Chapter 21

Promoting Resolution And Safety: A Case Study Example

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Introduction

The prevalence of emotional and behavioural difficulties in children and adolescents with intellectual disability has been reported to be between 30-50 % (Einfeld & Tonge, 1996b; Molteno, Molteno, Finchilescu, & Dawes, 2001). These difficulties may present in various ways including emotional outbursts, physical aggression, property damage, and self injury. Regardless of these differences in presentation and/or underlying causality, the issue of risk and risk management is inherent in each.

Risk is described as action(s) that jeopardise something of value (Reber, 1995). There are risks of physical harm to the child or young person, to others, and to the environment. There are also risks of harm to relationships and the emotional/psychological wellbeing of those involved including feelings of anger, resentment, sadness, and the potential for longer term development of mood or anxiety disorders, and disrupted attachment (Nugent, 2005). All of these risks necessitate careful consideration and response.

The challenge of balancing risk management with quality of life and least restrictive, least intrusive care is one which must be carefully negotiated. Risk management is of particular importance during crisis, when the child's emotional or behavioural difficulties are at their most extreme. Reber (1995) described crisis as a condition of instability or danger; a dramatic emotional or circumstantial upheaval; a point at which sudden change occurs, leading to sudden improvement or further deterioration of a situation. At these times, the goal is simply to promote safety and the resolution of the crisis situation. Crisis management strategies, also known as *reactive strategies* or *situational management strategies* are developed to achieve this end. While they may be devised to stand alone, crisis management strategies are more

commonly developed as part of a broader approach. They are necessary for as long as it takes for the proactive components of a plan to show some benefit. As Osgood (2004) states, ‘Reactive strategies are not aimed at teaching, but at stopping things with dignity and safety, so because they are not inherently constructive, they must never be used on their own but alongside proactive interventions’ (p. 6).

The case study example that follows illustrates the benefits of a multidisciplinary approach to the management of crisis and the risks associated with it. It highlights how the varied perspectives of members of a team can collectively offer useful insight in shaping a more holistic intervention for a child with complex needs.

Case Study: John

John is 12 years old and has a moderate intellectual disability and Autism Spectrum Disorder (ASD). He is highly mobile, is 135cm tall and weighs 64kg. While John has a few spoken words, his primary means of communication is key word sign and natural gesture. He also uses photographs and pictographs at school.

John lives in the inner city with his mother, Marnie, and his younger sister Olivia, who is 4 years old. The family has no contact with John’s father, who left the family home soon after Olivia was born. Marnie says that being a single mother is stressful and finds that no matter how much time and attention she gives John, he seems to need more. Marnie reports feeling frightened of John when he is in a rage and worries about Olivia’s safety. She also reports feeling concerned about how much damage John might do as he gets bigger and stronger. Marnie recently told her disability case manager that she didn’t know how long she could keep caring for John and wondered whether someone else might do a better job.

For the past two years, John has been receiving increasing amounts of care at a children's respite unit. The family's allocation is now Monday to Wednesday each week and one weekend per month. John is in Year 6 at a special school, 15 minutes from home.

All settings are finding it difficult to manage John's challenging behaviours. These challenging behaviours are described as,

- Screaming and crying;
- Hitting, pinching, and pulling hair of adults and other children;
- Eye gouging of other children causing injury;
- Grabbing at reading glasses being worn by adults and children; and
- Breaking and throwing objects.

Sometimes there will be a slow escalation of John's agitation and arousal. At other times, John will appear to move rapidly from a relatively calm state to crisis. John will sometimes use several of the listed behaviours in combination, or he will use one in isolation.

In the respite unit, John prefers to interact with staff rather than peers. When other children attempt to interact with him, they are usually ignored or hit by John. Staff are worried about the risk that John poses to other children, particularly those he has targeted before. It can be difficult to predict whom John will attack, but children who seem frightened, move slowly, or who wear glasses are more vulnerable. Staff have noticed that John seems bothered by children who squeal or cry. The respite unit manager is liaising with the disability case manager about which children requiring respite care are compatible with John.

At school, John has similar difficulties with peers, particularly in the playground. He requires close supervision around other children at all times. Assaults on peers and staff have led to two previous (2-day) suspensions from school. These suspensions complicate the respite situation, as the unit is not staffed during the day and cannot provide support to John. This means that John returns home and spends the days he is excluded from school with Marnie.

John becomes stressed when there are changes to his routine, such as staff changes at respite, school holidays, his teacher's aide being away, medical appointments, and school transport being late. John finds it easiest to manage his behaviour when boundaries and limits are clear. John becomes concerned when he is told 'no', or is punished or criticised.

John likes to be busy and enjoys cooking, watching selected DVDs (e.g., Ice Age), and activities involving drawing. He particularly likes drawing with chalk on the driveway. John enjoys outdoor activities such as going for a drive, walking, shopping, and riding the three-wheel bike. At the respite unit, John is happy to participate in household activities such as setting the table (placemats), hanging out the washing, and making his bed (pulling up the doona). John highly values positive feedback and enjoys sharing the news of his day at school. He loves to show off his merit awards and stickers for work well done.

The Support System

[Insert Figure 21.1 here]

Perspectives Of The Presenting Issues

Each person in John's family and service system is affected differently by his challenging behaviour. Socio/genograms (see Figure 21.1) help bring all the key elements of John's network into view. Each has a different role and set of responsibilities in relation to John's development and behavioural support. Perceptions will have been shaped by each person's understanding of John (based on assessment information and their experience of him), their own social history, their professional background or discipline, their role in the case, and their relationship(s) with others in the system. While it would be impossible to represent the entire range of insights generated by those in a system such as John's, a summary of the various perspectives makes a useful foundation for the exploration of a response/reactive strategy.

John's Perspective

When John went to school a few weeks ago and found that his teacher was away sick, he became very upset. His routine was different and he didn't get to clean the board or help take books to the library. When the casual teacher told John he needed to stop drawing and come to circle time, he began to scream, picking up his chair, and throwing it. He continued to escalate, throwing himself on the floor, and kicking out at peers. The others in the class had to be removed to the playground. While the teacher's aide was trying to prevent John from striking another child, he managed to forcibly pull her glasses off and strike her in the face.

After taking John home, at the request of the school, Marnie asked John about the incident. He shrugged his shoulders and walked away. Further attempts to discuss the issue only led to him crying and pinching his sister, so Marnie decided not to discuss

the event further with John. It was only later that she realised that John's teacher had been away and that he'd probably found the change of routine confusing and unsettling.

Marnie's Perspective (Mum)

Marnie explained that she is 'living in constant fear that John will go off'. She worries about Olivia being so much smaller and so vulnerable. She worries that John doesn't know his own strength and that one day he will really hurt either Olivia or herself. Marnie also worries about her ability to manage John's behaviours. She realises that, as John's behaviour escalates, she finds herself winding up too. After smacking John on one occasion, Marnie recalls the tremendous guilt and distress she felt. She didn't want to smack John - she just wanted him to stop. The potential for her to lose control again scares Marnie and she has started to doubt whether she can give John the care he needs. Marnie understands that John's ability to cope and her own ability to cope are intertwined. This dynamic is discussed by the psychologist at a later point in the chapter.

The Respite Team's Perspective

The issues raised by staff working in the respite setting suggest a growing apprehension about working with John. Although most of the team have several years experience in the field, there has been animated discussion at team meetings about the risks involved in managing John, particularly when the male staff are not on duty. Staff report being fearful that John will 'go off' at any moment and are worried that another child, a staff person, or John himself will be hurt.

Team members report trying a range of approaches and strategies to diffuse escalating behaviour. There is little consistency in their responses to crisis. Some feel strongly that John should be punished for attacking others and breaking items around the house. They believe consequences should be applied to John's actions as a way of teaching him that he can't hurt others or damage things that don't belong to him. Some of the suggestions include exclusion from swimming on Saturday mornings and no DVDs after dinner. These staff feel that 'if John is given an inch, he'll take a mile', in other words, that he'll learn that he can get away with unacceptable behaviour.

Other support staff believe that the challenging behaviour is John's way of telling them that his needs are not being met. They feel that the team should work to understand and enable him, rather than punish him. They are concerned that attempts to restrict his lifestyle might exacerbate the challenging behaviour and lead to further punishment. Some staff are worried that John has only limited control of his behaviour when he is highly agitated and feel that he needs more support to calm himself; they also doubt that John will connect the behaviour to the punishment.

This team clearly needs assistance to develop a consistent approach to the management of John's challenging behaviour. It is likely that team members will need opportunity to discuss and debate the strategies included in the response plan, to ensure that they understand the strengths and weaknesses of the various options, and commit to implementing them as prescribed. The strategies should be designed in a way that ensures the least confident, least powerful staff member can implement them, as this will promote consistent implementation. Staff will require training and opportunities to practise the new procedures. Given the stressful nature of shifts, the team will need regular opportunities to reflect on events and progress, vent and de-brief.

The Respite Manager's Perspective

The manager of the respite unit has become increasingly concerned about the risk of injury to children and staff. She recognises that staff are finding their shifts stressful and demanding. The families of two children who regularly access respite with John have asked that their respite allocation be changed as they are not confident their children be kept safe if John's stay coincides with their children's.

In processing leave forms, the manager has noticed a significant increase in the amount of leave taken by several staff. She wonders whether these leave patterns and the stress generated by John's behaviour are linked. Vacant shifts are becoming difficult to fill as casual staff are reluctant to work in the unit. Her greater concern is that staff employed at the house will resign and that staff turnover will become an issue.

Incident Reports are being filled out as required, though the language in some accounts has become emotive. Staff describe John's behaviour as 'vicious' and 'manipulating'. The manager suspects that some staff are personalising John's behaviour and are finding it difficult to feel positive about working with him. She recognises the need to maintain team meetings and thinks that staff might also benefit from de-briefing sessions. The manager is keen to have the respite team participate in any training offered by the psychologist and therapists, and is happy to liaise with the family and school.

The Paediatric Psychiatrist's Perspective

Referral to a paediatric psychiatrist was made by John's paediatrician. The paediatrician cited challenging behaviour as the primary reason for the referral and queried the

potential usefulness of PRN medication (pro re nata – according to circumstances) as part of the overall response to John's situation.

Following consultation, both doctors agreed that there were problems in medicating John's aggression for a number of reasons. Firstly, medication for aggression itself is seldom helpful. The value of oral PRN medication is limited by the time it takes to be digested and reach the blood stream (approximately 50 minutes). However, the two practitioners noted that PRN is sometimes helpful in anticipation of stressful situations, particularly to reduce the need for a regular medication that might have a problematic side effect (e.g., weight gain from increased appetite).

The psychiatrist described the necessity to check for a psychiatric disorder or vulnerability that might predispose John to aggression and the loss of emotional regulation. The psychiatrist reflected that aggression that is intentionally malicious seldom responds to medication; but that intellectually disabled young people, such as John, do not generally have capacity for malevolent intent or moral judgement of behaviour. Accordingly, John's aggression is expected to be affect-driven and likely to have associated developmental or mental disorders.

The two practitioners confirmed that John's profile and history indicate an Autistic Spectrum Disorder (ASD). They explored the possibility that aggression due to intense stereotypic behaviour or thinking might be helped by selective serotonin re-uptake inhibitors (SSRI) anti depressants. Also, given John's ASD diagnosis, the 50% chance of co-morbid Attention Deficit Hyperactive Disorder (ADHD) and its associated vulnerabilities (non compliance and anger dysregulation) should be considered as a focus for treatment (Bradley & Isaacs, 2006).

The doctors discussed pharmacological options, including trials of stimulants, daytime clonidine, anti depressants that benefit ADHD (e.g. Amitriptyline, Mirtazapine or Strattera), atypical antipsychotics (e.g., Risperidone, Olanzapine, Aripiprazole), and perhaps conventional antipsychotics. Unstable or labile mood, which some psychiatrists compare with Bipolar Disorders or Cyclothymia, might benefit from mood stabilisers such as carbamazepine, sodium valproate and lithium carbonate. Other medications such as beta adrenergic blockers could help with affectively driven aggression, as could antipsychotics.

The two agreed that it is always important to look carefully for evidence of depression, Panic Disorder, Post Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), Generalised Anxiety Disorder (GAD) and psychotic disorders. Dissociation is seldom a good target for medication. Organic mental states causing acute confusion or cognitive decline need consideration. In pharmacological treatment of those with intellectual difficulty there may be less frequent positive results and more frequent side effects from medications such as stimulants. This necessitates caution - starting low and going slow, and being available to consider side effects if they arise. Often, more than one co-morbid mental health disorder may be present and more than one medication may be required, with due caution about interactions and side effects. Finding an optimal medication regime may take patient trialling of drugs in sequence. This is best done in the patient's normal environment and seldom can a hospital in-patient admission be used for this purpose (Bhaumik & Branford, 2008; Dossetor, 2003; Lask, Taylor, & Nunn, 2003).

The consultation excluded evidence of major psychiatric disorder. The paediatrician and psychiatrist agreed to trial Amitriptyline in response to John's long

standing features of ADHD; this decision was made in the hope that the medication might make John more receptive to other interventions. As some outbursts were lasting for up two hours, the psychiatrist made PRN Risperidone available, in an attempt to reduce the risk of injury to John and others. The psychiatrist agreed to liaise with the psychologist in documenting a PRN protocol for inclusion in the reactive strategy, as part of the broader Behaviour Support Plan.

The psychiatrist flagged one last concern - in a situation such as this, there is a high risk that Marnie will be suffering an anxiety or depressive disorder requiring assessment and treatment. Attention to this possibility is critical for both John and Marnie as it determines, to a great extent, Marnie's capacity for warmth, responsiveness and affective regulation.

The Teacher's Perspective

The primary concerns raised by John's teacher and the school principal were those of safety and duty of care - the difficulty of managing John's behaviour while ensuring the safety of other students, staff, and John. In the past, the school has resorted to suspending him from school but staff feel that previous suspensions have only served to exacerbate the problem on his return to the classroom. Staff see John's potential and want to support him in developing skills for life.

In their endeavour to find a way to manage the presenting risks in the school environment, John's school made a number of important discoveries. The teacher observed that giving John errands when he appeared to be escalating (such as returning some heavy books to the library) was helpful in averting crises. During crisis, however, she felt John was virtually impossible to redirect – *'He just gets so worked up. It's like*

he can't hear you'. So, rather than focusing on John at these times, John's teacher redirected her attention to helping the other students remain safe and protecting the physical environment.

When John began to escalate, the teacher's aide began to calmly evacuate the five other students from the classroom and engage them in outdoor activities. Inside the classroom, John's teacher would calmly and quietly move around the room, removing potential missiles, pulling down blinds to protect windows, and pushing desks against a vulnerable gyprock wall. At times she would try to explain to John that she needed him to calm down and that she was wanted him to stay safe. However, this rarely seemed to help. John would grab at her hair and attempt to pull her glasses from her face, so for the most part, she would give him space.

These strategies were particularly helpful when they could see John's behaviour gradually escalating. However, on some occasions he seemed to move from being calm to a crisis state in a matter of seconds. In these scenarios the school felt at a loss. Several of the students had mobility issues and therefore the process of evacuating them from the classroom was slow. There was insufficient time when John escalated quickly. John's teacher wondered why John could be so volatile and what could be done to manage the risks at these times.

The Psychologist's Perspective

The psychologist involved expressed concerns regarding John's emotional reactivity, with relatively small things triggering rapid escalation and 'fight or flight' behaviours. In considering the stress response system, the psychologist hypothesised that changes in brain and physiological functioning during crisis could explain part of John's presenting

difficulties. When John perceives a situation as threatening, an alarm is sent to his hypothalamus which activates his sympathetic nervous system. Hormones such as adrenaline, noradrenaline, and cortisol are released and a range of bodily responses are triggered, including increased heart and respiration rate, dilated pupils, increased sweating, and increased blood clotting ability (Benson, 2000; Davis, Eshelman, & McKay, 2000; Kalat, 2009). This short-term, survival-oriented response prepares John's body to mobilise, hence enabling the individual to either confront or flee from the perceived source of danger (whether real or imagined). In John's case, this hyper-arousal might present as an assault on a peer or running from the classroom after being brushed against or touched unexpectedly.

Changes in John's brain activity also occur at these times, as blood is redirected away from the cerebral cortex to more primitive and survival-oriented parts of the brain (Perry & Szalavitz, 2006). This means that during crisis (i.e., when in a state of hyper-arousal) John has reduced capacity for higher order reasoning, abstract thinking, and problem solving (see Figure 21.2). Not surprisingly then, crisis is not the optimal time for teaching new skills. The focus must be resolution and promotion of safety. The strategies employed during crisis must take into account John's reduced capacity for planning and reasoning.

[Insert Figure 21.2 here]

Additionally, the psychologist also wondered whether any parallel processes were occurring. After reflecting on how John's challenging behaviour had impacted on her own levels of arousal during a home visit, she wondered whether a stress response

was simultaneously being triggered in others. John is not the only person experiencing a crisis situation, but his mother, teacher, carers, peers, and clinicians do as well. As illustrated in Figure 21.3, it is reasonable to suggest that during crisis, changes in the caregiver's behaviour, physiology, emotions, and cognitions, albeit to varying degrees, can be expected. This led the psychologist to realise that the reactive strategy component of John's multi-element behaviour support plan would need to be tailored to both the interactive and parallel processes occurring between John and his caregivers (and/or peers) during crises.

[Insert Figure 21.3 here]

The Speech Pathologist's Perspective

After observing John at school and home, the speech pathologist was particularly interested in the amount of information given to John during crisis and how this was communicated. For example, when John was screaming and attempting to hit others, it was common for adults to say, *'John, no hitting. I can see you're mad but it's not nice to hit. You need to calm down. I'm going to give you a break. I'll come back when you have calmed down. Ok?'* While the content of this information was respectful, reasonable, and usually augmented with key word sign and gesture, John still appeared to escalate. In fact, John often became more confused and agitated. Verbal support just didn't seem to help in diffusing crises. In trying to help John those supporting him seemed to be making things worse.

Drawing on the information presented in Figure 21.2, the speech pathologist suggested that John's capacity to comprehend and process language was being

compromised during crisis. Similarly, his ability to produce speech, or formulate a response, would be significantly reduced compared to his typical communication skills (i.e., when calm at baseline) (Cross, 2004). As the regions of the brain involved in language are located in the cerebral cortex (i.e., Broca's area, Wernicke's area, and the primary auditory cortex), they become increasingly inhibited as the intensity and/or duration of the perceived threat increases. As previously discussed, this is due to a redirection of blood flow to the more primitive centres of the brain which focus on safety and survival.

Thus, the amount of information conveyed during crisis should be limited and draw on the individual's communication strengths. In John's case, his proficiency in key word sign means that this is the most helpful mode of communication for others to use as his behaviour and level of emotional arousal escalates. At the peak of a crisis, however, the absence of communication and interactions with others might actually assist in promoting resolution and safety.

The speech pathologist also highlighted that the use of challenging behaviour during crisis might be John's way of telling others something about his needs, e.g., 'this is what I want or don't want to happen' (Emerson, 2000; Gardner, 2002; Prendergast, 2000). Understanding this communicative intent and ensuring that John's communication partners have a good understanding of his skills is essential to enhance everyday interactions, to respond to early indicators of distress, and ultimately to reduce the risk of incidents of challenging behaviour. The speech pathologist wondered how skilled John's communication partners were in using his augmentative communication strategies and whether they might benefit from additional training. She recognised the importance of consistent use of strategies across environments.

The Occupational Therapist's Perspective

After observing John in the classroom and school playground, the occupational therapist (OT) suspected that an underlying sensory processing disorder may be contributing to John's emotional and behavioural difficulties. Further assessment revealed that John is hypersensitive to light touch and noise (Brown & Dunn, 2002) which are considered to be sensory and arousal modulation problems. This means that John experiences this type of sensory information as distressing. The OT was interested in John's level of arousal which contributed to his heightened emotional state. She considered arousal in a functional way and described it as a state of alertness that matched the environmental and task demands for the child. She noticed John was frequently hyper or highly aroused which interferes with his ability to remain calm, attend, learn, and participate in daily activities (Kimball, 1999). In the classroom, these difficulties may present as difficulty screening out irrelevant information, high levels of distractibility, poor levels of work completion, and rapid behavioural escalation or overreaction when touched by others and/or exposed to high pitched and loud noises (e.g., kids squealing in the playground). It is important to note that heightened arousal (hyper arousal) is associated with the activation of the sympathetic nervous system ,i.e., the fight, flight, freeze response as previously discussed (Kimball, 1999).

The OT also identified John's processing of visual information as an area of personal strength. Thus visual support strategies could be very helpful in communicating information and teaching him new skills. Firm pressure (which is the proprioceptive sense in action) was also found to be very calming and organising for John. This could partly explain the enjoyment he receives from completing 'heavy work

activities' such as helping to hang out the washing, pushing the trolley at the shops and riding his bike. This type of sensory input assists John to maintain an optimal level of calmness, to interact with others and to participate in activities.

As previously discussed (see Figure 21.2), the cognitive processing capabilities of the brain alter during crisis. The parts of the brain which remain in working order play a significant role in the processing of sensory-based information. Therefore sensory-oriented strategies, such as visual, firm pressure or proprioceptive input in John's case can be effective intervention options at these times. That said, John would need to be taught these strategies systematically when he is calm rather than in the midst of a crisis situation. Finally, the OT acknowledged the need to build sensory-based activities (sensory diet) into John's routine so that he receives the necessary input to assist him in modulating his level of arousal and to be calm enough to attend to lessons in the classroom, and develop prosocial skills.

The Disability Case Manager's Perspective

The disability case manager has established a relationship with Marnie and John over 18 months. During this time she has watched John increase in size and strength, and frighten Marnie with his aggressive outbursts. She is concerned that Marnie has begun making statements about John living outside the home. The case manager isn't sure whether this stems more from Marnie's genuine fear for Olivia's safety, as well as her own, or her loss of confidence in managing John. She suspects it is a combination of both. The case manager is aware that there is no support provided by extended family and that Marnie has become increasingly isolated from her social network as John has become more difficult to take out. Thus, the centre-based respite is critical.

The case manager is aware of the requirement to make a report to child protection services due to Olivia being at risk of harm from John. John too may become homeless should Marnie cease to cope. She knows this will mean an open discussion with Marnie about the mandatory reporting responsibilities in relation to child protection issues and her intention to do everything possible to keep the family safe and intact. The case manager is also conscious of the number of service providers involved with John and his family, and is very keen that all services work collaboratively. She realises that she has a key role in bringing everyone together.

Multi-Disciplinary Collaboration

The case manager's concern for the safety of Marnie and Olivia prompted her to contact other service providers and suggest a meeting in order to develop a standard response to critical incidents. All agreed it was important to involve Marnie.

The Agenda For The Meeting

The group came together and included Marnie, the case manager, the respite unit manager, a support worker from the respite unit, John's teacher, the psychologist, the speech pathologist, and occupational therapist. John's paediatric psychiatrist offered to provide feedback on the approach developed in the meeting. After some initial information sharing regarding the current situation, the group set about verifying what the behaviour(s) of concern looked like in each context. With the behaviour described, they then planned to pool their ideas about critical inclusions in the reactive strategy, collectively develop the strategy, and a means of monitoring its implementation.

Defining The Behaviour

The group developed a working definition of the behaviour. Participants did this in a way that would assist them in measuring the behaviour and identifying points for intervention. This portion of the meeting was led by the psychologist, who drew on the collective knowledge of the group to map John's escalation cycle, including early warning signs of difficulties, escalation, crisis, de-escalation, and recovery (see Figure 21.4).

[Insert Figure 21.4 here]

[Insert Table 21.1 here]

Drawing On The Insights Of All Involved:

The whiteboard summary of issues and ideas for the development of a strategy (as drawn from individual perspectives) is summarised in Table 21.2.

[Insert Table 21.2 here]

Development Of The Strategies

The group discussed the various strategy options and their potential usefulness as part of the reactive strategy. Each was examined in terms of its strengths and weaknesses. This discussion was influenced by the understanding that responses needed to be individualised to meet the needs, abilities, and resources of both John and those supporting him. The group realised that the strategies selected would be most robust if they were viable for the smallest, least confident, and least experienced implementer.

Additionally, all agreed that according to the policies of all agencies represented, strategies needed to be

- Focussed on ending the crisis as quickly and safely as possible;
- Legal and ethical (e.g. all necessary consents and approvals obtained);
- Represent the least intrusive, least restrictive options available at the time. This does not preclude the implementation of strategies that are significantly restrictive if a potentially dangerous situation requires it (e.g. physical restraint, support from emergency services, acute care admission) (Hassiotis, Barron, & Hall, 2009);
- Respectful of the dignity of all involved; and
- Realistic given the resources available, i.e., physical, financial, and emotional resources.

The group debated and agreed on a response, and then recorded it below the escalation cycle already mapped on the board (see Table 21.1). In recognition of the importance of keeping the support mechanisms in optimal order, they also on agreed on response strategies for those managing the crises. These decisions were also mapped onto the escalation cycle, given the likelihood that a parallel process of escalation might happen for those trying to manage the situation (see Table 21.1).

Outcomes

At a recent case review, all agreed that forming collaborative partnerships across John's support system was an essential first step in better understanding John and the risks associated with his challenging behaviour. This collaboration also underpinned the design and implementation of the agreed reactive strategies to support John during crisis. The implementation and revision of John's individualised behaviour support plan

over time has also led to significant improvements in John's emotional and behavioural wellbeing. The number of reported incidents has reduced significantly across settings and, generally speaking, incidents are of shorter duration and are less severe. John's participation in his daily routines and his interactions with others are continuing to improve.

Marnie reports that she is no longer *'just trying to survive the day'* but is enjoying spending time with John and is feeling positive about life for all family members. John will start high school in the next year and his current school has commenced transition planning in partnership with John and Marnie. Staff report feeling less apprehensive about working with John and also confirm feeling better prepared to support John during crisis. While crises occur from time to time, the impact on John and those around him has reduced. Consequently, his relationships with others have improved.

A Last Thought

The notion of early intervention and prevention is central to a positive approach to challenging behaviour and the promotion of emotional wellbeing in children and adolescents with intellectual disability. The emphasis is on system-wide change and prevention through the management of environments rather than people (Sigafoos, Arthur, & O'Reilly, 2003). In effect, the quality of life of the child/adolescent with an intellectual disability is enhanced through early intervention. In John's case, without the development and implementation of positive supports, and proactive/preventative interventions, the underlying function of his presenting difficulties would not have been

identified, nor addressed. The positive outcomes achieved reflect the joint efforts of John’s support system and the broader intervention strategies applied system-wide.

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Table 21.1

Reactive Strategies

	Phase I	Phase II	Phase III	Phase IV	Phase V
Child focused	▪ Make eye contact with John. Call his name. ▪ Re-direct John to his routine or a job that provides calming sensory input (see list on file). ▪ Provide descriptive praise if he engages in his routine or job.	*1st staff person:* ▪ Reduce stimuli, e.g., turn off music, pull down blinds or turn down lights. ▪ Remove unnecessary demands. ▪ Reduce 'talk'. Use simple language augmented with keyword sign.	▪ Supervise and monitor from a safe distance. ▪ Remain available. ▪ Prompt John to use soothing and calming sensory based strategies or techniques (which have been taught to him when calm).	▪ Allow him some space and time to rest – direct him to his beanbag.	▪ Allow him to restore his relationship with you. ▪ Re-direct to his routine and praise attempts to participate. ▪ Gradually increase level of stimuli and demands. ▪ Move on.

- Draw his attention to his increasing arousal, e.g., *'John, I can see your engine is really revving, what's up?'*
- Attempt to resolve the issue by naming the problem & exploring options.
- Remind him of the rules/rewards.
- Allow him some extra time to respond.
- Provide low-key positive feedback if John attempts to calm himself, e.g., *'Good John, you're slowing down'* or a smile.
- Consider administration of PRN (as per protocol).

2nd staff person:

- Discretely remove others from area.
- Remove objects that

		could be used as missiles.			
Carer focused	▪ Check readiness for action. Consider clothing, shoes and hair. ▪ Be calm and confident or 'fake it'. ▪ Alert the 2nd staff person discretely that there has been some escalation in behaviour. Agree who will manage the	▪ Scan the environment for risks. ▪ Be aware of your physical positioning within a room, e.g., access to exits etc. ▪ Be aware of tone of voice and body language. ▪ Be aware of your own fight or flight response. Use	▪ Prioritise own safety. Maintain a safe distance while monitoring John. ▪ Tag team through this period if 1st staff person needs a break. ▪ Implement evasion and break-away techniques, as trained.	▪ Continue to tag team supporting John, as required.	▪ Report and record the event. ▪ Provide feedback about the efficiency of the strategies. ▪ Seek debriefing or additional support if necessary.

situation.	calming strategies as required.

Table 21.2

Summary Of Issues And Proposed Strategies

Issues and Ideas	Implications for the Reactive Strategies
Managing John's hypersensitivity to light (gentle) touch and noise.	Physical intervention likely to be unhelpful. Decrease arousal by turning off lights, pulling down blinds or closing curtains, turning down/off music, offering reassurance using an even and low tone, e.g., 'You're safe', offering a weighted blanket.
Helping John to recognise his escalating arousal.	Use a child-chosen metaphor in the very early stages of escalation, e.g., 'John you're like a fast horse now, its time for ...'
Providing John with information and support regarding change.	Try to recognise growing agitation as soon as possible and provide information that might help resolve the issue for John. Use key word sign to provide information.
Promoting the safety of John, family, peers, and staff.	Consider PRN at height of crisis. Remove others, as to remove John is likely to fuel his agitation and increase risk. Ensure appropriate clothing and footwear; limit jewellery.

	Teach self-protection strategies as part of the broader plan.
Emotional reactivity of Marnie and staff.	Be aware of any parallel escalation process - use tag team, de-briefing.
Modifying the physical environment to reduce risk.	Move or secure anything that can be thrown, tipped over, or smashed. Maintain a safe physical distance (to prevent John reaching for the glasses). Provide a door behind which family/staff can withdraw. Ensure garden is securely fenced to prevent John running off in a distressed state.
Responding to John's reduced capacity for higher order reasoning, abstract thinking, or problem solving during crisis.	Reduce demands and expectations.
Responding to John's reduced capacity to process and understand verbal language.	Reduce complexity and quantity of ***verbal*** support. Explore use of a small number of critical key word signs and natural gestures. Remain aware of body language and tone – stay available, at a safe distance, and present as calmly as possible.
Respond positively to John's attempts to	Provide low-key positive feedback - a

calm himself.	smile, a gentle ‘Good John, you’re slowing down’.
Assisting John’s recovery (and preventing re-escalation).	Allow John to rest briefly if he appears exhausted post-incident. As soon as reasonable, re-orient John by encouraging him to re-engage in activities according to his scheduled routine.
Addressing the confidence issues of family and staff.	Training, provide opportunities for practise, opportunities to review progress, and to modify strategies. Use accurate reporting/recording to enable the review of the strategies.
Teaching opportunities outside crises; ensuring best possible match between John and his environment.	Integration of the above into a broader multi-element plan.

Figure 21.1

John's Support System

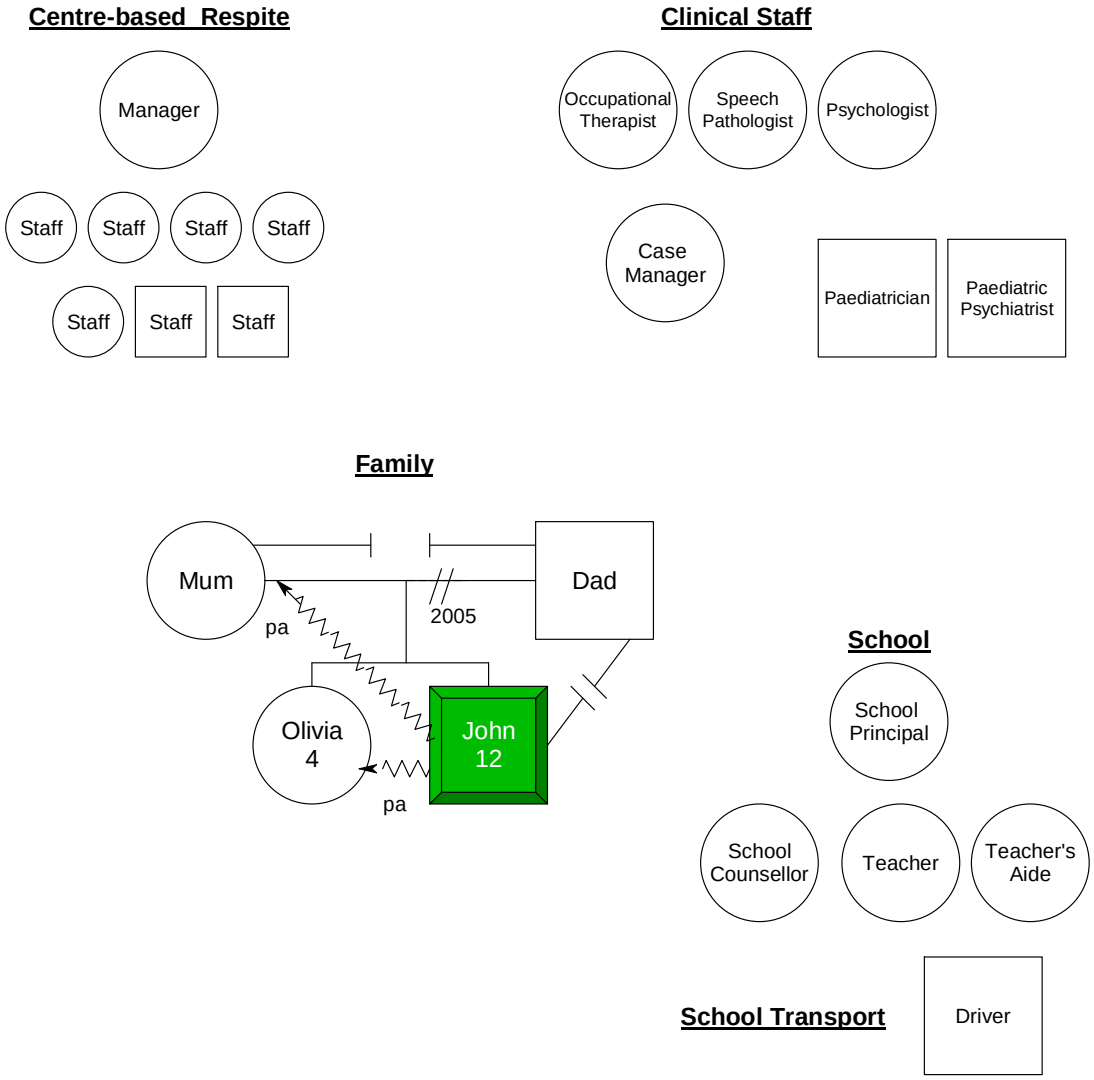
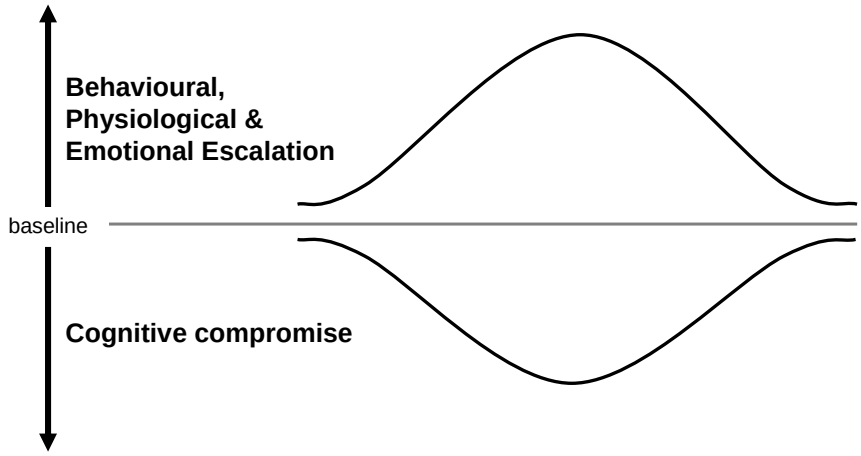


Figure 21.2

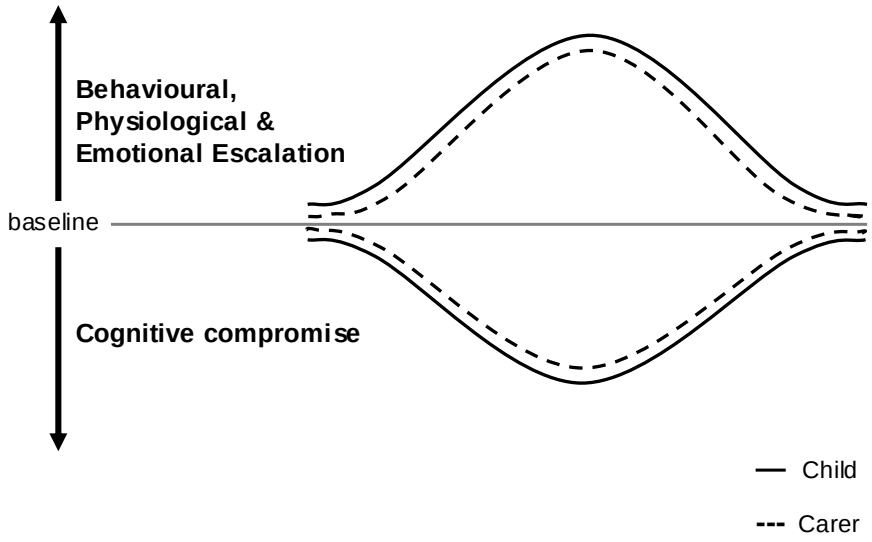
Behavioural, Physiological, Emotional And Cognitive Changes Across The Crisis Cycle



Source: Adapted from Holden et al. (2001).

Figure 21.3

Parallel Processes Between Child And Caregiver Across The Crisis Cycle



Source: Adapted from Holden et al. (2001).

Figure 21.4

Summary Of Crisis Management Strategy