SAFETY TRAINING CURRICULUM
CD 3–Part 5

Working with Developmentally Disabled Individuals

Presented by: The University of Washington,
The Department of Social and Health Services,
The Washington Institute of Mental Health Research and Training.

About This Training

This training is about how to work with developmentally disabled individuals in a manner that keeps you and them safe.

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We gratefully acknowledge their contributions.

DISCLAIMER

Although the information in this presentation has been tested through years of clinical practice, it is not enough to simply repeat what you see here in rote fashion. As professionals, you have the responsibility to assess the situation and the person you are dealing with to best determine how to create a peaceful resolution, or barring that, as safe an outcome as is possible.

Pre-requisites

Clinical Skills (risk assessment, treatment planning)
Centering – Maintaining Self-Control
De-escalation Skills
Personal Safety Techniques

Although this presentation is directed toward mental health staff working with developmentally disabled individuals, there should be no assumption that, just because someone has a diagnosis of developmental disability, that he or she presents a heightened risk of danger.

Danger is defined by behavior, not by diagnostic categorization.

LEARNING OBJECTIVES

Upon completion of this training you will:

1. Understand the practical effects of developmental disabilities and how the disability might “overshadow” other concerns
2. Know how to recognize the underlying causes or environmental triggers of aggression
3. Know how to communicate with and de-escalate developmentally disabled clients
4. Understand how and why to conduct a functional assessment
Opportunities to reflect. Chances to talk with your colleagues
Aim High TOGETHER

INTRODUCTION

CONTENT

1. About developmental disabilities
2. Aggression and developmental disabilities
3. General communication strategies
4. De-escalation strategies
5. Functional assessment

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There is no prototypical individual with developmental disabilities

Wide variety exists with regard to:
- Cognitive abilities
- Communication abilities
- Social understanding
- Physical abilities
- Etc.

Practical effects of developmental disabilities may include:

Decreased communication abilities:
- Receptive abilities may exceed expressive abilities.
- Person may use signs or non-vocal means to communicate.

Limitations in judgment or knowledge.
Limited performance abilities.
An excessive desire to please others.
Cognitive delay in response to instructions and/or questions.
Practical effects of developmental disabilities may also include:

“Overshadowing” of mental illness symptoms.
“Overshadowing” of substance abuse problems.
“Overshadowing” of medical symptoms.

EPIDEMIOLOGY STATISTICS

An estimated 20 to 30% of all persons with developmental disabilities have a psychiatric disorder as well:

Number 1: Depression and anxiety disorders
Number 2: Post-traumatic stress disorder
Number 3: Other mood disorders
1 to 2% have schizophrenia spectrum disorders.

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Most common reasons for psychiatric referrals are:

Acts of violence
Aggression
Severe property destruction

Why is this person resorting to aggression?

The challenge: determining the cause

Looking at the person and not resorting to quick assumptions about individuals who are developmentally disabled.
Understanding that the person is in distress and trying to express a need.
Being mindful of the possible complexities in diagnosing.
Being thorough.
Being good at recognizing nonverbal signs of distress.

The same behaviors in the same person can mean something different every time it happens.

Dr. Ruth Ryan
The Cycle of Aggression

- Baseline exaggerations
- Subtle signs of agitation
- Behaviors that are not typical for that person

Early intervention

“Out-of-control behaviors or violence do not happen out of the blue, but are as predictable as water coming to a boil.”

Pay close attention to:

- Baseline exaggerations
- Subtle signs of agitation
- Behaviors that are not typical for that person

Determining the underlying condition and trigger for the agitation calls for your astuteness and thoroughness

The clients may:

- Admit to things that they do not experience in order to please you.
- Try to hide their disability to appear more competent.
- May have been coerced by a person with higher abilities.
- May answer questions that they do not fully understand.
- May tell you what they think you want to hear.

Non-psychiatric medical problems are often the underlying condition.

Check for possible victimization.

Evaluate for depression, anxiety.

Consider the presence of phobias.

What else?

Your resources:

Caregiver or family member


Trainings and consultations at your regional DD office

See attached articles.

* Handout Available
You probably know what it feels like to be uncomfortable and frustrated because you can’t do anything about it. Now brainstorm—make a list of everything you can think of that might make a developmentally disabled client agitated or frustrated. It should be a long list! Keep this list to refer to whenever you are trying to determine the underlying cause of a person’s agitation or aggression when they are unable to express themselves.

Do you know where the nearest DD office is? Have you ever met with staff there? Consider making an appointment to introduce yourself, and ask for tips and strategies on working with DD clients. You might also share some information with them on what mental illness looks like and what services your agency provides.

**Means for effective communication with persons with developmental disabilities**

Treat adults as adults

Do not automatically assume that the person is not a reliable source of information.

Do not assume that a lack of responsiveness is a failure to understand/comprehend or that it is defiant behavior.

Do not assume that all DD clients have no self-control skills or no understanding of their behaviors.

**THE DON’T’S IN COMMUNICATION**

Do not talk to the person as though you are addressing a young child.

Do not talk to others as though the person isn’t there.

Avoid yes/no questions.

**COMMUNICATION TECHNIQUES**

- Use simple language.
- Avoid jargon, technical terms, abstract concepts.
- Give clear one or two-step instructions if necessary.
- Be prepared for a cognitive delay that may result in a delay in following your directions or answering your questions.
- It may be necessary to write down reminders for the person.
- If communication appears difficult, ask the person if they have a communication book, a board, or know sign language.
- If the person comes in alone, ask if he or she has a case manager, family member, someone paid to help them, who you can call for assistance.
Principle Number 1:

Take your time.

Don’t simply rush in and try to take over the situation.
Move slowly and smoothly.
Remain mindful and aware, so that moment-by-moment, you can decide the best thing to do.

Principle Number 2:

It’s only critical when it’s critical.

Principle Number 3:

In most instances, It will pass.
But don’t be too confident.

Positioning yourself during a crisis:

Do not stand directly in front of the person, rather slowly, smoothly move between the client’s left and right field of vision.
If person is agitated, keep a distance of two-arms length.
Don’t corner yourself or the person: arrange it so that the person does not have to pass by you to get to the door.
Can you move your coach one foot away from the wall?

DE-ESCALATION TECHNIQUES

Offer reassurance: “It’s OK, nothing bad has to happen here.”
Be in-flappable.
Give simple concrete requests, then wait …
Be mindful of the impact of ‘cascading’ requests.
Keep in mind that if something does not work the first time, it might work a few minutes later.
If the person makes a request that you cannot meet, don’t simply say no in return, but rather “We’ll have to work on that.”
Clients respond to soft objects. Offer something soft “Would you hold this for me, please?”
**A word about soft objects**

Have soft objects available:
- In your office
- When approaching a crisis
- When meeting a client in the ER
- Protection from self-harm
- Deflect blows

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**MORE DE-ESCALATION TECHNIQUES**

Give the person a choice
Set a tone of cooperation: ask them to do something that they would be very unlikely to refuse.
- “Could you bring me this paper?”
- “Could you hold this for me, please?”

Use distraction:
- “Look at that hummingbird! I haven’t seen one of them all year. What a beautiful green and blue color!”

If the person is very agitated, consider bringing him or her to a safer environment.

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**Chaotic rage**  
*(see CD on de-escalation)*

Individuals who go into a chaotic rage are usually suffering from a confusion of thoughts and perceptions. There is too much stimulation. They feel enraged and terribly frightened.

**Presentation:** Impulsive, unpredictable rage. Rage explodes, seemingly, out of nowhere. They strike out in all directions. They are not coordinated, yet without inhibitions. They may grab, scratch, bite, kick and strike in flailing blows. They are often indifferent or unaware of pain or injury to themselves.

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**DE-ESCALATION TECHNIQUES OF RAGE**

Your goal is to reassure them and calm them down.

**Technique:**
- Use calm movements.
- Soft, firm, but reassuring voice.
- Distract them if you can.
- Use their name to get their attention.
- Be very cautious about touching them.
- Use simple, concrete sentences.
- Use simple summary statements, like:
  - “Really scary, huh?”
  - “You don’t like that, do you?”

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**Post-Crisis Depression Phase**

Discuss with your team how you would communicate differently with a developmentally disabled client:
1) During a normal interaction
2) If he or she was becoming increasingly agitated
3) In a chaotic rage state
4) In a state of post-crisis depression
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From the client’s perspective

The behavior makes total sense.
It has become his most effective response.
It got what he wanted: attention.

*Response Efficiency*

One more word about *Functional Assessments*

It means:

Entering the world, the experience of your consumer.
Empathizing with his or her needs.
Being the voice of a person who has difficulties communicating with you.
Finding ways to alleviate the distress of people who are hard pressed to explain what they experience.
Increasing their quality of life.

What’s a Positive Behavioral Support Plan?

A formal plan that contains information on:

- Environmental and training supports
- Replacement behaviors
- Interventions for challenging/crisis behaviors
What’s a Cross-System Crisis Plan?
For clients who are at risk of losing placement:
- Police involvement
- Mental health involvement
- ER visits
- Threatening behaviors, etc.

Identifies risk factors, issues, the guardian, interventions that work, that do not work, replacement behaviors, and more.

Let’s try an imaginary functional assessment. You have a developmentally disabled client who is refusing to eat, smearing food around and throwing silverware on the floor.

1) What could this client be trying to tell you? Is he achieving response efficiency with this behavior?
2) Assuming your functional assessment is correct, can you suggest any replacement behaviors for your client?

What are the advantages of a Cross-System Crisis Plan, instead of a Positive Behavioral Support Plan alone? Have you ever used one? Can you think of clients of yours who would benefit from having one?

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Thank you for participating in this training!

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PDF documents found on the main disc menu:
- Staff handout
- Trainer handout
- Functional assessment worksheet
- Sign language basics
- Article 1, 2, 3
- Creative Team questions