

VIDEO V



PMD B



**Therapeutic
Containment**

Trainers Reminder. In preparation for program, review video on trainer's tips in demonstrating therapeutic containment if needed, video is intended for trainers only.

- ✓ **All participants should have signed the Acknowledge of Risk/Statement of Health form.**
- ✓ **Have participants noted any medical problems? If so, inquire about their limitations. Do not allow staff to participate who are unable to sign both portions of the risk/health form.**

If early verbal interventions prove unsuccessful and the patient continues to escalate, staff members should prepare for physical intervention. Therapeutic containment is a team-oriented process used to physically intervene with a patient that represents a danger to themselves and/or others. A three-person team best handles crisis situations. A trained team is usually more effective than an individual in dealing with the demands of a crisis. This is true to the extent that the team members are able to interact with each other and react to the crisis in an effective manner. Under ideal circumstances, this team can represent a cohesive, well-coordinated, effective vehicle for intervening in a crisis. An untrained team or a show of force usually represents a disjointed, competitive, uncoordinated and disorganized approach to crisis, which often escalates the situation.

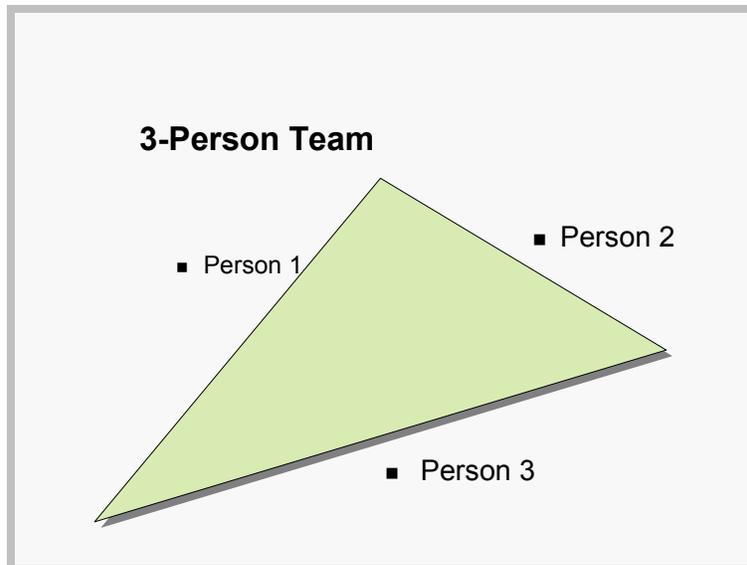
Cautionary Note: A restraint technique used at times by law enforcement personnel for controlling violent suspects involves placing the suspect in a hog-tied and prone position: binding the suspect's hands and feet together behind their back and placing them on their stomach. It has been noted that this physically incapacitating position makes it difficult for suspects to breathe and can cause them to die according to *FBI Law Enforcement Bulletin*, May 1996, Volume 65, Number 5. The Crisis Prevention Institute, (CPI), Inc., in their publication, *The Journal of Safe Management of Disruptive and Assaultive Behavior*, September 1998, suggest that restraining patients with excited delirium in the prone position is particularly hazardous and increases the risk of death. CPI points out that positional asphyxia occurs when the position of a person's body interferes with their respiration and they die from suffocation.

A LAST RESORT

It is important to note that PMDB training in general and the therapeutic containment procedure in particular emphasize that physical interventions are the last resort and used only when the patient represents a danger to themselves or others. The therapeutic containment procedure used in PMDB emphasizes the use of weight-based techniques employed in a prescribed manner to very specific locations of the patient's body. Applying pressure or weight on the patient's back, particularly over the lung-area, must be avoided. It is important that staff understand this point during training. When in a prone position PMDB techniques apply weight to the upper shoulder/rotator cuff area of the patient paying attention to not put weight or pressure on the back.

Trainers Note: This section of the manual is designed to provide the trainer with a systematic approach for assisting the trainee in functioning as a more effective team member. The trainer's task is made more difficult by the fact that the trainees are not generally trained with their work team. Once trained, they will return to their work environment without knowledge of their work team's effectiveness in a crisis situation. In addition, trained staff may be called upon to serve as a team member for situations occurring outside their work area.

PMDB Module 8



Objectives

1. Participants will develop skills and successfully demonstrate the 4 steps in providing a safe three-person containment for an acting out individual.
2. Participants will use safe weight based techniques in containing an individual.

Key Concepts

- Demonstrate and lead group in stretching and flexing muscles prior to demo and practice sessions (morning, after breaks/lunch). Remember “safety first.”
- Remember, all participants are encouraged to observe the demonstration, then practice the techniques at their comfort and level of ability, in a slow controlled manner.
- Inform the group it is natural to feel a little sore the day after the physical training.
- Introduce & reinforce the concept “challenge by choice.” All participants at any time have the option of observing and not participating in a particular exercise.
- Three-person containment is a 4 step process: 1,2,3, & 4. It is best taught out of order in the following sequence: 2, 1, 4, & 3.

LEVELS OF STRESS

Stress Level	Staff Action
Moderate Stress	Verbal Intervention
Severe Stress	Limit Setting
Panic	Personal Safety Skills or Therapeutic Containment
Tension Reduction	Therapeutic Rapport

Reminder: Personal Safety Skills and/or Therapeutic Containment procedures are used when an individual is at the panic level of stress, has become physical or assaultive by grabbing or striking a staff member, or is danger to themselves or others. At the panic level of stress the patient is no longer able to process information. Physical interventions should be used as a **LAST RESORT**.

- Introduce the safety measure / word **“BREAK”** at any time for trainers or participants to use as a signal for all participants to discontinue the particular activity, due to feeling physical discomfort or potential harm. These techniques do not and should not cause pain.
- Three-person containment only used on acting out individuals, by three or more PMDB trained staff - initiated by code word.
- Remember: The decision to use hands-on techniques is dictated by the person/patient’s behavior. The person/patient’s behavior also determines the amount of weight to be applied during the containment process.
- Reminder - check on physical health of person/patient during/after containment “Are you breathing okay?” Check color of patient, insure that patient is not struggling to breathe, assess if patient is experiencing pain. Communication with the patient continues throughout the process.
- In all situations, safety of the patient and staff are the main priority. Therapeutic containment should only be used by trained staff.
- Teach techniques for when “things go wrong”. **What ifs.**
- Use verbal interventions throughout the containment.

- Re-establish therapeutic rapport after the containment. De-brief with patient about incident and help identify triggers for anger - discuss positive solutions for next time.

Therapeutic Containment

- Team Concept
- Seek Assistance
- Role of Other Staff
- Follow Facility Policies in Use of Restraints or PRN Medication
- Documentation of Incident

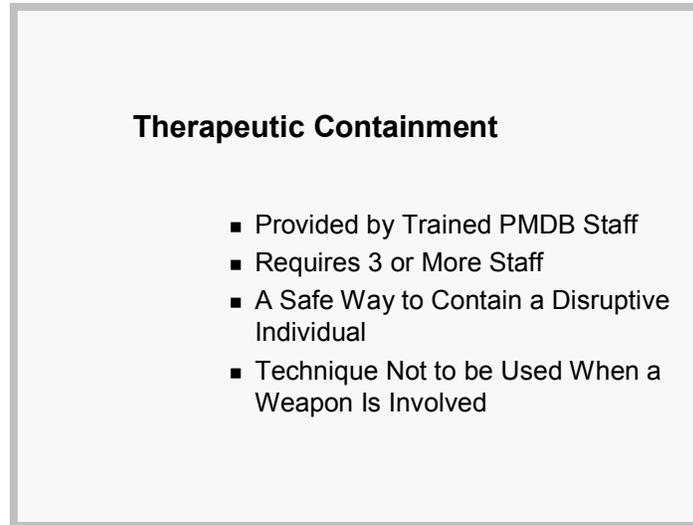
- Team concept - the three staff members are continually communicating with each other on safely containing individual.
- Team provides ongoing communication with person/patient of their goal in assisting them to calm down & set limits to avoid harming themselves or others. It is best for team members to talk with the patient one at a time, otherwise, too many voices at once can add to the panic and confusion.
- PMDB trained staff – can if necessary exchange positions with other staff who are containing individual; spot the person/patient to provide safety; remove the audience; divert traffic from the area; call for assistance.
- Follow facility policies and procedures when dealing with suicidal or homicidal individuals.
- Follow facility policies and procedures when using restraints or PRN medications.
- **Reminder:** documentation is essential.
- Debrief staff after incident – fact finding, not fault finding.
- Remind teams to develop appropriate code word.

Team Building

- Structure
- Size
- Disciplinary Makeup
- Leadership
- Role Clarity
- Team Members
- Experience as a Team
- Effectiveness

1. Structure: Some facilities have instituted very structured crisis response teams, it is important to note that given the size of some facilities it will take time for a response team to arrive. This can leave untrained staff in a difficult position, as they will have to manage the situation until help arrives. One approach minimize this possibility is to train staff from each area to respond to incidents as they arise. It is recommended that a mechanism for identifying trained team members must be developed so that staff can easily recognize others that have completed training. This can be accomplished by providing staff that have completed training with a colored sticker to be placed on their nametags.
2. Size: The size of a crisis team must **never** be less than three trained individuals.
3. Disciplinary Makeup: Crisis teams may vary considerably in their makeup; however, everyone in the facility should be considered for team membership.
4. Leadership: A trained team will always have a leader. This leader should be the person most capable of de-escalating the situation at the moment. Leadership during a crisis is dynamic and can change as long as the first leader disengages when the new leader takes charge. Allowing the patient to decide who the team leader will be is a good idea as the patient may not want to speak with the “formal” or “clinical” leader.
5. Role Clarity: Team roles must be interchangeable. All trained individuals must be able to assume any role. If possible, let the person who has the best rapport with the patient verbally intervene.
6. Team Members: PMDB trainers can assist in identifying potential team members. Individuals who have mastered the techniques taught in class typically make excellent team members.

7. Experience as a Team: Generally, work teams are not trained together—as staffing issues often prevent this. Therefore, once all individuals in a given area are trained, it will be important to have them role-play crisis situations to build team confidence.
8. Effectiveness: Team effectiveness is directly related to mastery of the concepts learned in class. If the team lacks confidence it will also be lacking in effectiveness.



The team should have a predetermined plan for diffusing the situation should it escalate into an acting-out incident. The three staff members form a triangle around the patient.

Staff must always be cognizant of **3** things.

- (1) Avoid encroaching in the patient's personal space**
- (2) Don't allow the patient to encroach in your personal space, and**
- (3) Utilize the supportive position.**

Note that while the team is in a triangle formation the patient must pass between at least two staff members in order to escape, no one staff member is directly confronting the patient. The first step in the plan involves setting an enforceable limit on this disruptive behavior. An example might be to ask the patient if he/she would like to sit in a chair to discuss the situation further. It is important to assess whether the patient is capable of processing the information you are providing. If the patient is unable to process additional information and is not willing to move

towards the chair then a phrase such as, "I need you to sit in a chair," would be the signal that indicates to the team members that we will use a therapeutic containment to escort the patient to the chair. The staff member at the patient's back is positioned to apply a bear hug when the code phrase is given and will be the first person to touch the patient. This will permit the two staff members at the front of the triangle to hold the patient's arms in a simple escort position.

Hang Technique

If the patient struggles, the staff members on the arms will utilize the **Hang Technique**. This consists of dropping on the arms and locking their legs around the patient's legs while using their weight to contain the patient when he/she struggles. The third person at the back performs a variety of roles:

- (1) This person controls the patient's arms so the hangers can approach without injury.
- (2) The back person acts as the steering committee, meaning that this person contains the forward and backward motion. This is done by placing the hands above the patient's elbows and the head to the side pressed against the patient's mid-back to avoid head butting by the patient. This person always maintains the supportive stance.
- (3) This person also serves to assist the team members on the arms in case they should lose their grip or are thrown off. If a staff member on the arm loses his grip while hanging, he can alert the third person who then reapplies the bear hug which secures the arm while the staff member reapplies the hang.
- (4) If the patient is extremely strong, the third person grabs the patient's arms at the elbows and hangs from behind; feet are still positioned at a 90-degree angle. This additional weight should be all it takes to 'plant' most patients.
- (5) The third person serves a critical role in the containment if this becomes necessary. The third person will prevent the team and the patient from dropping to the floor in an uncontrolled manner. Placing the knee under the patient's buttocks so that he/she ends up sitting on the back person's thigh does this. This person slowly lowers his/her knee to the floor, thereby lowering the patient to his knees as well. The transition to the final secure position is performed when the patient is on his/her knees. When the team members on the arms prepare to slide into the final secure position on the floor, the third person **slowly** eases the patient's feet out from under him, keeping the patient from going down too quickly.

The scenario might occur as follows: the patient is asked to sit in the chair; we assess that he/she is unwilling or unable to process information, and we begin to escort the patient to the chair. If the patient goes to the chair, staff would simply sit with him/her and verbally intervene. If the patient struggles during the escort, we would perform the Therapeutic Containment to contain the acting out behavior. The patient is placed in the final secure position when he/she is no

longer attempting to strike or grab staff. Generally the patient will go down on at least one knee as described above.

Once the patient and team members are on their knees the team members on the arms will immediately:

- (1) Face forward and move in close to the patient's sides.
- (2) They then place their hand closest to the patient on the patient's shoulder to control his/her descent (inside hand to inside shoulder).
- (3) At the same time, staff moves the leg closest to the patient in front of the patient (the inside knee of each staff member should meet in front of the patient). This will position their thigh under the patient's armpit as he/she is being lowered to the ground. This will allow the patient to slide down to the floor using staff's legs as a ramp while the person in the back **slowly** pulls the feet out.

Once on the ground, staff on the arms will slide into position over the patient's rotator cuff (shoulders). This position is achieved by positioning ones body perpendicular to the patients body, hips positioned at the curve between the patient's arm and latissimus dorsi (Large muscle on the flank of the patient's back) Staff then position their latissimus dorsi over the patients shoulder. The latissimus dorsi serves as a funnel to channel staffs weight to the patient's shoulder. It is **CRITICAL** that staff have their weight applied to the shoulders of the patient and not the patients back. **Placing weight on the patient's back can result in compression of the lungs and impair the patient's ability to breathe.** It is Important that trainers demonstrate this to staff during training by simply applying a small amount of weight on the back of staff over the lung area. Staff will understand the significance and importance of proper body position. While in a proper body position staff will be able to see the face of the patient and can monitor color, and breathing and determine if the patient is having any difficulties. The third person will lie across the legs, at the ankles, to prevent kicks.

Once the violent patient is on the floor, the task of moving him/her to a location, which you have previously determined, still remains. Each facility should develop a plan specific to the unique needs of their facility insuring that appropriate staff are informed. Using a backboard to restrain the patient prior to any movement is an option.. The staff member next to the backboard will move the patient's right arm next to his head, continually holding the arm firmly against the floor. The staff member will now be at the patient's head. The staff member on the opposite side of the board will step over the patient's body and bring the patient's arm over as well. The third staff member will be holding the ankles and help turn the legs. The patient will now be on his back on the backboard. If necessary a gurney can be at hand for transporting.

Carrying the Patient

At this point restraints are applied. If no backboard is available and the staff needs to carry the patient, the following procedure applies:

- (1) The patient's arms are managed with staff member's arms under the armpit and holding securely to their own wrists.
- (2) Two staff members must be positioned at the patient's feet and will place the arm closest to the patient over the leg with the other arm under the knee. Place the hand farthest from the patient on the patient's shin. With the hand under the knee, reach up and grab the wrist of the hand holding the shin. This assures support for the knee and also secures the patient so he cannot kick or straighten the leg.
- (3) Next all staff members bring one knee up in preparation to lift. On the count of three, staff members step forward and into the patient. The patient may now be lifted and carried securely.
- (4) Remember, the team leader gives all commands so the technique will move smoothly. Carrying a patient is dangerous and should be carefully assessed and used **only** when backboards are not available.

Teaching Therapeutic Containment

A. Overview: SEE IT, FEEL IT, DO IT!

1. First you should demonstrate earlier versions of patient control:
 - (a) A patient would punch at a staff member
 - (b) staff member would see the punch coming and while blocking would catch the punch---by grabbing the patient's arm
 - (c) while holding the patient's punching arm staff would place the free hand on the back of the patient's neck and begin to move the patient in small circles
 - (d) another staff member would then attempt to grab the other arm of the patient
 - (e) if successful at grabbing the free arm the two staff members would then place the patient in a prone position.
2. Critique why patient control techniques can be potentially dangerous to staff.
 - A. Performed in the danger zone.
 - B. Signal for hands-on is usually after a patient strikes at staff.

- C. Staff must approach patient unprotected.
- D. Staff must be strong enough to overpower the patient.
- 3. Demonstrate the **Hang Technique** and compare advantages against the old techniques.
 - A. Performed in the secondary safety zone (as close to the patient as possible).
 - B. Key word is given for signal to begin hands-on containment.
 - C. Back person applies bear hug before the front people begin.
 - D. Staff uses their weight to contain patient rather than strength.

B. Teaching the Hang Technique (2)

Allow participants to See It, Feel It, and Do It.

1. First make sure only the participants who signed both parts of the acknowledgement or risk/statement of health form experience and practice the techniques.
2. Then, ask all participants to stand up while you demonstrate, on each of them, the difference between pulling on the arm and hanging with dead weight. Hanging is not a straight drop on the arm, but rather a falling into the patient while hanging.
3. Next you must teach the **Hang Technique**. The best way to accomplish this is to break the group up into 3 person teams. Have one person be the patient while the other two hang. To prevent struggling by the person playing the patient, ask him to help you by showing the persons hanging on his/her arms how to hang properly. Emphasize that unless they learn to hang properly the technique will not be effective. Further, reinforce the fact that there is no back person yet to stabilize the team. (Instructor must be a spotter for the team.) This approach generally prevents any acting-out behavior while students are learning to hang.

Providing **examples** to participants helps them visualize the various techniques.

- In this process you can visualize the patient as a tree and staff as the roots of the tree----the goal is to plant the patient----not interested in eliminating movement, rather interested in making movement difficult. Note that during a storm a tree is able to move as that it does not break. It is important that the tree does not come up-rooted.
- Another example is to view the patient as a Bomb that is going to explode. Staff represents the box in which the bomb explodes----thus reducing damage and containing the explosion.

- Another example could be the notion of a Straight-Jacket, staff represent the jacket and again---not with the intent of eliminating the ability to move, rather making movement difficult.
- The more relaxed staff are during this process the more effective they will be utilizing their weight and the least likely they will be to use strength. Generally females tend to have a better understanding of the advantages of weight versus strength. Trainers will notice that females are generally better able to relax while practicing these techniques. It is often helpful to point this phenomenon out as it occurs.
- It is helpful to explain the concept of dead weight to participants. Framing the issue in terms participants will understand and can identify with will assist in the learning process. For example: the weight of a child asleep in a vehicle and the difficulty involved in moving the child without waking he/she up. The connection is that dead weight has little to no structure and is difficult to manage. Another example provided by children occurs when the two-year old child has a temper-tantrum in the middle of the store---- the child grabs the parents arm and hangs with all their weight. Watching this happen, one can see the effect that weight can have.
- Having staff recall the book, or movie, *Peter Pan*, ask how the children were able to fly? The answer is, a bit of fairy dust from Tinkerbell, and each child had to find his/her “happy place.” The happy place represents a thought that facilitates relaxation. Most situations that require a team response and subsequent therapeutic containment procedure do not typically lend themselves to thoughts of ones happy place. It is important to acknowledge the anxiety that accompanies physical intervention; however, it is equally important to emphasize the need to mitigate the stress in such a way that staff is able to maintain focus on utilizing weight based techniques. Otherwise, the tendency is to allow the stress to prevent relaxation and effective utilization of weight. This results in reliance on physical strength, which typically ends in exhaustion and increases the likelihood of injuries.

C. Teaching the Back Person's Role - The Bear Hug (1)

Allow participants to See It, Feel It, and Do It.

1. Once you are certain that everyone has had the chance to learn how to hang properly and also to serve as patient, demonstrate what the third person does.
 - A. Back person is the first to respond when the code is called.

- B. Back person approaches using the supportive stance.
 - C. The front leg is slightly bent and placed between the patient's legs.
 - D. The rear leg is straight back with foot in the 90 degree position.
 - E. Grab patient around the arms at the elbows, interlocking the fingers to insure a secure grip.
 - F. Head is placed to the side, out of the way of the patient's head so that head-butting is eliminated as a possibility.
2. Have the students line up behind patient and one at a time call a key word for hands-on. Allow each participant to master the third person role.
 3. Once they have successfully mastered this role, demonstrate how the back person then adds weight once the hangers have arrived. Also the back person can place the patient in an off-balanced position by leaning forward slightly.
 4. Demonstrate what can happen if the back person applies the bear hug too high and too low on the patients arms. Show why proper body position is necessary in order to be effective.

C. Teaching the Final Secure Position (4)

Allow participants to See It, Feel It, and Do It.

1. The hangers will roll into the armpit with latissimus dorsi over the patient's rotator cuff (shoulder). Arm is held in a slightly elevated position. Hangers must be sure the patient's arm is in the proper position to bend around the waist of the hanger. In order to accomplish this without injuring the patient, staff must verify that they can see the palm of the patient's hand---the patient's thumb will be pointing toward his/her own feet. If the palm of the hand is not visible, the patient's elbow will not bend around the waist of the hanger.
2. The back person will lie across the patient's ankles with one arm around the ankles and using one arm as a brace at the patient's thigh or buttock, facing the team members in front.
3. If the patient starts to pull his arms loose, the hangers should not fight for the arm, but rather maintain their position over the rotator cuff, shifting weight as necessary.
4. Allow each student to experience how this control position feels.
5. Next allow participants to perform this function. Usually the trainer will need to direct participants into the proper positions. Trainers must allow

sufficient time so that participants understand the technique and how to correctly utilize it.

Next allow them to perform this function. Usually the trainer will need to direct them into the proper position.

D. Teaching the Transition (3)

Allow participants to See It, Feel It, and Do It.

1. Demonstrate the process first. Show how the patient comes down on the back person's thigh, the back person will then indicate that the patient is "Going down", and the patient slides down the thigh to the floor. Again, placing the thigh under the patient's buttocks so that he/she ends up sitting on your thigh does this. Slowly lower your knee to the floor, thereby lowering the patient to his/her knees as well. The transition to the final secure position is performed when the patient is on his/her knees.
2. Explain how the hangers unlock their legs as the patient's knees begin to bend, while maintaining their grip on the patient's arm.
3. Demonstrate how the hangers line up with the patient prior to the transition to the final secure position. Note: The transition to the final secure position is performed from the knees, not from a standing position.
4. The hangers will place the hand closest to the patient on the patient's shoulder to hold the patient up when he /she starts to go down. Their knee or hip closest to the patient will move forward and inward towards the patient providing a ramp of support (if possible, staff at the patient's side should attempt to touch knees in front of the patient).
5. When the team members on the arms are prepared to slide into the control position on the ground, the third person ***slowly*** eases the patient's feet out from under him, keeping him from going down too quickly.

E. Teaching the Team Approach

1. After you are certain that all participants are now able to perform the Hang Technique and the Back Person role, ask the group to sit down. Break participants into three-person teams. Ask for a three-person team to volunteer to try the hang technique on you. Start slowly; as they become proficient, you can become more realistic with your struggle. It is important to note that the team will usually forget to meet prior to their intervention;

therefore, they will not have a **key word** to initiate the physical intervention. At this point, discuss the concept of the team leader, the triangle approach, reinforcing the concept of the key word.

Stress Level	Staff Action
Moderate Stress	Verbal Intervention
Severe Stress	Limit Setting
Panic	Personal Safety Skills or Therapeutic Containment
Tension Reduction	Therapeutic Rapport

2. Finally, allow the three-person teams to role-play an entire scenario from start to finish. At this point it will be important to note the staff intervention during the stages of stress. Refer to the Level of Stress chart above. Also, note the timing of the hands-on intervention. Identify whether a key word was mentioned or if the patient invaded the staff's personal space and would not retreat when asked. Of course, if the patient strikes out at a staff member, it's time for hands on intervention. It is important to mention that communication should not stop when therapeutic containment techniques are being used. Continue to tell the patient that you don't want anyone to get hurt, "please stop, someone could get hurt, we are here to help you, no one wants to hurt you, relax, please calm down..."
3. Finally, you might notice that the team is placing hands-on sooner than they should. This is generally done because they are more concerned about learning this new skill than conducting a proper intervention. Therefore, after several role-plays, it's helpful to point this out and then instruct students to use the technique as it was designed to be used: **AS A LAST RESORT.**

Note: Always have a spotter standing by when a role-play begins.

Important: Always identify a key word that supercedes the role play, such as "**break**" so that trainees know that if something is wrong or painful and they should release their hold immediately.

F. Teaching the "What ifs"

1. When teaching the physical takedowns, the sequence of events may not follow this manual. Using this technique, the patient's descent is a controlled descent. However, the patient may stagger and lose his/her balance while the hangers are in place. Therefore, the patient may fall in either of these directions:
 - A. To the right or left side. In this event, the hanger will sit down to allow the patient to fall against his/her body. The other hanger will take the patient's free arm and step over the patient, rolling the patient over into a prone position, the other hanger will assist by pushing the patient in the same direction. The hangers will then position themselves in the secure position over the rotator cuff and the back person will assume the secure position at the legs. Note that this process is effective because it uses the team of 3 working together.
 - B. Backward. In this event, the back person will sit down allowing the patient to rest against his/her body. The hangers are also on the ground as they would be if, while hanging, the group fell backwards. The hangers maintain control of the patient's arm. The hangers will then decide in which direction the patient will be rolled. One hanger will offer the patient's arm to the other hanger and begin to push on the patient's shoulder. The other hanger will stand, pulling the patient into a prone position, and over the leg of the back person. This will free the back person. The back person will be in position to assume the position of the hanger and the hanger will assume the position of the back person. It is important to note that during the turning of the patient the back person and one hanger switch positions because it makes sense to do so. Not switching positions would involve unnecessary movement of the team. .
2. The patient may get up on his/her hands and knees from the secure position (all fours). In this event, the hangers will remain in their positions with the weight applied at the patient's rotator cuffs. The back person will release the patient's feet and assume a wide supportive stance. (Place one hand between the patient's shoulder blades.) While kneeling along side of the patient, with one knee placed along side of the patient, and the other knee is placed on the floor between the patient's legs. With his/her inside leg against the patient's buttocks, the back person will then step forward easing the patient down to the floor thus returning the patient to the prone position.

3. **While training prepares staff to respond to incidents, we must stress that some behaviors are unpredictable and require staff to react. It is important that staff understand this technique, the philosophy of weight-based techniques, the notion of passive resistance, thereby allowing the patient to expend the violent energy in a safe and controlled manner. It is a fundamental understanding of the basics that allows staff to adjust/adapt to the various behaviors that patients will exhibit. At no time should staff be using strength or the patient be experiencing pain as a result of this intervention.**

I have found it easiest to teach these sections in the following order:

Overview

Teaching the Hang Technique (2)

Teaching the Back Person's Role - The Bear Hug (1)

Teaching the Final Secure Position (4)

Teaching the Transition to the final secure position (3)

Teaching the Team Approach

Teaching the "What-Ifs"

Team Assessment

The trainer should bear in mind that the first step in change is to heighten the awareness of the team members regarding the current level of functioning of their team. Only when the team members clearly recognize and are able to explicitly state the current characteristics and problems of the team, can they hope to institute constructive changes. The trainer should spend time during the training period facilitating an in-depth evaluation of the current level of functioning and characteristics of each trainee's team. This evaluation will have the team members looking at the following areas:

- Describe the goals and objectives of the team
- Assess their own level of functioning of the team
- Identify problems within their team

Team Interventions

The first and most obvious intervention is to meet as a team to openly and honestly discuss issues that impact on team effectiveness. If this approach is unsuccessful, it may require the assistance of an outside consultant.