STRATEGIES FOR CRISIS INTERVENTION AND PREVENTION – REVISED

The focus of this revised program is to empower staff with the methods of assisting and teaching individuals to maintain self-control and to train staff to engage in proactive methods of positive support.

Recognizing the right of people to exercise the fullest range of experiences, choices and opportunities possible, it is OPWDD's intent to minimize the use of personal interventions and to emphasize sound behavior support programs based on individual need.

New York State

Office for People with Developmental Disabilities

Handout Developed by AABR Inc.

Education and Training Department

Mission Statement

In meeting the challenges of the decade AABR continues to offer people with disabilities and autism homes of their choice, quality medical care, a lifestyle that encourages positive life choices, the cultivation of healthy meaningful relationships and the promotion of self worth, personal growth and productivity.

AABR is committed to accomplish its mission; following the lifespan of people served while providing services including education, training and housing with the support of their family, agency staff and the communities in which they live.

Valued Outcomes

- Home of their Choice
- Personal Health and Growth
- Meaningful Relationships
- Community Inclusion

Beliefs – **Opinions, views, conclusions you have made; things you hold as fact.**

Values – **Things or ideas of relative worth or importance.**

Attitudes – **Postures or positions expressive of an action or emotion, a position held in regard to a person, group or thing.**

FACTORS THAT CHANGES BELIEFS AND ATTITUDES:

1. Knowledge and Understanding.
2. Changes in values and attitudes can lead to changes in behavior.
3. If we maintain preconceived ideas about person with developmental disabilities, then we may fail to appreciate the uniqueness of each person.

BELIEFS, VALUES, AND ATTITUDES

- Each person is unique in his or her needs and leaning style.
- Positive expectations have a positive effect on the behavior of others.
- As staff we must be as free as possible from stereotyped notions of what persons with developmental disabilities are like and what they can and can't do.
- Regardless of the severity of one's handicap, all persons can learn and grow.
- Each person is of equal human value and deserving of respect.
- Expectations can either challenge or limit the growth of individuals.
- Each person deserves quality services and is deserving of our best efforts.
- We must learn to perceive and understand the thoughts, feelings, wants and needs of the people we serve.

BELIEFS, VALUES, AND ATTITUDES

- Cultural, societal and family factors influence our beliefs, values, and attitudes.

- These same factors have contributed to our beliefs and attitudes about people with developmental disabilities, especially those who exhibit challenging behavior.

- Beliefs and attitudes can change.

- Our laws, regulations and mission statements are an indicator of our societal regard for people with developmental disabilities.

- Our belief systems are likely to influence our own actions in dealing with people with developmental disabilities.

REASONS WHY PROGRAMS LIKE BEHAVIOR SUPPORT AND SCIP WERE DEVELOPED

- Decrease numbers of injuries to everyone**.**

- Improve reactions of care providers when responding to a crisis situation.

- Decrease incidents of abuse through increasing awareness of the definitions and causes of abuse.

- Establish an effective and humane training program for addressing challenging behaviors.

- Fulfill the need for a training program that focuses on a proactive, least restrictive approach.

- Increase awareness of negative effects of institutionalization:
    - Depersonalization
    - Modeling of violence
    - Lack of freedom
    - Regimentation (subject to order or uniformity)
    - Lack of stimulation
    - Learned helplessness
    - Lack of appropriate outlets for normal human emotions

EMOTIONAL AND PHYSICAL REACTIONS PEOPLE EXPERIENCE DURING A CRISIS

Common Emotional Reactions

Panic	Disappointment
Fear	Helplessness; Despair
Anger	Annoyance
Confusion	Embarrassment

Common Physical Reactions

Increased blood pressure	Tightness in stomach
Increased heart rate	Lump in throat
Sweaty palms	Headache
Muscular twitching	Adrenaline rush

- **EMOTIONAL AND PHYSICAL REACTIONS MAY OCCUR AT THE SAME TIME.**

STRATEGIES THAT CAN BE USED TO DEAL WITH STRESS AND BURNOUT

- ☐ Look at a situation from another perspective (reframe)
- ☐ Express feelings and emotions
- ☐ Use physical exercise
- ☐ Use relaxation techniques
- ☐ Try humor
- ☐ Distract yourself/escape
- ☐ Learn new skills in applicable areas
- ☐ Focus on the present
- ☐ Go to your supervisor for assistance

What works for you?

_____

_____

_____

_____

_____

_____

WHAT CONSTITUTES ABUSE OR NEGLECT?

(Definitions provided by the NY Justice Center)

Terms	Examples
Physical Abuse	Intentional contact (hitting, kicking, shoving, etc.) corporal punishment, injury which can't be explained and is suspicious due to extent or location, the number of injuries at one time, or the frequency over time
Psychological Abuse	Taunting, name calling, using threatening words or gestures
Sexual Abuse	Inappropriate touching, indecent exposure, sexual assault, taking or distributing sexually explicit pictures, voyeurism or other sexual exploitation. All sexual contact between Custodian and a service recipient is sexual abuse, unless the Custodian is also a person receiving services.
Neglect	Failure to provide supervision, or adequate food, clothing, shelter, health care; or access to an educational entitlement.
Deliberate Misuse of Restraint or Seclusion	Use of interventions with excessive force, as a punishment or for the convenience of staff.
Controlled Substances	Using, administering or providing any controlled substance contrary to law.
Aversive Conditioning	Unpleasant physical stimulus used to modify behavior without person-specific legal authorization.
Obstruction	Interfering with the discovery, reporting or investigation of abuse/neglect, falsifying records or intentionally making false statements.

Please list 10 causes of abuse:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

According to your list, what can be done to prevent the causes of abuse?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

UNDERSTANDING CHALLENGING BEHAVIOR

- In general challenging behavior is seen as serving a necessary purpose for the individual.
- Challenging behaviors are largely learned through a history of interactions between the person and the environment.
- Problem behavior may communicate something about the person's unmet wants or needs.
- A group of behaviors may be used to achieve a single outcome

IMPORTANT BELIEFS AND ATTITUDES ABOUT BEHAVIOR

- People can change even over-learned behavior.
- People can make their own decisions about behavioral change.
- A major staff role is to help people solve their own problems.
- Staff do not always have to control behaviors of others.
- Idleness, boredom lead to behavior problems.

FIVE FUNCTIONS FOR BEHAVIOR

Medical – Any pain, illness, physical discomfort, or any condition that is continuous (diabetes, menstruation, headaches, flu, etc.)

Escape – An avoidance of a demand, task or activity.

Attention – Need for another person to attend to or spend time with. Can be verbal, physical, social, or related to distance from a person.

Tangible – Want or access to an item, service, food, or activity.

Sensory – Looks, sounds, feels, smells, or tastes good or otherwise produces pleasure for the person.

WHAT IS FUNCTIONAL ANALYSIS?

- **The Process of looking at relationships between behavior and the environment.**
  (O'Neill, Horner, Albin, Storey & Sprague, 1990)
- **A full range of strategies used to identify the antecedents and consequences that control behavior.**
  (Horner, 1994)
- **An assessment process for gathering information that can be used to build effective behavioral support plans.**
  (Mace, Lalli & Lalli, 1991)

FOUR REQUIREMENTS FOR FUNCTIONAL ANALYSIS:

1. Challenging behaviors are specifically defined.
2. Events are identified that predict when the behavior is likely to occur.
3. Hypotheses or ideas are developed as to the function(s) of the behavior.
4. Data is collected.

(ABC Chart)

FACTORS THAT CONTRIBUTE TO CHALLENGING BEHAVIOR

1. **<u>Internal Antecedents</u>** – Conditions within the body that contribute to challenging behavior.

THINK MEDICAL FIRST

<u>Examples:</u> _____ _____

_____ _____

_____ _____

2. **<u>External Antecedents</u>** – Conditions or events occurring outside the person which increase the chance of a behavior occurring.

THINK ENVIRONMENT

<u>Examples:</u> _____ _____

_____ _____

_____ _____

OVERVIEW OF DEVELOPMENTAL DISABILITY

1. Is attributable to intellectual disability, cerebral palsy, epilepsy, neurological impairment or autism.
2. Is attributable to any other condition of a person found to be closely related to intellectual disability because such conditions result in similar impairment of general intellectual functioning or adaptive behavior to that of people with intellectual disabilities or requires treatment and services similar to those required for such persons.
3. Originates before such persons attain age twenty-two.
4. Has continued or can be expected to continue indefinitely.
5. Constitutes substantial disability to such person's ability to function normally in society.

This definition is taken from the New York State Mental Hygiene Law (Chapter 987, & 1.03(22).

Eligibility for OPWDD services is determined by this definition.

Characteristics of people with developmental disabilities which may impact their daily lives, lead to feelings of frustration, and may contribute to challenging behavior and crisis situations:

SENSORY/MOTOR DEVELOPMENT

- Disturbances in most any of the senses
- Disturbances in posture, motor skills and voluntary coordination difficulties

COMMUNICATION

- Difficulty organizing or articulating a message
- Stereotyped and perseverative language
- Limited ability to take listener's needs into account

COGNITIVE PROCESSING

- Attention
- Distractibility
- Comprehension
- Encoding – decoding information
- Memory difficulties
- Central auditory processing difficulties
- Limited problem solving skills/decision making skills

SOCIAL DEVELOPMENT

- Labeling
- Rejection and social disruption
- Segregation
- Restricted opportunities
- Victimization
- Infantilization

EMOTIONAL DEVELOPMENT

- Limited coping and problem solving skills
- Lack of appropriate alternative responses
- A long history of inappropriate responses
- Limited dealings with loss, death and grieving issues
- Psychiatric conditions such as dual diagnosis
- Self esteem issues
- Emotional control difficulties
- Difficulty reading self and other's moods
- Low tolerance for frustration

THE SCIP GRADIENT

Proactive – Interventions are those which address people's needs before problems arise.

Active – If needs are not met, problems begin to bubble up as warning signs. Active interventions are designed to help people calm down so that needs may be addressed.

Reactive – Interventions are those which deal with challenging behaviors as they occur. The person has to calm down in order to go back to a point where it is possible to address needs.

(SCIP gradient graph)

A "POSITIVE ENVIRONMENT" IS ON THAT IS BOTH "FUNCTIONAL" AND "SUPPORTIVE"

SUPPORTIVE	FUNCTIONAL
Positive Encouraging Consistent Patient Forgiving Empathetic Non-judgmental Caring Togetherness Teamwork Self Esteem Flexible Comforting Trusting Rewarding Promotes Growth Honest Nurturant Understanding Helpful Kind Cheerful Generous Friendly Respectful Accepting	Meets Needs Useful Meaningful Purposeful Consistent Dependable Safe Flexible Organized Workable Manageable Optimally Stimulating Has Variety Choices Available Fun Accessible Therapeutic Age appropriate Educational Adaptive (Equipment) Has Value Worthwhile Motivating Comfortable Interesting

Five Major Categories of a Positive Environment:

- **Physical Setting**
- **Social Setting**
- **Activities and Instruction**
- **Scheduling and Predictability**
- **Communication**

(Behavior Support Planning Tool)

FIVE COMPONENTS OF BEHAVIOR CHANGE

1. **Lifestyle Enhancement –** Helping individuals to experience a wide range of positive choices and opportunities will assist them in developing adaptive self-image and a sense of personal control.

2. **Environmental Change –** If aspects of the environment are dysfunctional or non-supportive for the individual, changing those aspects may reduce the likelihood of challenging behavior occurring.

3. **Consequences to Behavior –** Focus is on the use of positive reinforcers as opposed to artificial consequences.

4. **Teaching Substitute Skills –** Doing a functional analysis will give insights into the function(s) of challenging behavior. With "positive approaches" the idea is to teach the person positive skill(s) that will have to same or similar function(s) or outcome for the person as the problem behavior. Example: if a person steals other's property, skills may be taught to help the person get what he or she wants in a more socially acceptable fashion.

5. **Teaching General Alternatives –** These would include communication skills, social skills, relaxation training, self confidence, problem solving and coping skills. Such skills provide individuals with the tools they need to deal appropriately and successfully with a variety of difficult situations which might otherwise result in challenging behavior. Any intervention developed to reduce challenging behavior should be designed based on information gained from a functional analysis where a hypothesis regarding the function of the challenging behavior is developed and tested, and multi-component interventions then focus directly on assisting an individual to achieve the purpose of their challenging behavior in a more functional manner.

PHASES OF ESCALATION

Phase 1 **SETTING EVENTS**

What type of intervention would you use?

Proactive **Active** **Reactive**

Phase 2 **EARLY WARNING SIGNS**

Examples: increased tension, agitation, verbal aggression, threatening looks, person-specific signs or any behavior change

What type of intervention would you use?

Proactive **Active** **Reactive**

Phase 3 **CRISIS**

What type of intervention would you use?

Proactive **Active** **Reactive**

Phase 4 **RECOVERY**

How long should a person have to calm down?

10 minutes **20 minutes** **30 minutes**

PHYSICAL CONSIDERATIONS STAFF SHOULD REMEMBER WHEN DEALING WITH A CRISIS

1. **ATTIRE** can hinder a staff person's ability to handle a challenging behavior.
   Examples: _____
   _____
   _____

2. **ENVIRONMENT**
   Physical Setting – Examples: _____
   _____
   _____
   Objects in Area – Examples: _____
   _____
   _____

PSYCHOLOGICAL CONSIDERATIONS STAFF SHOULD REMEMBER WHEN DEALING WITH A CRISIS

- Know yourself
- Keep yourself calm, act with competent self-assurance
- Listen
- Be sensitive to a person's self-esteem
- Identify the person's feelings
- Do not create a power struggle
- Provide support

(Personal Appearance Policy, pg19)

INTERVENTIONS TO BE USED DURING THE ACTIVE PHASE OF BEHAVIOR ESCALATION

Non-Verbal Calming Techniques	Verbal Calming Techniques
• Redirect to Another Activity • Eye Contact • Close Proximity • Touch • Effective Use of Space • Body Posture • Facial Expressions • Provide Access to Preferred Objects/Activities	• Ventilation • Active Listening • Distraction • Reassurance • Understanding • Modeling • Humor • One-to-One • Encourage Coping Strategies • Use Positive Language • Remind of Natural Consequences to Behavior • Facilitate Relaxation

EXAMPLES OF VERBAL ESCALATORS

1. Planting the suggestion of misbehavior. **"Don't hit me."**
2. Threaten consequences of a behavior. **"If you throw that I'll wrap you."**
3. Presenting commands in the form of a question. **"Are you ready to get on the van now?"**
4. Restarting confrontation by immediately demanding emotionally difficult actions. **"You hit Marla, now apologize to her."**
5. Rehashing the incident within hearing range of the individual. **"Did you hear what Olga did last night?"**

GUIDELINES FOR THE USE OF PERSONAL INTERVENTION TECHNIQUES

Personal Intervention Techniques are grouped into three categories: Core, Specialized, and Restrictive. Core Interventions are the techniques taught to everyone who takes SCIP-R for certification. Specialized and Restrictive Interventions are available to be taught on an as needed basis. Restrictive Interventions are the most intrusive, to be taught only when absolutely necessary, and are not to be considered part of the Core training. Therefore, only staff working with individuals who require Restrictive Interventions should be trained to use Restrictive Interventions.

1. THE SCIP GRADIENT

If preventative steps are unsuccessful or not feasible in averting a behavioral crisis, and if the person is in danger of hurting himself or others, approved personal intervention techniques may be used on an emergency basis. These techniques are to be used only until the person is calm. Such techniques are only used after other methods of intervention (early intervention, non-verbal, and verbal calming techniques) have been considered, and determined to be clinically inappropriate and unlikely to succeed, or have been tried and failed.

- Personal Intervention Techniques are defensive interventions are not to be used offensively. Excessive force in the use of any personal intervention technique may constitute abuse.
- Personal Interventions follow a gradient system of implementation. The minimal amount of intervention to help a person gain control should be utilized. A sequence of least restrictive to more restrictive techniques should be followed.
- **Restrictive Personal Interventions are considered to be the most intrusive. These techniques are only to be employed to interrupt or terminate a truly dangerous situation where serious injury could result.**
- Whenever Restrictive Personal Intervention techniques are utilized on an emergency basis more than two times during a thirty day period, the person's Team must address the behavior(s) by conducting or reviewing a functional analysis and revising a person's plan of services as necessary to address the challenging behaviors using positive supports.

2. MONITORING AND DOCUMENTATION

The use of Restrictive Personal Intervention Techniques is to be documented in the person's clinical record, and include:

- A description of the behavior and situation/environmental conditions which necessitated the use of the intervention; the name(s) of person(s) implementing the intervention; the personal techniques used; the time of initiation and termination; outcome and resolution.

The use of all Restrictive Personal Intervention Techniques is to be monitored on an agency-wide basis with the frequency of use, as well as staff and individual injury summarized on a monthly basis. This is to be done to evaluate the impact of these techniques on individuals and groups with the overall goal of reducing the frequency of their use. Any use of a non-approved personal intervention that results in a reportable injury, will require the reporting of an allegation of abuse. The case must be investigated as physical abuse.

CONSIDER THESE POINTS BEFORE USING A PHYSICAL INTERVENTION:

- **Communication –** Have you offered an opportunity for the individual to communicate using objectives, signs, symbols, or speech, and have you responded positively?
- **Choice –** Have you offered another activity and encouraged the individual to choose?
- **Environment –** Have you offered a change of location or setting, such as a smaller space, a low distraction area and have you adapted the environment to support the individual?
- **Physical Needs –** Have you considered hunger, thirst, pain, heat, cold, tiredness, activity, or need of the toilet?
- **Interaction –** Have you offered a change of staff member and responded to the need for attention?
- **Therapeutic Alternative –** Have you offered music, aromatherapy, practicing coping strategies?
- **Relaxation –** Have you tried deep breathing, slow breathing, yoga?
- **Calming Techniques –** Have you used verbal and non-verbal calming to include: reflection, empathy, reassurance, redirection, incentives and rewards?
- **Listening Techniques –** Have you listened, read the signs, picked up clues, and given prompts rather than hurrying to give advice?
- **Sensitivity –** Have you helped to restore the individual's confidence and dignity by sensitivity rather than being confrontational and have you offered a constructive functional activity?

USING A PHYSICAL INTERVENTION

Consider if you really need to use a physical intervention. If so, then use the least restrictive first and return to the least restrictive as soon as possible.

HEALTH AND SAFETY CONSIDERATIONS WHEN USING PERSONAL INTERVENTION TECHNIQUES

When utilizing personal intervention techniques, the person's health and safety must always be considered and monitored. A minimum amount of force is to be utilized, with the hold gradually released as the person begins to calm. Always assess the possibility of moving to a s less intrusive intervention, with the goal of releasing the person as soon as possible. The individual's circulation, respiration and state of consciousness must be monitored. An open airway passage must be ensured. The use of any personal intervention must be terminated immediately if the individual shows signs of physical distress, such as sudden change in skin color, hyperventilation, difficulty breathing, or vomiting. **Excessive struggling may indicate severe distress.

Staff are to be especially cautious about initiating a Restrictive Personal Intervention if a person has recently eaten a meal because of the risk of death due to aspiration. If a Restrictive Personal Intervention should be determined to be necessary due to the critical nature of the situation, and the person has eaten, it is even more important to monitor for the signs of physical distress mentioned above and to attempt to have the person respond vocally to staff efforts at verbal calming.

The use of a Restrictive Personal Intervention presents a risk whenever it is used, and should not be used when there is a medical contraindication. Such medical conditions may include cardiac or pulmonary problems, physical disabilities and other medical problems identified by a health care professional. This is particularly true for people with Down Syndrome due to their particular physiognomy. Persons with this congenital disability typically have broad, flat faces and noses, and short necks with small oral cavities, yet larger tongues. This condition may result in a compromised air exchange, interfere with oxygen intake, and enhance the possibility of asphyxia. Respiratory difficulties can be further accentuated if the person is agitated and struggling. Another known abnormal feature of Down Syndrome is the increased potential for the dislocation of the first cervical vertebra, which is near the respiratory control center. Excessive pressure applied to the region of the neck could result in dislocation of this vertebra and inhibit breathing.

B – BREATHING: hyperventilation; rapid breathing
hypoventilation; shallow breathing
Asthmatic Attack
Vomiting

A – ACTIVITY: Individual - Becomes Calm
Becomes Unresponsive
Has a Seizure
Excited Delirium

N – NOISE: You hear a bone break
Individual crying and unable to calm down

C – COLOR: Individual's body or turns blue or pale

****IMPORTANT****

If an individual continues to be held in a Restrictive Personal Intervention for 10 minutes, a supervisor must be notified. The application of a Restrictive Personal Intervention shall be done with minimum amount of control necessary to safely interrupt the behavior, and the duration of the application of a single episode should not exceed 20 minutes.

Subsequent to the use of any Restrictive Personal Intervention, a staff member (preferably a health care professional) is to examine the person for evidence of injury and so document.

GENERAL SCIP TIPS: DO's and DON'Ts

DO's

- Know the people you are working with: typical behavioral responses in various situations, physical conditions/ medical problems, significant reinforcers, overall program especially goals or ongoing services pertaining to maladaptive behavior.
- Remember the principle of "The SCIP GRADIENT." Use less intrusive interventions (i.e. verbal calming, humor, redirection) whenever possible.
- Get out of the way!
- When a personal intervention needs to be used to help a person regain self-control, try to lessen the potential for injury. Call for assistance, move furniture away and move toward areas where there are fewer hard surfaces/edges.
- During implementation of personal interventions, monitor the person's respiration and general physical well-being at all times (remember BANC). Release the person from the restrictive hold if he or she becomes calm.
- As the person gradually regains his or her composure, gradually fad the amount of restriction placed on him or her. Reinforce calm, controlled behavior. Check for injuries.
- After a behavioral incident requiring implementation of personal interventions, fully document use of SCIP-R techniques noting antecedents, any injuries or suspected injuries and ultimate results/outcomes.

DON'Ts

- DO NOT overreact to behavior problems!
- DO NOT take a person's behavior personally.
- DO NOT feel it is your responsibility to control another person's behavior. Instead, figure out what will enable that person to regain self-control.
- DO NOT continue to progress through a "hold" if the person becomes calm.
- DO NOT personalize the situation.
- DO NOT create a power struggle.
- DO NOT use personal interventions to "punish" people who misbehave.

Listing of Personal Intervention Techniques:

Core

To be taught to all certified staff

Touch
One Person Escort
One Person Escort-Seated Variation
Two Person Escort
Two Person Escort-Seated Variation
Arm Support by One Person or With Assistance
Standing Wrap
Front Deflection
Bite Release
One Arm Release
Two Arm Release
Front Choke Release
Back Choke Release
Front Hair Pull Stabilization/Release
Back Hair Pull Stabilization/Release
Back Hair Pull Stabilization/Release with Assistance

Specialized

To be taught based on program needs

Blocking Punches
Seated Wrap
Approach Prevention
Bite Prevention Front Hold
Front Arm Catch
Front Choke Release
Head Lock Prevention
Head Lock Release
Front Kick Avoidance/Deflection
Back Hold Under Arms Release
Back Hold Low Over Arms
Back Hold High Over Arms
Chair Deflection
Protection From Chair as a Weapon
Protection from Thrown Objects
One Person Wrap/Removal
Two Person Removal

Restrictive

To be taught based on program needs

Two Person Take Down
Two Person Take Down with Assistance