the warning signs of pending asphyxia, regardless of whether or not it is suspected manipulation.



Professionals must never fail to take immediate action to provide emergency medical treatment. Intervening staff, and those in the orbit of a crisis event, must respond to warning signs with their highest level of first aid training and call for medical help immediately.



WARNING SIGNS INCLUDE

- Statement of not being able to breathe.
- Breathing is labored, there is evidence of shortness of breath, coughing, wheezing, or bobbing of the head.
- Grunting noises or a struggle to use intercostal muscles to breathe.
- Gagging or vomiting.
- Decreasing level of response or consciousness.
- Change in skin tone and color, such as rash-like appearance of tiny red spots (petechiae).



FACTORS THAT INCREASE THE RISK OF RESTRAINT

- Size discrepancy—if intervening professional(s) are larger than the person held in restraint, this may cause added complications no matter how carefully they try to keep weight off the child or adult in crisis.
- High body mass index—people with a higher body mass index may put additional pressure on their own breathing apparatus in certain positions.
- Psychotropic medication side effects and/or other complications from prescribed medication.

- Underlying disease or medical condition—children and adults often come into treatment settings unknown medical risk factors that may put them at greater risk when held in restraint. Risk factors need to be identified and communicated as soon as possible.
- Substance abuse/intoxication.
- Asthma.
- Trauma history.
- Particular diagnosis such as (but not limited to) individuals with intellectual and/or developmental delays, who are more likely to have secondary health issues that may increase risk.
- Preexisting injuries.

Barnett, R., Hanson, P., Stirling, C., & Pandyan, A. D. (2013). The physiological impact of upper limb position in prone restraint. *Medicine, Science and the Law*, 53(1). <https://doi.org/10.1258/msl.2012.012044>

Barnett, R., Stirling, C., Hall, J., Davies, A., & Orme, P. (2016). Perceptions of supported and unsupported prone-restraint positions. *Journal of Psychiatric and Mental Health Nursing*, 23(3–4), 172–178. <https://doi.org/10.1111/jpm.12295>

Barnett, R., Stirling, C., & Pandyan, A. D. (2012). A review of the scientific literature related to the adverse impact of physical restraint: Gaining a clearer understanding of the physiological factors involved in cases of restraint-related death. *Medicine, Science and the Law*, 52(3), 137–142. <https://doi.org/10.1258/msl.2011.011101>

Davidson, J., McCullough, D., Steckley, L., & Warren, T. (2005). Holding safely: Guidance for residential child care practitioners and managers about physically restraining children and young people. Scottish Institute for Residential Child Care.

Independent Advisory Panel on Deaths in Custody. (2012). *IAP E-Bulletin*. March, Issue 7.

Miller, C. (2004). *Restraint asphyxia—Silent killer*. charlydmiller.com/RA/restrasphyx02.html

Mohr, W. K., Petti, T. A., Mohr, B. D. (2003) Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry* 48(5), 330–337. <https://doi.org/10.1177/070674370304800509>. PMID: 12866339

Morrison, L., Duryea, P. B., Moore, C., & Nathanson-Shinn, A. (2002). *The lethal hazard of prone restraint: Positional asphyxiation*. Protection and Advocacy, Inc. (now Disability Rights California). <https://www.disabilityrightsca.org/system/files?file=file-attachments/701801.pdf>

National Institute for Health and Care Excellence. (2015). *Violence and aggression: Short-term management in mental health, health and community settings*. <https://www.nice.org.uk/guidance/ng10>

Nunno, M. A., Holden, M. J., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child and Youth Services Review*, 25(4), 295–315.

O'Halloran, R. L., & Frank, J. G. (2000). Asphyxial death during prone restraint revisited: A report of 21 cases. *American Journal of Forensic Medicine and Pathology*, 21(1), 39–52.

Parkes, J. (2000). Sudden death during restraint: A study to measure the effect of restraint positions on the rate of recovery from exercise. *Medicine, Science and the Law*, 40(1), 39–44.

Reay, D., Howard, J., Fligner, C., Ward, R. (1998). Effects of positional restraint on oxygen saturation and heart rate following exercise. *American Journal of Forensic Medicine and Pathology*, 9(1), 16–18.

United States General Accounting Office. (1999). *Mental Health: Improper restraint or seclusion places people at risk*. <https://www.gao.gov/products/hehs-99-176>

4.3 MOVING TO PHYSICAL INTERVENTION

Physical intervention is used only when at least one of the following five safety concerns is **imminent**:

1. IMMINENT SAFETY THREAT TO SELF

2. IMMINENT SAFETY THREAT TO OTHERS

3. ABSCONDING OR ELOPEMENT

Per program or organization licensure.

4. IMMINENT THREAT TO VALUABLE PROPERTY

Valuable property never refers to a dollar amount. Valuable property must be safety equipment and clearly defined by program policy and procedure that is accepted by oversight authority or licensing agent.

5. REFUSAL OF NECESSARY TRANSPORT

Necessary transport must be clearly defined by program policy and procedure and accepted by oversight authority or licensing agent.

The Aegis System™ makes no warranty or assertion that the physical techniques included within the system comply with all local laws, regulations, and ordinances that may be directly relevant to person(s) and/or organizations utilizing The Aegis System™. The Aegis System™ should be used only in a way that is in accordance with local laws. It is the responsibility of each participating organization to operate in accordance with local laws.



BEFORE USING AN AEGIS HOLD

ASK YOURSELF

What is the imminent safety threat?

Can I or we safely control this person?

SELF-CHECK

Your own level of escalation and nonverbal presentation.

Apply Box Breathing.

THE AEGIS SYSTEM™ REFERENCES

- Allen, D. (2001). *Training careers in physical interventions: Research towards evidence-based practice*. British Institute of Learning Disabilities.
- Allen, D. (Ed.) (2002). *Ethical approaches to physical interventions*. British Institute of Learning Disabilities.
- Allen, D. (2008). Risk and prone restraint: Reviewing the evidence. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 87–106). Child Welfare League of America.
- American Organization of Nurse Executives. (2014). *AONE Guiding Principles: Mitigating violence in the workplace*. <https://www.aonl.org/sites/default/files/aone/mitigating-workplace-violence.pdf>
- American Psychological Association. (2020, February 1). *Building your resilience*. <https://www.apa.org/topics/resilience>.
- Annie E Casey Foundation. (n.d.) *ARC Reflections Training Program*. <https://www.aecf.org/work/child-welfare/child-welfare-strategy-group/arc-reflections-training-program>
- Ardrey, R. (1966). *The Territorial Imperative*. Atheneum.
- Bailey, K. A., Mrock, G., & Davis, F. (n.d.). *Changing the culture of care: From restraints to relationship*. Holson United Methodist Home for Children.
- Bandler, R., Roberti, A., & Fitzpatrick, O. (2013). *The ultimate introduction to NLP: How to build a successful life*. Harper Collins.
- Barnett, R., Hanson, P., Stirling, C., & Pandyan, A. D. (2013). The physiological impact of upper limb position in prone restraint. *Medicine, Science and the Law*, 53(1). <https://doi.org/10.1258/msl.2012.012044>
- Barnett, R., Stirling, C., Hall, J., Davies, A., & Orme, P. (2016). Perceptions of supported and unsupported prone-restraint positions. *Journal of Psychiatric and Mental Health Nursing*, 23(3–4), 172–178. <https://doi.org/10.1111/jpm.12295>
- Barnett, R., Stirling, C., & Pandyan, A. D. (2012). A review of the scientific literature related to the adverse impact of physical restraint: Gaining a clearer understanding of the physiological factors involved in cases of restraint-related death. *Medicine, Science and the Law*, 52(3), 137–142. <http://doi.org/10.1258/msl.2011.011101>
- Barwick, M. A., Boydell, K. M., Stasiulis, E., Ferguson, H. B., Blase, K., & Fixsen, D. (2005). *Knowledge transfer and implementation of evidence-based practices in children's mental health*. Children's Mental Health Ontario.
- Bath, H. (1994). The physical restraint of children: Is it therapeutic? *American Journal of Orthopsychiatry*, 64(1), 40–49.
- Birdwhistell, R. (1970). *Kinesics and context: Essays on body motion communication*. University of Pennsylvania Press.
- Bower, F. L., McCullough, S. C., & Timmons, M. E. (2003). A synthesis of what we know about the use of physical restraints and seclusion with patients in psychiatric and acute care settings: 2003 Update. *Online Journal of Knowledge Synthesis for Nursing*, E10(1), 1–29. <https://doi.org/10.1111/j.1524-475X.2003.00001.x>
- Brooks, M. (1989). *Instant rapport*. Warner Books.
- Blaustein, M., & Kinniburgh, K. (2018). *Treating traumatic stress in children and adolescents: How to foster resilience through attachment, self-regulation, and competency* (2nd ed.). Guilford Publications.
- Blume, T. W. (2006). *Becoming a family counselor: A bridge to family therapy theory and practice*. J. Wiley.
- Brom, D., Pat-Horenczyk, R., & Ford, J. D. (Eds.). (2009). *Treating traumatized children: Risk, resilience and recovery*. Routledge.
- Bowden, M. (2010). *Winning body language*. McGraw Hill Professional.
- Bowie, V. (1996). *Coping with violence: A guide for the human services* (2nd ed.). Whiting and Birch.

THE AEGIS SYSTEM™ REFERENCES

- Brendtro, L. K. (2004, January). *From coercive to strength-based intervention: Responding to the needs of children in pain* [Conference presentation]. Children & Youth: Their Needs, Our Commitment, Alliance for Children and Families, Naples Beach, FL.
- Burgoon, J. K., Buller, D. B., & Woodall, W. G. (1996). *Nonverbal communication: The unspoken dialogue* (2nd ed.). McGraw-Hill.
- Carmel, H., & Hunter, M. (1990). Compliance with training in managing assaultive behavior and injuries from inpatient violence. *Hospital and Community Psychiatry, 41*(5), 558–560. <https://doi.org/10.1176/ps.41.5.558>
- Carter, J., Jones, J., & Stevens, K. (2008). Beyond a crisis management program: How we reduced our restraints by half in one year. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 183–200). Child Welfare League of America.
- Caudill, W., & Stainbrook, E. (1954). Some covert effects of communication difficulties in a psychiatric hospital. *Psychiatry, 17*(1), 27–40. <https://doi.org/10.1080/00332747.1954.11022950>
- Chan, T. C., Neuman, T., Clausen, J., Eisele, J., & Vilke, G. M. (2004). Weight force during prone restraint and respiratory function. *American Journal of Forensic Medicine Pathology, 25*(3), 185–189. <https://doi.org/10.1097/01.paf.0000136639.69128.bc>
- Chan, T. C., Vilke, G. M., Neuman, T., & Clausen, J. L. (1997). Restraint position and positional asphyxia. *Annals of Emergency Medicine, 30*(5), 578–586. [https://doi.org/10.1016/s0196-0644\(97\)70072-6](https://doi.org/10.1016/s0196-0644(97)70072-6)
- Chan, T. C., Vilke, G. M., & Neuman, T. (1998). Reexamination of custody restraint position and positional asphyxia. *American Journal of Forensic Medicine Pathology, 19*(3), 201–205. <https://doi.org/10.1097/00000433-199809000-00001>
- Cicchetti, D. (2013). Annual Research Review: Resilient functioning in maltreated children—past, present, and future perspectives. *Journal of Child Psychology and Psychiatry, 54*(4), 402–422. <https://doi.org/10.1111/j.1469-7610.2012.02608.x>
- Clark, L. (2002). *SOS help for emotions: Managing anxiety, anger and depression* (2nd ed.). SOS Programs and Parents Press.
- Colton, D. (2008). Leadership's and program's role in organizational and cultural change to reduce seclusions and restraints. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 143–166). Child Welfare League of America.
- Confer, C. (1987). *Managing anger: Yours and mine*. Jacob R. Sprouse, Jr., American Foster Care Resources.
- Cormier, S., Nurius, P. S., & Osborn, C. J. (2013). *Interviewing and change strategies for helpers* (7th ed.). Brooks/Cole Cengage Learning.
- Corrigan, P. W., & McCracken, S. G. (1995). Contingencies for dangerous behavior. *American Journal of Psychiatry, 152*(11), 1696–1697. <https://doi.org/10.1176/ajp.152.11.1696b>
- Crenshaw, W. B., & Francis, P. S. (1995). A national survey on seclusion and restraint in state psychiatric hospitals. *Psychiatric Services, 46*(10), 1026–1031. <https://doi.org/10.1176/ps.46.10.1026>
- Curry, D. H., Kaplan, P., & Knuppel, J. (1994). Transfer of training and adult learning (TOTAL). *Journal of Continuing Social Work, 6*(1), 8–14.
- CWLA. (2002). *Best practice guidelines: Behavior management*. Child Welfare League of America.
- CWLA. (2004) *Best practice guidelines: Behavior support and intervention training*. Child Welfare League of America.
- Daffern, M., & Howells, K. (2002). Psychiatric inpatient aggression: A review of structural and functional assessment approaches. *Aggression and Violent Behavior, 7*(5), 477–497. [https://doi.org/10.1016/S1359-1789\(01\)00073-8](https://doi.org/10.1016/S1359-1789(01)00073-8)
- Daly, D. L., & Dowd, T. P. (1992). Characteristics of effective, harm-free environments for children in out-of-home care. *Child Welfare, 71*(6), 487–496.
- Darwin, C. (1872). *The expression of the emotions in man and animals*. Murray.
- Dattilio, F., & Freeman, A. (Eds.). (2000). *Cognitive-behavioral strategies in crisis intervention* (2nd ed.). Guilford Publications.

THE AEGIS SYSTEM™ REFERENCES

Davidson, J., McCullough, D., Steckley, L., & Warren, T. (2005). Holding safely: Guidance for residential child care practitioners and managers about physically restraining children and young people. Scottish Institute for Residential Child Care.

Day, D. M. (2002). Examining the therapeutic utility of restraints and seclusion with children and youth: The role of theory and research in practice. *American Journal of Orthopsychiatry*, 72(2), 266–278. <https://doi.apa.org/doi/10.1037/0002-9432.72.2.266>

Day, D. M. (2008). Literature on the therapeutic effectiveness of physical restraints with children and youth. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 27–44). Child Welfare League of America.

Day, D. M., Bullard, L. B., & Nunno, M. A. (2008). Moving Forward. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 257–264). Child Welfare League of America.

DeBecker, G. (1997). *The gift of fear*. Bloomsbury.

National Law Enforcement Technology Center. (1995). *Positional asphyxia—sudden death*. <https://www.ojp.gov/pdffiles/posasph.pdf>

DiFabio, S., & Ackerhalt, E. J. (1978). Teaching the use of restraint through role play. *Perspectives in Psychiatric Care*, 16(5–6), 218–222. <https://psycnet.apa.org/doi/10.1111/j.1744-6163.1978.tb00944.x>

Dinkmeyer, D. C., & McKay, G. D. (1990). *Parenting teenagers: Systematic training for effective parenting of teens* (2nd ed.). American Guidance Service.

Dix, R., & Page, M. J. (2008). De-escalation. In M. D. Beer, S. M. Pereira, & C. Paton, (Eds.), *Psychiatric intensive care* (2nd ed.). Cambridge University Press.

Donat, D. C. (1998). Impact of a mandatory behavioral consultation on seclusion/restraint utilization in a psychiatric hospital. *Journal of Behavior Therapy and Experimental Psychiatry*, 29(1), 13–19. [https://doi.org/10.1016/S0005-7916\(97\)00039-6](https://doi.org/10.1016/S0005-7916(97)00039-6)

Drisko, J. W. (1981). Therapeutic use of physical restraint. *Child Care Quarterly*, 10(4), 318–328. <https://doi.org/10.1007/BF01160687>

Driscoll, M. P. (2000). *Psychology of learning for instruction* (2nd ed.). Allyn and Bacon.

Dryden, W. (2012). *Dealing with emotional problems using rational-emotive cognitive behaviour therapy: A practitioner's guide*. Routledge.

Duewel, C. (2015). *Compassionate Care in the Emergency Room*. National Alliance on Mental Illness. <https://www.nami.org/Blogs/NAMI-Blog/June-2015/Compassionate-Care-in-the-Emergency-Room#>.

Ekman, P. (1992). An argument for basic emotions. *Cognition and Emotion*, 6(3–4), 169–200. <https://doi.org/10.1080/02699939208411068>

Ekman, P. (2007). *Emotions revealed: Recognizing faces and feelings to improve communication and emotional life* (2nd ed.). Owl Books.

Ekman, P. (Ed.) (2013). *Emotion in the human face* (2nd ed.). Malor Books.

Ekman, P., & Friesen, W. V. (2003). *Unmasking the face*. Malor Books.

Emergency Nurses Association, Institute for Emergency Nursing Research. (2011). *Emergency Department Violence Surveillance Study*. http://www.ncdsv.org/images/ENA_EmergencyDeptViolenceSurveillanceStudy_November2011.pdf

Emergency Nurses Association. (2010). *Workplace Violence Toolkit*. <https://www.ena.org/practice-research/Practice/ToolKits/Pages/Toolkit.aspx>.

Engel, F., & Marsh, S. (1986). Helping the employee victim of violence in hospitals. *Hospital and Community Psychiatry*, 37(2), 159–162. <https://doi.org/10.1176/ps.37.2.159>

Evans, O. N., Faulkner, L. R., Hodo, G. L., Mahrer, D. L., & Bevilacqua, J. J. (1992). A quality improvement process for state mental health systems. *Hospital & Community Psychiatry*, 43(5), 465–469. <https://doi.org/10.1176/ps.43.5.465>

THE AEGIS SYSTEM™ REFERENCES

- Farragher, B. (2002). A system-wide approach to reducing incidents of therapeutic restraint. *Residential Treatment for Children & Youth, 20*(1), 1–14. https://doi.org/10.1300/J007v20n01_01
- Farragher, B., & Yanosy, S. (2005). Creating a trauma-sensitive culture in residential treatment. *Therapeutic Communities, 26*(1), 97–113.
- Felce, D., Lowe, K., & Blackman, D. (1995). Resident behaviour and staff interaction with people with intellectual disabilities and seriously challenging behaviour in residential services. *Mental Handicap Research, 8*(4), 272–295. <https://doi.org/10.1111/j.1468-3148.1995.tb00162.x>
- Fisher, R., & Brown, S. (1988). *Getting together*. Houghton Mifflin.
- Fisher, R., & Ury, W. (1981). *Getting to yes: Negotiating agreement without giving in*. Houghton Mifflin.
- Fisher, W. A. (1994). Restraint and seclusion: A review of the literature. *American Journal of Psychiatry, 151*(11), 1584–1591. <https://doi.org/10.1176/ajp.151.11.1584>
- Frankl, V. E. (2006). *Man's search for meaning*. Beacon Press.
- Friman, P. C., Jones, M., Smith, G. L., Daly, D. L., & Larzelere, R. E. (1997). Decreasing disruptive behavior by adolescent boys in residential care by increasing their positive to negative interaction ratios. *Behavior Modification, 21*(4), 470–486. <https://doi.org/10.1177/01454455970214005>
- Gagné, R. M., Briggs, L. J., Wager, W. W. (1992). *Principles of instructional design* (4th ed.). Wadsworth/Thomson Learning.
- Garrison, W. T. (1984a). Aggressive behavior, seclusion and physical restraint in an inpatient child population. *Journal of the American Academy of Child Psychiatry, 23*(4), 448–452. [https://doi.org/10.1016/S0002-7138\(09\)60323-X](https://doi.org/10.1016/S0002-7138(09)60323-X)
- Garrison, W. T. (1984b). Inpatient psychiatric treatment of the difficult child: Common practices and their ethical implications. *Children and Youth Services Review, 6*(4), 353–365. [https://doi.org/10.1016/0190-7409\(84\)90054-9](https://doi.org/10.1016/0190-7409(84)90054-9)
- Gertz, B. (1980) Training for prevention of assaultive behavior in a psychiatric setting, *Hospital and Community Psychiatry, 31*(9), 628–30. <https://doi.org/10.1176/ps.31.9.628>
- Gillespie, G. L., Gates, D. M., & Berry, P. (2013) Stressful Incidents of Physical Violence Against Emergency Nurses. *Online Journal of Issues in Nursing, 18*(1), 2. <https://doi.org/10.3912/OJIN.Vol18No01Man02>
- Goleman, D. (1995). *Emotional intelligence*. Bantam Books.
- Goleman, D. (1998). *Working with emotional intelligence*. Bantam Books.
- Grossman, D., & Christensen L. W. (2008). *On combat: The psychology and physiology of deadly conflict in war and peace*. Warrior Science Publications.
- Heilbrun, K., Golloway, G. G., Shoukry, V. E., & Gustafson, D. (1995). Physical control of patients on an inpatient setting: Forensic vs. civil populations. *Psychiatric Quarterly, 66*(2), 133–145. <https://doi.org/10.1007/BF02238860>
- Hellerstein, D. J., Staub, A. B., & Lequesne, E. (2007). Decreasing the use of restraint and seclusion among psychiatric inpatients. *Journal of Psychiatric Practice, 13*(5), 308–317. <https://doi.org/10.1097/01.pra.0000290669.10107.ba>
- Holden, J. (2010). *Developing competent crisis intervention trainers: Assessing the disparity of participant's curriculum knowledge/skills and training skills in a crisis intervention train-the-trainer program*. Lambert Academic Publishing.
- Holden, J. C., Johnson, T. D., Nunno, M. A., & Leidy, B. (2007). Using a prone/supine perception and literature review to forward the conversation regarding all restraints. In M. J. Holden (Ed.), *Therapeutic Crisis Intervention Update: Safety Interventions*. Family Life Development Center, Cornell University.
- Holden, J. C., & Holden, M. J. (2000). The working system. *Training and Development in Human Services, 1*, 34–38.
- Holden, M., & Curry, D. (2008). Learning from the research. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 107–126). Child Welfare League of America.

THE AEGIS SYSTEM™ REFERENCES

- Howells, K., & Hollin, C. R. (1989). *Clinical approaches to violence*. Wiley.
- Huckshorn, K. A. (2005). *Six core strategies to reduce the use of seclusion and restraint: Planning tool*. National Association of State Mental Health Program Directors. <https://www.choiceforum.org/docs/sixcore.pdf>
- Iacoboni, M. (2008). *Mirroring people: The new science how we connect with others*. Farrar, Straus and Giroux.
- Infantino, J. A., Jr., & Musingo, S. Y. (1985). Assaults and injuries among staff with and without training in aggression control techniques, *Journal of Hospital and Community Psychiatry*, 36(12), 1312–1314. <https://doi.org/10.1176/ps.36.12.1312>
- Independent Advisory Panel on Deaths in Custody. (2011). *IAP E-Bulletin*. April, Issue 4.
- Independent Advisory Panel on Deaths in Custody. (2012). *IAP E-Bulletin*. March, Issue 7.
- Intersectoral/Interministerial Steering Committee on Behaviour Management Interventions for Children and Youth in Residential and Hospital Settings. (2001). *Report of the Intersectoral/Interministerial Steering Committee on Behaviour Management Interventions for Children and Youth in Residential and Hospital Settings*.
- Janoff-Bulman, R. (1992). *Shattered Assumptions*. Free Press.
- Jennings, P. A. (2019). Teaching in trauma sensitive classroom: What educators can do to support students. *American Educator*. <https://www.aft.org/ae/summer2019/jennings>
- Johnson, M. E., & Delaney, K. R. (2007). Keeping the unit safe: The anatomy of escalation. *Journal of the American Psychiatric Nurses Association*, 13(1), 42–52. <https://doi.org/10.1177%2F1078390307301736>
- Jones-Smith, E. (2012). *Theories of counseling and psychotherapy: An integrative approach*. Sage.
- Kalogjera, I. J., Bedi, A., Watson, W. N., & Meyer, A. D. (1989). Impact of therapeutic management on use of seclusion and restraint with disruptive adolescent inpatients. *Hospital and Community Psychiatry*, 40(3), 280–285. <https://doi.org/10.1176/ps.40.3.280>
- Kaplan, S. G., & Wheeler, E. G. (1983). Survival skills for working with potentially violent clients. *Social Casework*, 64(6), 339–345. <https://doi.org/10.1177%2F104438948306400603>
- Kennedy, S. (2008). Using restraint: The legal context of high-risk interventions. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 227–244). Child Welfare League of America.
- Knapp, M. L., & Hall, J. A. (2006). *Nonverbal communication in human interaction* (6th ed.). Wadsworth/Thomas Learning.
- Laursen, E. K., & Birmingham, S. M. (2003). Caring relationships as a protective factor for at-risk youth: An ethnographic study. *Families in Society*, 84(2), 240–246. <https://doi.org/10.1606/1044-3894.101>
- Ledoux, J. (2002). *Synaptic self: How our brains become who we are*. Viking.
- Long, N., & Morse, W. (1996). *Conflict in the classroom: The education of at-risk and troubled students* (5th ed.). Pro-Ed.
- Lovett, H. (1996). *Learning to listen: Positive approaches and people with difficult behavior*. Paul H. Brooks Publishing.
- Macedo, T., Wilhelm, L., Gonçalves, R., Coutinho, E. S. F., Vilete, L., Figueira, I., & Ventura, P. (2014). Building resilience for future adversity: A systematic review of interventions in non-clinical samples of adults. *Biomedcentral Psychiatry* 14, 227. <https://doi.org/10.1186/s12888-014-0227-6>
- Mager, R. F. (1984). *Preparing instructional objectives* (2nd ed.). David S. Lake.
- Masker, A. S., & Steele, J. (2004). Reducing physical management and time-out: A five-year update on one agency's experience. *Residential Group Care Quarterly*, 4(3), 6–7.

THE AEGIS SYSTEM™ REFERENCES

- Masters, K. J. (2008). Modernizing seclusion and restraint. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 45–68). Child Welfare League of America.
- Marshall, S., & Turnbull J. (Eds.). (1996). *Cognitive behaviour therapy: An introduction to theory and practice*. Baillière Tindall.
- Matsumoto, D., Frank, M. G., & Hwang, H. S. (Eds.). (2013). *Nonverbal communication: Science and applications*. Sage Publications.
- McCowan, R. J., & Weganast, D. P. (1997). *Embedded training evaluation: Blending training and assessment*. SUC Buffalo.
- McDonnel, A., Water, T., & Jones, D. (2002). Low arousal approaches in the management of challenging behaviors. In D. Allen, (Ed.), *Ethical approaches to physical interventions*. British Institute of Learning Disabilities.
- McPhaul, K. M., London, M., & Lipscomb, J. A. (2013). A framework for translating workplace violence intervention research into evidence-based programs. *Online Journal of Issues in Nursing*, 18(1), 4. <https://doi.org/10.3912/OJIN.Vol18No01Man04>
- Measham, T. J. (1995). The acute management of aggressive behaviour in hospitalized children and adolescents. *Canadian Journal of Psychiatry*, 40(6), 330–336. <https://doi.org/10.1177%2F070674379504000609>
- Mercy, J. A. (1990). Mortality associated with use of upper-body control holds by police. *Violence Victim*, 5(3), 215–222.
- Miller, C. (2004). *Restraint asphyxia—Silent killer*. charlydmiller.com/RA/restrasphyx02.html
- Miller, D., Walker, M. C., & Freidman, D. (1989). Use of a holding technique to control the violent behavior of seriously disturbed adolescents. *Hospital and Community Psychiatry*, 40(5), 520–524. <https://doi.org/10.1176/ps.40.5.520>
- Mitchell, J., & Varley, C. (1990). Isolation and restraint in juvenile correctional facilities. *Journal of the American Academy of Child and Adolescent Psychiatry*, 29(2), 251–255. <https://doi.org/10.1097/00004583-199003000-00014>
- Mohr, W. K. (2008). Physical restraints: Are they ever safe and how safe is safe enough? In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 69–86). Child Welfare League of America.
- Mohr, W. K., Mahon, M. M., & Noone, M. J. (1998). A restraint on restraints: The need to reconsider the use of restrictive interventions. *Archives of Psychiatric Nursing*, 12(2), 95–106. [https://doi.org/10.1016/s0883-9417\(98\)80059-9](https://doi.org/10.1016/s0883-9417(98)80059-9)
- Mohr, W. K., & Mohr, B. D. (2000). Mechanisms of injury and death proximal to restraint use. *Archival Psychiatric Nursing*, 14(6), 285–295. <https://doi.org/10.1053/apnu.2000.19091>
- Mohr, W. K., Petti, T. A., & Mohr, B. D. (2003). Adverse effects associated with physical restraint. *Canadian Journal of Psychiatry*, 48(5), 330–337. <https://doi.org/10.1177/070674370304800509>
- Mooney, A. J. (2008). The reach of liability for physical restraints: A question of professional judgment. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 245–255). Child Welfare League of America.
- Morin, J. P. (1997). Reducing the risk of positional asphyxia. *Journal of Correctional Training*, Winter, 15–17.
- Morton, T. D., & DePanfilis, D. (1987). *Supervisory effectiveness training in child welfare services*. Child Welfare Institute.
- Mueller, A. (1998). De-escalating aggressive behaviors of young girls in residential treatment. *The Child and Youth Leader*, 7(2).
- Murphy, T., & Bennington-Davis, M. (2005). *Restraint and seclusion: The model for eliminating their use in healthcare*. HCPro.
- National Institute for Health and Care Excellence. (2015). *Violence and aggression: Short-term management in mental health, health and community settings*. <https://www.nice.org.uk/guidance/ng10>
- Navarro, J., & Karlins, M. (2008). *What every BODY is saying: An ex-FBI agent's guide to speed-reading people*. Harper Collins Living.

THE AEGIS SYSTEM™ REFERENCES

- Nelson, J. E. (1978). Child care crises and the role of the supervisor. *Child Care Quarterly*, 7(4), 318–326.
- Noesner, G. W., & Webster, M. (1997). Crisis intervention: Using active listening skills in negotiations. *FBI Law Enforcement Bulletin* (pp. 13–19).
- Nunno, M. A., Day, D. M., & Bullard, L. B. (Eds.). (2008). *For our own safety: Examining the safety of high-risk interventions for children and young people*. Child Welfare League of America.
- Nunno, M. A., Holden, M. J., & Leidy, B. D. (2003). Evaluating and monitoring the impact of a crisis intervention system on a residential child care facility. *Children and Youth Services Review*, 25(4), 295–315. [https://doi.org/10.1016/S0190-7409\(03\)00013-6](https://doi.org/10.1016/S0190-7409(03)00013-6)
- Nunno, M. A., Holden, M. J., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child and Youth Services Review*, 25(4), 295–315.
- O'Connor, J., & Seymour, J. (2011). *Introducing NLP: Psychological skills for understanding and influencing people*. Conari Press.
- O'Halloran, R. L., & Frank, J. G. (2000). Asphyxial death during prone restraint revisited: A report of 21 cases. *American Journal of Forensic Medicine and Pathology*, 21(1), 39–52.
- Olweus, D. (1993). *Bullying at School: What we know and what we can do*. Blackwell.
- Outlaw, F. H., & Lowery, B. S. (1994). An attributional study of seclusion and restraint of psychiatric patients. *Archives of Psychiatric Nursing*, 8(2), 69–77. [https://doi.org/10.1016/0883-9417\(94\)90036-1](https://doi.org/10.1016/0883-9417(94)90036-1)
- Parad, H. J. (Ed.). (1965). *Crisis intervention: Selected readings*. Family Service Association of America.
- Parad, H. J., & Parad, L. G. (Eds.). (200). *Crisis intervention: The practitioner's sourcebook for brief therapy* (2nd ed., book 2). Fenestra Books.
- Parkes, J. (2000). Sudden death during restraint: A study to measure the effect of restraint positions on the rate of recovery from exercise. *Medicine, Science and the Law*, 40(1), 39–44.
- Papa, A., & Venella, J. (2013). Workplace violence in healthcare: Strategies for advocacy, *Online Journal of Issues in Nursing*, 18(1), 5. <https://doi.org/10.3912/OJIN.Vol18No01Man05>
- Paterson, B., & Leadbetter, D. (1999). De-escalation in the management of aggression and violence: Towards evidence-based practice. In J. Turnbull & B. Paterson (Eds.), *Aggression and violence: Approaches to effective management* (pp. 95–123). Macmillan.
- Paterson, B., Leadbetter, D., Miller, G., and Crichton, J. (2008). Adopting a public health model to reduce violence and restraints in children's residential care facilities. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 127–143). Child Welfare League of America.
- Paterson, B., & Tringham, C. (1999). Legal and ethical issues in the management of aggression and violence. In J. Turnbull & B. Paterson (Eds.), *Aggression and violence: Approaches to effective management* (pp. 52–78). Macmillan.
- Paterson, B., Turnbull, J., & Aitkin, I. (1992). An evaluation of a training course in the management of violence, *Nurse Education Today*, 12(5), 368–375. [https://doi.org/10.1016/0260-6917\(92\)90113-3](https://doi.org/10.1016/0260-6917(92)90113-3)
- Phillips, D., & Rudestam, K. E. (1995). Effect of nonviolent self-defense training on male psychiatric staff members' aggression and fear. *Psychiatric Services*, 46(2), 164–168. <https://doi.org/10.1176/ps.46.2.164>
- Polsky, H. W. (1962). *Cottage Six: The Social System of Delinquent Boys in Residential Treatment*. Russell Sage Foundation.
- Reay, D., Howard, J., Fligner, C., & Ward, R. (1998). Effects of positional restraint on oxygen saturation and heart rate following exercise. *American Journal of Forensic Medicine and Pathology*, 9(1), 16–18.
- Redl, F., & Wineman, D. (1952). *Controls from within: Techniques for the treatment of the aggressive child*. Free Press.
- Roberts, A. (Ed.). (2005). *Crisis intervention handbook: Assessment, treatment, and research* (3rd ed.). Oxford University Press.

THE AEGIS SYSTEM™ REFERENCES

- Rosenberg, M. B. (2003). *Nonviolent communication: A language of life* (2nd ed.). PuddleDancer Press.
- Shipton, H. (2004). *Organizational learning: Reality or myth?* Aston Business School.
- Smith, P. A. (1993). *Professional assault response training* (rev. ed.). Professional Growth Facilitators.
- Steckley, L., & Kendrick, A. (2008). Young people's experiences of physical restraint in residential care: Subtlety and complexity in policy and practice. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 3–27). Child Welfare League of America.
- Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. <https://store.samhsa.gov/product/SAMHSA-s-Concept-of-Trauma-and-Guidance-for-a-Trauma-Informed-Approach/SMA14-4884>
- Suess, G. (2008). Lessons learned from 30 plus years of no physical intervention. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 217–224). Child Welfare League of America.
- Sugar, M. (1994). Wrist-holding for the out of control child. *Child Psychiatry and Human Development*, 24(3), 145–155. <https://doi.org/10.1007/bf02353192>
- Sullivan, A. M., Bezman, J., Barron, C. T., Rivera, J., Curley-Casey, L., & Marino, D. (2005). Reducing restraints: Alternatives to restraints on an inpatient psychiatric service—Utilizing safe and effective methods to evaluate and treat the violent patient. *Psychiatric Quarterly*, 76(1), 51–65. <https://doi.org/10.1007/s11089-005-5581-3>
- Talbot, A., Manton, M., & Dunn, P. J. (1992). Debriefing the debriefers: An intervention strategy to assist psychologists after a crisis. *Journal of Traumatic Stress*, 5(1), 45–62. <https://doi.org/10.1002/jts.2490050106>
- The Joint Commission. (2010). *Sentinel Event Alert 45: Preventing violence in the health care setting*. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea_45_preventing_violence_in_hcos_rev_2_14_19.pdf?db=web&hash=9B93997B242F265669B9AD8FBD670E03&hash=9B93997B242F265669B9AD8FBD670E03#:~:text=%E2%80%9CThe%20most%20important%20factor%20in,mandating%20staff%20to%20report%20any
- Thompson, R. W., Huefner, J. C., Vollmer, D. G., Davis, J. L., & Daly, D. L. (2008). A case study of an organizational intervention to reduce physical interventions: Creating effective, harm-free environments. In M. A. Nunno, D. M. Day, & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people* (pp. 167–182). Child Welfare League of America.
- United States Government Accountability Office. (1999). *Mental Health: Improper restraint or seclusion places people at risk*. <https://www.gao.gov/products/hehs-99-176>
- Weiss, E. M., Altamari, D., Blint, D. F., & Megan, K. (1998, October 11–15). Deadly restraint [five-part investigative report]. *Hartford Courant*.
- Vander Ven, K. (1988). A conceptual overview: Issues in responding to physical assaultiveness. *Children and Youth Services*, 10, 5–27.
- Wimberley, L. (1985). Guidelines for crisis management. *Pointer*, 29(2), 22–26. <https://doi.org/10.1080/05544246.1985.9944689>
- Yalom, I. D. (2002). *The gift of therapy: An open letter to a new generation of therapists and their patients*. Harper Perennial.
- Ziegler, D. (2004). Is there a therapeutic value to physical restraint? *Children's Voice*, 13(4), 1–6.