STRATEGIES FOR CRISIS INTERVENTION AND PREVENTION-REVISED AS A CURRENT PROPOSAL IN CARE OF INDIVIDUALS WITH INTELLECTUAL DISABILITIES AND CHALLENGING BEHAVIOURS

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The article relates to the author's former experiences gained during the work with individuals with developmental disabilities at the Association for the Help of Retarded Children, Nassau Chapter in New York State in the United States (US), as well as with autistic children at the Loddon School in Hampshire County in the United Kingdom (UK). Strategies for Crisis Intervention and Prevention–Revised (SCIP–R) were used in both settings. The history of the Strategies for Crisis Intervention and Prevention (SCIP) training program began in the US in the 1980s and was connected with some of the most difficult turning points in the US social care system. For many years, one of the most disturbing issues in providing professional care to individuals with challenging behaviors was to find an appropriate approach to them, especially during their aggressive and self–injurious incidents. SCIP–R is one of the proposals of contemporary solutions to aggressive and challenging behavior of developmentally disabled individuals in care facilities. Its content refers to programs for individuals with other disabilities, as well. SCIP–R is addressed to staff members with direct care responsibilities. The general idea of this comparatively new training program is to prepare employees for prevention crisis and to effectively intervene when behavioral crisis occurs.

Introduction

There are various ways in which social workers recognize the needs of developmentally disabled individuals and in which they get them meet. The most common reactions of individuals with challenging behaviors to their unmet needs are frustration, aggression, crying, and self–injurious behaviors. One of the significant, relatively new in Europe, sets of numerous techniques which help to resolve dangerous situations caused by their unmet needs is SCIP-R. Because of the fact that there is little literature regarding SCIP–R in Europe, this article is one of the first publications that offers an overview of the topic.

The development of the SCIP-R originated from the New York State care system and the New York State Office of Mental Retardation and Developmental Disabilities (Cornick, 2004). In the mid–1960s, the movement known as *deinstitutionalization* initiated the removal of people with mental illnesses from state run institutions (O'Connor, 1998). Due to drastic cuts in New York State financing of governmental institutions in the late 1960s, many of the disabled residents were forced to live in appalling squalor and virtually unattended. The poor conditions in the governmental facilities determined action of residents' families and American society. A key turning point was the Willowbrook case. Willowbrook State School was established in the 1930s as a state-supported institution for mentally retarded children located in central Staten Island in New York City. In the mid–1960s, the compilation of budget cuts, arrogance, and indifference created dangerous conditions for residents at the Willowbrook School. The residents were abused in various ways by the staff, with the use of physical restraint and violence. Willowbrook finally closed its doors in 1987 (Rothman & Rothman, 2005). The history of the Willowbrook State School had a great impact on providing future professional services to mentally disabled individuals and preparing special programs for them. The Willowbrook case led New York State to adopt sweeping changes . The changes had started even before the school was closed. In 1978, the New York State Department of Mental Hygiene, which primarily was responsible for provision of services including care, treatment, habilitation, and rehabilitation of their citizens with mental retardation, was separated into three offices, including the

Office of Mental Retardation and Developmental Disabilities (OMRDD). One of the priorities of the OMRDD's mission statement was the development of comprehensive, integrated system of services which promotes independence, inclusion, individuality, and productivity for people with mental retardation and developmental disabilities (SCIP-R, Participant Guide, 1998). In 1980, according to the above-mentioned issue, the OMRDD prepared one of its programs, called Behavior Management for the Aggressive Client (B–MAC) training program, to manage violent and aggressive behavior of mentally disabled individuals using humane and compassionate methods. In 1988, the B–MAC was replaced by the SCIP training program to provide better help to all staff members working in various New York State facilities for intellectually disabled people; and to manage their aggressive, violent and self-injurious behavior during a crisis episode. In 1998, the OMRDD introduced an extensively revised SCIP training program. The revised material emphasizes positive approaches to behavior control that prevents incidents from escalating to the point where *hands-on* approaches become necessary. All the changes and improvements firstly to the B–MAC and then to the SCIP–R are not the result of any direct research on their effectiveness but come as a consequence of collaboration, discussion and practical experiences of Developmental Disabilities Service Offices and nonprofit providers.

While trying to place the SCIP-R training among other solutions to aggressive and self-injurious behaviors of intellectually disabled individuals it needs to be outlined that the above program is one of the approaches currently in use in the world. Due to the complexity, diversity and little research on various methods and techniques being used as physical interventions while responding to challenging behaviors of individuals with intellectual disabilities it is difficult to estimate precisely their complete number and to describe them all. Allen (2001) reviewed worldwide research in approaches regarding physical interventions and reported that the evidence base for behavior management training was extremely poor methodologically. However with the SCIP-R program there can be distinguished, as examples, a few, the most common training organizations and approaches: *Control and Restraint* (C&R), *Care and Responsibility*, Studio III , Non-Abusive Psychological and Physical Interventions (NAPPI), Timian training, Team Teach and many others.

Control and Restrain (C&R) is the best well known approach in the United Kingdom. Starting from the mid-1980's, many British professionals who worked with intellectually disabled individuals were offered training in *Control and Restraint* originally developed in prison service (Murphy et al. 2003, p. 116). C&R techniques allow staff to work quietly and professionally in teams, and to safely include such incidents. Control of the incident is assumed by the leader of this team, and the patient is quickly immobilised and prevented from causing further harm. The team has the option of restraining the patient standing, on the ground, or of moving them to another suitable room or location, to minimise further stimuli.

Care and Responsibility is defined as a method of training staff in techniques to provide them with skills to manage and deal with aggression and/or physical violence. It also provides staff with information about triggers for aggression and violence, which gives them an understanding and knowledge allowing them to defuse and de-escalate potentially dangerous situations before they become physical. Physical intervention should always be a last resort.

Studio III consists of three individual UK companies, which promote the ideals, philosophies and benefits of non-aversive behavior management. They further provide a fusion of skills drawn from academic researchers, applied clinicians, psychologists (educational and clinical), speech and language therapists, doctors, teachers, movement skills trainers as well as nurses.

Non-Abusive Psychological and Physical Interventions (NAPPI) was established in the United States in 1977. It was developed in a health care setting as a result of litigation directed against a facility in Maine that cared for residents with severe Learning Disabilities. NAPPI teaches three levels of prevention strategies: *long-term, relationship-building strategies* that reduce the likelihood of escalating situations; *intermediate strategies* that redirect potentially physical situations; and *emergency skills* that help defuse violent reactions.

Timian training, established in 1994 in the United Kingdom, is a system of conflict management and physical interventions which were appropriate to the client groups with challenging behaviors**.**

Crisis Aggression Limitation and Management (CALM), was developed with the aim of producing an effective, criteria and evidence based system of training in aggression management, to help protect both staff and service users from abuse and injury.

Team Teach is the largest provider of training for mainstream, special, child and increasingly adult services in the UK. The training has evolved from a residential care, education and health background working with service users with a variety of emotional, social, behavioral, learning, communication and medical needs. The recalled examples of the best practices in coping with challenging behaviors of intellectually disabled individuals are very differential relating to their various aspects. Despite many

differences between the above approaches and many others, which cannot be precisely characterized in this paper, the one common aim of them all is a principle that physical intervention should always be applied as a last resort.

In *The evidence base for the management of imminent violence in learning disability settings,* prepared by the Royal College of Psychiatrists, it was showed that there is little research on any aspect of the SCIP–R, including its effectiveness (Deb & Roberts, 2005). The only one instance which was cited in that document was a study on staff confidence in their ability to prevent and respond to crisis situations before participation in the SCIP–R training and three months later (Baker & Bissmire, 2000). In the study participated all care staff in an independent residential service (n=17) for people with learning disabilities and challenging behavior. The study revealed that after the SCIP–R training the staff felt more confident in the management of crisis and more supported by their organization. There was an increasing tendency to use physical interventions relative to other methods following the training. The other study, entitled as *Physical Interventions with People with Intellectual Disabilities: Staff Training and Policy Frameworks*, was focused on the extent to which staff (n=341) were trained in the use of physical interventions or restraint (Murphy et al, 2003). According to one of the parts of the study called *Comparison of methods of physical interventions used in participants' own services* it was revealed that the SCIP–R is very often used by staff right after the *Control & Restraint* method. In the research, the SCIP–R was used by 75 staff members and *Control & Restraint* by 97. In the conclusion of the study, it was outlined that the C&R and the SCIP-R appear to be *market leaders* in intellectual disability services. However, whether this is because they are actually more effective or whether it is merely historical accident is not known.

SCIP – R in Theory and Practice
The most important aspect of SCIP-R is awareness that physical intervention must be used minimally when there is a crisis episode. This particular program was developed to: decrease the number of injuries to everyone, improve reactions of care providers when responding to challenging behavior, decrease incidents of abuse through increasing awareness of the definitions and causes of abuse, establish an effective and humane training program that focuses on proactive and least restrictive approach, and increase awareness of the effects of institutionalization. The SCIP–R training program, defined by the OMRDD, is designed to present staff with a comprehensive approach in dealing with aggressive, violent, and self-injurious behavior which may occur during a crisis episode. The main goal of the program is to give staff the knowledge and necessary skills to anticipate and avoid crisis episodes of aggressive and/or acting out behavior while assisting program participants to maintain self control using positive approaches to support positive behaviors (SCIP-R, Participant Guide, 1998).
A term, defined in the OMRDD Regulations and Client Protection, which influences the use of SCIP–R is abuse. The term abuse is needed not only while using SCIP–R, but also to identify its premises in everyday work with intellectually disabled individuals. According to Part 624 of OMRDD's Regulations, abuse is defined as the mistreatment or mishandling of a person receiving services which could endanger the physical or emotional well–being of the person through the action or inaction on the part of any individual, including an employee, volunteer, consultant, contractor, visitor or other persons, whether or not the person receiving services is or appears to be injured or harmed (SCIP-R, Participant Guide, 1998). The failure to exercise one's duty to intercede on behalf of a person receiving services also constitutes abuse. Therefore every time SCIP-R is used one of the most important principles obeyed by staff is to avoid any abusive actions against individuals.

Relating to a crisis episode caused by aggressive, violent, self–injurious or challenging behavior of intellectually disabled individuals there are five functional reasons, called *STEAM*, which may lead them to exhibit challenging behaviors such as *S*elf-stimulatory or sensory, *T*angibles, *E*scape, *A*ttention and *M*edical (AHRC's Behavior Management/Positive Approaches Training Curriculum, 1998). Self-stimulatory or sensory reason for behavior provides input into one or more sensory–perceptual pathways. Examples are looks, sounds, feelings, smells, tastes. Tangible reason is when an individual wants or takes an item, service, food, or activity; for example, when a child in supermarket picks up a piece of candy before their parent has purchased it. Escape occurs when an inappropriate behavior can be reinforced by the escape or avoidance of a demand, task, or activity; for instance when a person does not perform a task because he or she perceives the task to be too difficult. Attention relates to a situation when a person can engage in an inappropriate behavior to get another person to attend to or spend time with him or her, such as a child in a classroom who makes snide remarks during class while the teacher responds in a socially disapproving manner. The medical reason is associated with an inappropriate behavior caused by a medical condition or medical problem.

The escalation process of behavior consists of four phases which are 1) setting events, 2) early warnings, 3) crisis, and 4) recovery. The SCIP–R training program includes three strategies - early intervention, calming techniques, and physical intervention (SCIP-R, Participant Guide, 1998). These strategies are dependent on the phase of behavior exhibited by the individual. Early intervention is recognition and responding to warning signs so a violent or aggressive episode can be avoided. These behavioral clues may include increased tension, agitation, verbal outbursts, threatening looks. In order to recognize and assess early behavioral warning signs, it is important to know a variety of information about the program participant.

When early intervention fails, calming techniques are used. The first type of calming techniques are non–verbal techniques such as ignoring the behavior, making eye contact, close proximity to an individual may serve as a deterrent, placing one's hand on the individual's hand may control the behavior, limitation of space (removing the individual or other program participants at the first warning signs of aggression), body posture (staff member must appear comfortable and relaxed), redirection to another activity, facial expressions. The next type of the calming techniques are verbal techniques such as allowing the individual to say anything they want, distraction (changing subject of conversation), reassurance (letting other staff members know about crisis situation), understanding (letting the individual know that the caregiver understands the reason for agitation), modeling the caregiver's voice to calm the individual, humor, *one-on-one* work with the individual. When using verbal techniques, it is important to avoid telling the individual suggestions for their misbehavior, threatening consequences of a misbehavior, presenting commands in the form of a question, having more than one staff member give directions to the program participant at one time, restarting confrontation by immediately demanding an emotionally difficult action, rehashing the incident in front of the program participant.

In order to ensure effective calming techniques, there is a six-step sequence (Cornick et al, 1996). The first step, called *identify*, recognizes the program participant's feelings. The program participant may appear angry but is primarily fearful and his fear has converted to anger. Step two, entitled *reflect*, means that it is very important to tell the individual the name of their emotion. This helps the individual differentiate and understand how they are feeling. *Empathy* is the third step of the calming techniques in which the caregiver is providing a concrete example from his own life that proves that he understands what the individual is feeling. This keeps the person from feeling alone with the problem and helps them understand that the caregiver has feelings, as well. Letting the individual know that the caregiver is ready to help him is the fourth step called *reassure*. The program participant must know that the problem is under control. The fifth step, *redirect*, refers to getting a person physically involved in a different activity so he or she cannot dwell on the problem. The last step, *praise*, is rewarding the individual when he or she complies with the redirection activity.

Physical interventions are used when calming techniques fail. It is important to remember that they are one element of a whole program. If the caregiver wants to aid the individual in gaining control over his or her behavior, he uses *gradient control*, which means that only the least amount of force should be used to get the situation under control. Restrictive techniques are allowed only as a last resort (Harris et al, 1996). They can be applied only if other approaches, such as early intervention and calming techniques fail. One of the most important things while applying physical intervention is to stop as soon as the individual has gained control of their behavior. It is also important to use *reverse gradient control* and move *backward* from a restrictive technique toward maintaining some amount of touch control, offering continued verbal empathy or support. After the individual has gained control of their behavior it is necessary to redirect them towards a relaxing activity.
Continued use of force when it is no longer necessary is considered abuse. Physical intervention includes dozens of techniques such as: touch, one-person escort, two-person escort, one-person escort (seated), two-person escort (seated), one-person arm control, two-person arm control, seated wrap, standing wrap, one-person warp with removal, bite release, one arm release - same arm, one arm release – opposite arm, two arm release, two arm release – both wrists, front deflection, front arm catch, front choke release, front choke windmill release, back choke arm catch release, front hair pull stabilization and release, back hair pull stabilization and release. Other restrictive techniques include: two-person removal, two- person take down, two- or three-person supine control (SCIP-R, Participant Guide, 1998).

Prior to SCIP–R interventions the caregiver must be aware of any medical precautions for the individual (Cornick et al, 1996). There are four physical areas, known as *BANC*, which the caregiver

must be conscious of when performing physical interventions. *BANC* stands for *B*reathing, *A*bility to move, *N*oise or sound, and *C*olor of facial skin. All SCIP–R trained staff should be aware that the medical conditions of certain individuals such as cardiac conditions, respiratory conditions, gastrointestinal conditions, hemophilia, history of injuries to muscles or bones, recent surgery, severe scoliosis, and others may effect and preclude the use of physical interventions. This should be reviewed with medical personnel before SCIP–R interventions are used. There are special precautions for individuals with Down's Syndrome. Relating to their particular physiognomy there are a potential risks when using SCIP–R interventions. Persons with this congenital disability typically have broad, flat faces and noses and short necks with smaller oral cavities, yet larger tongues. This may result in a compromised air exchange, interfere with oxygen intake, and enhance the possibility of asphyxia, if such individuals are held face down. Respiratory difficulties can be further accentuated if the person is agitated and struggling. Another known abnormal feature of Down's Syndrome is the increased potential for dislocation of the first cervical vertebrae, which is near the respiratory control center. Excessive pressure applied to the region of neck could result in the dislocation of the vertebrae and inhibit breathing. During the SCIP–R intervention, there has to be remedial action if the following signs or symptoms are observed: cyanosis (blue color of a body part), mottling (paleness, yellow color of any body part), hyperventilation (rapid breathing), hypoventilation (decreased breathing), vomiting, broken bones, unresponsiveness and/or a seizure. SCIP–R requires that the caregiver be knowledgeable of typical behavior responses of the individual in various situations, his or her physical conditions, problems and significant reinforcers.

It is very important to use less restrictive interventions such as verbal calming, humor, redirection, whenever possible. If there is a need for physical interventions, because of the individual's dangerous and maladaptive behavior, there should be an attempt to lessen the potential for injury. Therefore assistance is required to move all uninvolved individuals away from the immediate area as well as move the involved person toward areas where there are fewer hard surfaces or edges. During implementation of physical interventions, it is required to monitor person's respiration and general physical well being at all times, remembering *BANC*. If he or she becomes calm it is the caregiver's duty to release the person from the restrictive hold. The restrictive techniques should always be used as a last resort. If maintained beyond 10 minutes, the supervisor or psychologist needs to be notified. The caregiver must be calm throughout the whole crisis episode as the intent of SCIP–R interventions is to reduce the potential for injury and to help the person to regain control of his or her behavior. As the individual regains composure, gradually decrease the amount of restriction placed on them. When using SCIP–R interventions, it is necessary not to use them in order to *punish* the individual who misbehaves; not to overreact to behavior problems; not to turn your back on a person who is agitated; not to use soft furniture or beds as surfaces for restrictive techniques; not to place your weight on individual's back, chest or neck; not to get involved in a *power play*; not to personalize the situation; and not to block the individual's punches or slaps with your hands (use your forearm).

Based on experiences and consequences of the SCIP–R interventions; there are staff safety guidelines developed that include important principles: 1) keeping a safe distance from the individual who is agitated and not putting one's face near her or his hands and feet, 2) keeping caregiver's arms and hands away from person's mouth in order to avoid being bitten, 3) protecting other staff members who may be assisting the caregiver with the intervention and remember not to release a person without first communicating with the other staff members, 4) uninvolved staff and individuals should be asked to leave the area.

The group of strategies being used after a crisis has occurred includes medical examination of the individual, checking their basic physical needs such as thirstiness, need of going to bathroom, etc. The other strategy includes reassuring the caregiver and others. The above group includes strategies which are characterized by single words such as *isolate, explore, share, connect, alternatives, plan* and *enter. Isolate* means encouraging a person to leave the problem situation in order to decrease the amount of stimulation, distraction or stress. *Explore* the person's point of view including their concerns in the situation. The cargiver *shares* his views after the individual shares his or her opinions. *Connect* the individual's behavior and the problem with exhibiting that behavior to fulfill certain feelings or needs (such as frustration, disappointment, being hurt or loneliness). Develop *alternative* behaviors and a trial plan as well as helping the person to think of different choices they could have made. *Plan*, on how and when the person will demonstrate the desired behavior. *Enter* the person back to the place where the crisis occurred and prepare them to deal with any consequences of the crisis.

When a crisis episode has finished, there should be documentation of the SCIP–R techniques noting antecedents, any injuries or suspected injuries, and ultimate outcomes. There are three important principles which have to be taken under consideration while filling out documentation. The first principle indicates that the report has to be written right after the incident occurs. The next rule underlines that documentation should include what interventions were tried during the crisis and what their effectiveness was. The third principle was designed to document exactly what kind of interventions and strategies were used, including a list of early intervention approaches, list of used calming techniques, list of used intervention techniques and indication of staff involved in the crisis. The Association for the Help of Retarded Children, Nassau Chapter in New York State utilizes the *ABC Sheet* for reporting a crisis. This document contains the name and date of birth of an individual, name of staff member responsible for a person, target behavior to be observed, date of incident, time of incident, antecedent, description of behavior, staff response, and client response.

An Example of Implementing the SCIP–R Perspectives in the UK
Despite its widespread practice in New York State residential facilities, the SCIP–R Program is not well known in European countries. The UK is the second country utilizing the SCIP–R. Today's care services in the UK provide various solutions and programs whose content is aimed at giving intellectually disabled individuals an enhanced quality of life. One of the numerous programs is the PROACT SCIPr UK® designed by the Loddon School in Hampshire County. The PROACT SCIPr UK®, based on the American SCIP–R, stands for Positive Range of Options to Avoid Crisis and use Therapy, Strategies for Crisis Intervention and Prevention revised for the UK with trademark of Marion Cornick – former principal of the Loddon School. The PROACT SCIPr UK® program supports the Loddon School philosophy based on positive programming. The SCIPr strategies provide an alternative to other methods available in England. The Loddon School was established in 1988 by Marion and Tim Cornick. There were no other specialized provisions in the south of England for children with serious disabilities associated with autism. The Loddon School is a home and school for 27 pupils who have severe and complex learning difficulties. Many pupils have additional disabilities such as epilepsy, blindness, brain damage, extreme hyperactivity. Most of them pose challenging behaviors, including violence to others, self–injury, damage to the environment, extreme disruption, severe stereotyped behaviors, social unawareness and communication difficulties. It is the intent of the PROACT SCIPr UK® to minimise the use of physical interventions and to emphasize sound behavioral support strategies based upon an individual's needs, characteristics, and preferences. The SCIPr UK® is 'a whole approach' designed to help pupils and service users by providing positive behavior supports. The underpinning philosophy of the PROACT SCIPr UK® is based on the following principle, developed by the New York State OMRDD: *The purpose of our behavior is to get our needs met (People do Matter. There is no Excuse for Abuse)* (Cornick, 2005). The Loddon School provides training to all caregivers through three courses (introductory course, foundation course, and instructor course) accredited by the BILD (*British Institute of Learning Disabilities*) Code of Practice for Trainers in the Use of Physical Interventions. Marion Cornick and Janet Bromley from the Loddon School are master trainers for the PROACT SCIPr UK® training in the UK. One of the main goals of the PROACT SCIPr UK® training is to improve the quality of life for the individual by providing staff with the necessary skills and information to provide a therapeutic environment. The other goals are to increase the competences and confidence of all those who manage crisis situations as well as to develop a proactive approach to the management of a crisis. The basis of the PROACT SCIPr UK® is very similar to the SCIP–R developed in America. Because of the fact that PROACT SCIPr UK® is a continuously evolving program, there are some differences between the above programs. However they do not cause significant changes in the overall perception of the whole SCIP concept.

Conclusion
It seems that about one-third of the UK organizations do not have written policies for the use of physical intervention (Murphy et al, 2003). Due to such worrying fact the above paper provides an opportunity for all social workers to get acquainted with one of the methods of coping with challenging behaviors, which has been accredited by the British Institute of Learning Disabilities.
The reason for writing this paper was to present one of the numerous, current proposals in the system of care of individuals with intellectual disabilities and challenging behaviors as well as the preferred method of using physical intervention as a last resort. The paper outlines only the most significant key points of the SCIP–R intervention-related to provide an overview for the reader. Thus, it does not exhaust or describe all intervention details.

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