

“*Doing It For Attention*”: Non Physical Reactive Strategies

Tony Osgood

Behaviour Specialist, East Kent NHS & Social Care Partnership Trust's Positive Behaviour Support Team and
Lecturer in Learning Disability, Tizard Centre, University of Kent

The Parable of the 'Behaviourist'

You're driving home after a scintillating day's work in the local authority/health service/voluntary sector/private organisation. Important papers have been signed. Memos have been emailed to people using a mailing list three years out of date. You've consigned the funky Local Authority/Health Service etc. Monthly Newsletter "Your Voice!" to the recycling bin, having detached your pay slip first of course. You've watched paint dry during endless meetings discussing how to empower staff, how to liberate "your inner child" for "added productivity", and you've just attended a training workshop called Challenging Behaviour for Residential Social Workers run by a large tanned man in a tracksuit (possibly ex-military? It's difficult to tell but the tattoo saying "Kill Everything" and "Rehab is for Quitters" might be a clue). In this workshop you've learned how to "protect yet care, hold yet reassure, empower yet control". You turn the music up in your car.

You stop at traffic lights in a small seaside shanty just outside Whitstable, the Beirut of Kent. You lock your doors. Boy, are you nervous. It *feels* rough, here. Policemen go around in gangs. Seagulls fly with one eye cocked to the ground, ready to avoid surface to air missiles (there's good eating on a seagull, the locals know). You lock your doors again, just in case one didn't catch before. You ease the windows up even tighter.

As you wait for the lights to turn green, there's a knock at your window, and you turn to see an 86-year old woman threatening you with a large sub-machine gun. Apart from wondering how on earth she's holding the gun upright, you notice a look of steely determination in her one good eye (the other is covered by an eye-patch with rhinestones spelling out 'Mudder'). "Open the window!" she bellows, asthmatically, and you comply. "Get out the car!" she shouts, wheezing, and you leap out the car, hand her the keys, and watch as she drives away at speed, laughing, leaving you standing in tyre smoke, oil and shame. Shame, only partially assuaged when you watch her crash into a streetlight 30 metres down the road, wrecking your car. Your smile is sickly.

The next day, a 'Good' Behaviourist (he has certificates) is pausing by the same traffic lights (unaware the lights are controlled by thugs using Bluetooth technology). He too is waiting impatiently. The little old woman rolls her newly acquired NHS wheelchair toward the door (she mugged someone for it- there is a four year waiting time normally), and pointing her gun at the driver, demands he leave the car and handover his wallet. A NHS standard black eye patch has replaced her rhinestone eye patch. He knows all about the dangers of reinforcing such behaviour. He even goes into learning disability services and teaches support workers "*do not reinforce inappropriate behaviour*" explaining if they did, they would go to Behavioural Hell, should such a mentalistic concept actually exist. So, he takes a breath and shakes his head, mouthing through the window the word "No". There is a bang, seagulls fly away, and the woman inherits the car...

Third Star to the Right and Straight On 'til Mourning: Serviceland

"*Don't reinforce!*" is a poor mantra to repeat in services. In a crisis situation, where you and the person are in a potentially dangerous situation, you might well benefit from re-thinking the received knowledge from basic training on challenging behaviour. A different perspective on basic principles is required, because reinforcement is one thing, resolution another.

Reinforcement: the contingent appearance or removal of a thing or event resulting in an increase in the future probability of a behaviour. Translation: making a behaviour more likely to happen again.

Resolution: the contingent appearance or removal of a thing or event resulting in a decrease in the immediate probability of behaviour or escalation. Translation: stopping a behaviour.

Let me give you an example. Once upon a time I was driving a person and his service's senior support worker to a day service. The service was a specialist challenging behaviour service run by a statutory agency- they completed functional assessments and gave advice and training to other services. But the service had been having problems- the person kept trying to leap from moving vehicles when being driven at fifty nine miles an hour along a dual carriage way. Each time he removed his seatbelt, staff stopped the minibus. A long conversation would follow. The person smiled and chatted away. They'd get the seatbelt on again and off they'd go. For thirty metres. Pause. Chat. Clunk-click every seven and a half minutes. Forward. Screech. Stop. Chat. Clunk-click. Give up. Go home. From the air, the vehicle looked like a hiccupping white thing.

Interesting point: there is nothing to do in the back of a minibus. It is dull. Especially when the person has no particularly interesting place to go to. Especially when staff are trying to "not reinforce attention seeking behaviour." A steely silence tended to be the norm in the back of that minibus. Tumble-weed interlude. Hiccup! If staff tried to ignore the person and his seatbelt removal, he would flick the door handle suggestively: this guaranteed an emergency stop and a very long conversation indeed. Staff said: "it's for attention, so ignore him". It seemed sensible to agree with the service about why the person did the behaviour. So we had behaviour and we had likely function, we had consequences and we had antecedents. I just thought their intervention wasn't helping.

So I said I'd drive the person and the staff to the day service. The proviso being they would follow my very technically demanding intervention on the journey back. So we set off to the day service, following their intervention, the staff staring manfully out of the window, muttering, no doubt, under his breath, "don't reinforce! Don't reinforce!" whilst the person stared out the window for a couple of minutes, then at the staff, then at me in the rearview mirror. The person looked at the staff. Staff looked at the dual carriageway: what interesting white lines. What fascinating junctions. What remarkable cones. The person flicked the door handle and looked at the staff. Staff stared fixedly out the window. His breath fogged the glass. The person flicked the door handle twice and

looked at the staff member, who by now was sweating in his determination to “not reinforce, not reinforce!” So, the person flicked it four, five, six times (I’d locked the door- don’t worry all you health and safety guys! It all ends safely and consent was considered too!). Staff, remarkably, did nothing. In the end the person hit the staff member a light tap on his shoulder, at which point staff turn around to the person and said “Hey! Why’d you do that?”

Once we got to the day center the person wandered off, in and out of not very interesting sessions. He hung around the coffee machine. We twiddled our thumbs. Staff rushed by. Gosh, talk about a quality of life. On the way back, my high tech intervention was this. Look, we know he likes attention right? Right, said Mr. Staff. OK, how about we give him attention before he takes his seatbelt off or tries to open the door? Well, said Mr Staff, unsure. Oh go on! I cajoled. Oh alright then, Mr. staff agreed.

On the journey back staff spoke with the person about the day center, about tea, about what they could see out the window, about staff on shift that afternoon. And there was no behaviour problem. Mr. Staff fell out of the door, rushed into the service shouting “It’s a miracle!” whilst the person and I exchanged glances in the car.

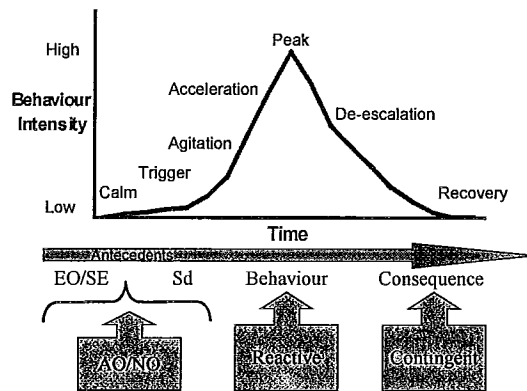
A couple or three points: cars are often more interesting than a minibus (more knobs to play with), going to do something nice is better than going to do nothing in particular, and having your needs met tends to make things run smoothly. High technology behavioural interventions indeed. The intervention (pre-empting a problem behaviour by encouraging a functionally equivalent behaviour) was technically an antecedent intervention. But as Gary LaVigna and Thom Willis suggest, the best reactive strategy is to avoid a war in the first place.

If the only time the person gets attention is following an outburst, sure, you might increase the possibility of the person “selecting” the problem behaviour to gain attention. If the person gets attention unconditionally, at times other than when problem behaviour is occurring, then you don’t need to be so concerned. It also liberates you from tying yourself up in knots trying to avoid reinforcing behaviour.

Welcome to Serviceland. Have a nice life?

Where Reactive Strategies Fit

I've just typed reactive into the software helping me write this paper, and checked out the synonyms: hasty, unthinking, knee-jerk, imprudent, rash etc. etc. But in positive behaviour support terms, reactive strategies are planned, thought out approaches that aim to stop a crisis **after** the behaviour has occurred. Because even with the best planning in the world, sometimes behaviour becomes "out of control", and people may need to intervene to help the person not hurt themselves, others, or the environment. You'll need reactive strategies- a plan that tells you what to do in such a crisis. Reactive strategies are planned ways of responding to specific incidents that aim to keep you and the focus person as safe as possible: reactive strategies aim to stop the behaviour rapidly with some dignity. They're not clever or smart.



In the illustration, I've shown what textbooks suggest to be a "typical" pattern of arousal: things are fairly ok, then a trigger (more usually, triggers), and before you know it, an incident is in full flight. Underneath the graph I've drawn a time line and underneath that the terminology used in describing events in time and relation to each other. Here, EO/SE

signifies establishing operations/setting events- things that change the "motivation" of the person- for example, a lack of sleep might make you more sensitive to being cut-up at a roundabout by a man in a white van. In this example, being cut up would equate to the trigger or antecedent event. The behaviour and consequence are self-explanatory. The green boxes show the types of intervention: AO/NO equate to abolishing operations/neutralising operations- interventions to avoid problems- such as ensuring you get enough sleep before setting off on a journey... enough sleep might mean you'd be calmer and less likely to react badly if some man cuts you up at a roundabout.

So, reactive strategies are used in response to identified behaviours. If you've identified a "chain" of behaviours that might result in a serious incident, it makes sense to use reactive strategies early in the chain, for less intense behaviours. Early intervention in the

chain leading to the challenging behaviour can save a lot of problems. Good reactive plans follow a gradient approach, with the early signs being responded to. In this way, some of the strategies discussed may well “bleed-into” antecedent interventions (see above).

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. These proactive plans may include steps for reducing sensitivity to identified antecedents (or identifying ways to reduce environmental aversiveness), teaching of coping skills, etc. Gary LaVigna and others (1989) provide an excellent summary of multi-element interventions, including reactive strategies. The secret of good reactive and proactive strategies is a comprehensive knowledge of the person’s behaviour, in the same way the secret of good person centred action is to know the person’s preferences, wishes, aspirations and gifts. By moving the “teaching” part of your interventions to pro-active non-crisis situations, you liberate yourself from concerns in a crisis about counter-therapeutic effects- reinforcing more challenging behaviours. Teaching the person constructively is effectively achieved through positive proactive strategies.

Your own emotions are important. If you don’t consider the emotions, attributions, and well-being of people facing challenging behaviour everyday, interventions may simply not be implemented. Always consider “contextual fit” issues: can the people intervening do this safely and well- are the interventions useful and doable? Punishment paradigms, and an overarching sense in people to control a crisis situation will heavily impact on whether non-aversive reactive strategies are used in practice. Working with people who present challenging behaviour can be a highly stressful experience. Dealing with challenging behaviour is for many people a day-to-day occurrence.

Punishment: Some Dangers

“She can’t go into Margate now. She’s blown her chances because she was bad. She’s lost her privileges.”

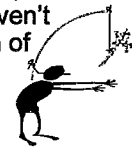
- a. It’s been shown that using ‘punishment’ tends not to help build positive respectful relationships, and tends not to teach. So, leaving aside ethics, consent, legal issues such as gradient interventions (little things like these!)... from a purely technical point of view, punishing someone for having done

something is often less effective than helping the person and the environment learn the skills to help the person avoid needing to select the problem behaviour. If I slap my daughters for making a mess I don't teach them much beyond Dad gets angry and hits, *and* more importantly, it's ok to hit people smaller than you, *and* techniques to avoid getting caught (I end up with sneaky kids who think I'm an unfair bully... how will that effect their own growing sense of self?).

- b. It presumes the person and the behaviour are the same.
- c. It presumes the person controls the behaviour.
- d. It presumes people have the right to restrict access to everyday things and suspend human rights.
- e. It assumes a positive trip out in the afternoon will reinforce an unsavoury behaviour that occurred in the morning. It shows a lack of knowledge about human behaviour. Reinforcement tends to need to be immediate and contingent to strengthen a behaviour. So, if it's a *really* bad behaviour (these judgements are often subjective anyway!) shall we ban her from going out for a week, a fortnight, a month? Daft, isn't it?

"If the behaviour guy says I have to earn soda rather than just have it in the fridge that's what happens. If the legalised drug dealer says that I should take this pill then that is what will happen. If I spit it out it will be buried in my ice cream. That is, if I'm allowed ice cream and haven't been put on a diet by a bunch of overweight suits calling themselves the team."

-John Clements & Neil Martin, 2002



Need I go on? Challenging behaviour tends to signify we're not meeting somebody's needs. So, shall we punish or seek to understand and enable? Following incidents of challenging behaviour, staff are unlikely to be particularly positive about people who may have assaulted them (Cottle *et al.* 1995).

Some Reactive Strategies

Someone is demanding attention and behaviour is escalating. Therefore, provide attention early on. Don't ignore what might be the only effective method the person possesses to control their environment. Do you ignore your partner? Do you ignore your kids? Will this reinforce the problem behaviour? Such a counter-therapeutic outcome can be managed by ensuring the person gains attention at other times, is taught different skills to gain attention... and the concern about reinforcement misses the point- in a

crisis, forget reinforcement, focus on resolution. This liberates reactive strategies from the straightjacket of future consequences. This is indeed counter-intuitive. But be a smart, not a dead, behaviourist.

When agreeing and writing reactive strategies, there is a straightforward process to follow

- Describe precisely the behaviour
- Assess the risks
- Describe any apparent cues before the behaviour occurs
- Describe any setting events and Sds that might precipitate the behaviour
- Set out a range of gradient strategies for preventing, minimising or managing the behaviour: identify the chain of behaviours that can often lead to the target challenging behaviour. In effect, focus on intervening on the pre-cursor behaviours *“those minor behavior problems, those low levels of agitation that may signal that the person is preparing to engage in something serious. These precursors might be understood as the whispers of behavior... It seems to us that we are requiring that the person not whisper to us, but shout at us; and it is the “shout” we then call severe and challenging behavior. The consultant you are likely to hire off the street for advice on what to do with problem behavior is likely to say ignore it. However, if you want to avoid crises, good advice may be don’t ignore it”* (from LaVigna & Willis, 1997, p.14).

Neutralise setting events, interrupt early on in chains of behaviour, capitulate to the person’s wishes early on. Work out non verbal early interventions: specify the type of eye contact you can safely make, how close can you be, be aware of what body language works best at diffusing situations (be creative!) and always think what’s your body “saying”? Likewise, think about your facial expression (if, like me, you scowl even when you’re smiling, go to the mirror and practice neutral faces). Consider touch: what sort is helpful- is it likely to just antagonise?

List possible verbal interventions- you should also try to identify what exactly is occurring- is the person afraid or angry? Active listening (empathy, understanding, emotional solidarity) is often excellent (see below). Redirection often helps with some people... some people may do exactly the opposite of whatever you suggest apparently on principle- so knowing this is likely, phrase your verbal interventions accordingly (“Whatever you do, don’t sit down!”). Offer tangible things the person values, or

activities. Consider changing things around the person. Sometimes doing unexpected things can “break” the tension and incident: singing badly, farting, falling over, copying the person, impersonating large African land mammals, all are fun and unexpected- find out what makes the person laugh. Try offering high probability requests (“Let’s get a chocolate biscuit?”) in order to build up a “behavioural momentum”. Some people may have grown used to being told what to do: if this works, in a crisis, it might be more ethical to say “Sit down!” than let the person hurt themselves (some people I’ve worked with do seem to be ‘searching’ for clear direction. Being woolly and ‘nice’ may not be right for everybody). Offer alternative behaviours, thank the person for what they’re doing well (“I can see you calming down, thank you!”). Base your ideas on the person’s communication preferences (don’t use too many words if you can avoid it- less is often more).

Some people won’t react well to you planting suggestions (“Just don’t throw the chair. Put that staff member down!”), and threatening the person is a real no-no (“There’s no chips tonight if you do that and you *love* chips!”), and please don’t give choices if there are none. Having several people trying to communicate with the person at the same time is often not good, and may simply ‘re-escalate’ the person. Don’t revisit the events immediately afterwards. We may think it’s counseling, others may think it’s nagging. Immediately following an incident, the person may well still be emotionally volatile and unpredictable. So continue with calming measures to avoid a further incident. And remember, you yourself may feel an emotional need to control, a need to show who is in charge. You may feel hurt and angry and less than positive about the person.

Active Listening

When a crisis develops, and people are trying to contain the situation, lots of directions and advice are often offered. This tends to make people either even more annoyed or simply withdrawn (real challenging challenging behaviour!). Active listening requires you to intentionally focus on the person, on understanding what is being said. Active listening is about listening and responding to the speaker. This doesn’t mean you agree with the person necessarily, but rather, understand what is being said. Your ability to listen to the person will be influenced by how you think about them and what you think about their motives and actions. A good listener tries to understand thoroughly what the other person is saying. I’ve used it effectively with people with no verbal language, when I’ve

interpreted behaviour as a form of communication. Take care to attend fully to the speaker, repeat back what's said in the listener's own words, and what he or she might mean, if you think this might help. You might interpret the speaker's words or behaviours in terms of feelings: instead of just repeating words, you might add "I see you feel *angry*". This emotional recognition of another's discomfort can effectively avoid escalation.

Don't judge the person, don't think you know what the person is going to say next (ask someone with a serious stutter just how much they enjoy it when you finish their sentences for them), and don't twist the message to make it say what you want to hear. Humans love to cling to first impressions, even if they are wrong. Many people tend to favour negative rather than the positive impressions. People sometimes blame people for their misfortunes: we tend to assume it's all due to negative personal qualities. But when we have problems, we "externalise" the blame - we tend to find outside people or things as the cause. Avoid these traps when actively listening.

Physical Intervention

Physical interventions refer to 'any method of responding to challenging behaviour which involves some degree of direct physical force to limit or restrict movement or mobility' (Harris et al, 1996). All restraint procedures carry the possibility of injury. Physical interventions are emotive, and produce heated debate. Emerson (2003) suggests over 50% of people with learning disabilities who display various forms of challenging behaviour are regularly restrained. The British Institute for Learning Disabilities produced a set of policy guidelines (BILD 1996):

- Physical interventions should only be used in the best interests of the person
- They should only be used in conjunction with other strategies to help people learn to behave in non-challenging ways
- They should be tailored for the person and regularly reviewed
- They should employ minimal force and not cause pain.

Certain types of physical interventions have been associated with deaths of service users (Paterson et al., 2002). An additional issue in using physical interventions is that of generalisation: if staff are taught physical interventions for seriously challenging behaviours, they'll tend to use it for less serious incidents also (Harris, 1996). Often the

most common response is physical intervention followed by ignoring behaviour. Spreat *et al* found most physical interventions were emergency, unplanned responses (Speat *et al*, 1986). Physical interventions might be considered illegal unless a clear justification capable of withstanding examination in court is found. Any defence might attempt to establish the minimum level of physical intervention was used for the shortest period, and that the intervention was used as just one component of a broader treatment strategy (Harris *et al*, 1996). People using even approved physical interventions must show they've unsuccessfully tried all reasonable non-physical interventions first. The Human Rights Act 1998 gives the right not to be subject to torture, to inhuman or degrading treatment or punishment, and the right to liberty and security.

Some Ideas for Reactive Strategies (from LaVigna & Willis, 1997)

- **Avoiding Natural Consequences.**

- "...if the natural consequence is aversive for the person, it may escalate the person's behavior to a potentially crisis level. In addition, consider that the natural consequence can itself lead to further exclusion and devaluation. When natural consequences have the potential for causing crisis level escalation, and when they further stigmatize the person, we suggest that maybe we should avoid the natural consequence. The proponents of natural consequences argue that the people we serve have the right to these consequences and that we devalue them by not providing them. They ask, "What is wrong with natural consequences? I experienced them and I turned out OK." If there is one thing that characterizes the people we are discussing today, it is they are not going to learn from their natural consequences. If they were going to learn from natural consequences, this newsletter wouldn't exist." (p.13)

- **Don't Ignore Behavior Under Certain Conditions.**

- "How many of you really believe there is something to the idea that aberrant behaviors communicate legitimate messages? Most of us do. If that is true, what is worse than to advise somebody to ignore the behavior? What you would be saying functionally is to ignore their efforts to communicate. What happens if you ignore a person's communication? The person's behavior escalates." (p.14)

- **Diversion to a Reinforcing or Compelling Event or Activity.**
 - “...when the person is starting to act up, divert him or her with the most powerful reinforcing or compelling activity or event you can identify.” (p.15)
- **Strategic Capitulation.**
 - “Last, and perhaps most counter-intuitive of all reactive strategies is what we call *strategic capitulation*. Many times we know what the message is. We know what the person is asking for. We know what the person wants. When you know what the person wants, it is obvious that the quickest way to get him to stop asking for it is to give it to him.” (p.16) “If you are going to use capitulation, the earlier you use it the better. Ideally, this would even be in response to precursor behavior.” (p.17)
- **Don't Punish**
 - “We don't have to earn most our pleasures in life; then, why should they?” (p.11).

Strategies, summarised...

- Antecedent strategies- eliminate aversive contexts
- Skills Building- coping strategies/self-management
 - Interruptions
 - Interrupt an episode of challenging behaviour with an activity the person really enjoys.
 - Distraction/Diversion/novel stimuli/stimulus change/instructional control
 - Active Listening/enabling communication
 - Verbal calming/Verbal direction
 - Facilitated Relaxation
 - Containment
 - Physical intervention

A Recent Real Example

Mary screamed. She screamed a lot. It got everyone in the house down: it frustrated the staff and annoyed the other five service users. The Community Team asked for advice- they feared Mary's service might call it a day. Mary screamed from when she woke 'til when she slept. This was an emergency. I spoke with staff and met with Mary. The contexts are always important to ascertain. Staff said "She screams all the time", and I asked if she ever breathed? I asked staff about the things Mary liked. I asked about how Mary got to be where she was. It turns out she'd been living at the service for years, fairly happily. One day someone noticed her discomfort at moving around, and it was discovered this thirty something lady with autism and learning disabilities had two fractures in her leg. Seven weeks or so in hospital followed, and staff worked beside Mary, every day, responding to her wishes, pre-empting her wants. On her return to the service, two things became evident: she'd have to re-learn how to walk again (in some pain) and that she no longer had access to 24 hour one to one support. Mary screamed to get attention. She screamed to get out of physiotherapy. She just screamed when people asked her to do stuff.

Reactive strategy: when she took a breath during screaming, staff would sing to Mary. When she took a breath, staff would blow a raspberry. While she laughed, staff would laugh and smile back. When she laughed, staff would prolong the non-screaming period with other things Mary enjoyed- talk about TV, favourite videos, make tea... in effect, do good things with her. An additional strategy which was used infrequently was quite simple: sometimes staff felt Mary really did want to be on her own (she sometimes preferred time in her bedroom alone before going into hospital), so we created some criteria when we interpreted the screaming as saying "OK, I'm serious now, I want to be left alone", and Mary would be offered time alone with preferred music or videos in her room. Pro-active strategies included hiding "demands" (physiotherapy, getting up, having a bath, going out) in fun interactions Mary enjoyed. We created a zero-demand ecology, as the research articles put it, and removed all demands, given the seriousness of the possible outcomes for Mary (homelessness). We re-introduced demands slowly and gently, building Mary's tolerance and confidence slowly. Screaming reduced, Mary learned not all demands were aversive for her, and staff learned they could influence her behaviour by using

subtle approaches. Relationships improved. Rapport improved. Communication increased. Interestingly, the Community Team objected to this zero-demand approach: how would Mary learn to walk again without demands, they wondered. Over time, more formal communication programmes could commence. Outcomes included Mary screaming less and speaking more. She started walking, slowly, but she started.

These interventions were very simple and my brief involvement did not address fundamentally important issues, for example, the lack of a person centred plan, a lack of an activity programme selected by Mary, and service systems and structures. But like all good reactive strategies, it bought time for people involved to begin reconsidering how to support Mary without the

threat of homelessness taking all their time and energy. You need to practice such strategies and ensure they fit the individual's preferences. You need to be creative. You need to spread the responsibility for implementing such strategies amongst many people, including the person themselves where possible. Some of these techniques are counter-intuitive. Therefore, we sometimes find them difficult to grasp.

If you inadvertently assist the person to escalate, do not panic; you will get another chance to do it right the next time around.



Practice, Persistence, Pondering

Cooking from a recipe is only the beginning of learning to cook: with repeated practice, by learning from doing, we become able to cook freely without a cookbook. Likewise, creatively and humanely using behavioural techniques is something you need to practice. We are required to reflect not only upon the technical correctness of the techniques, but what results from our using them, how others feel, how interventions improve the dignity of the people we serve and ourselves.

We should practice mindfully, our work with people who challenge the system (Lehr & Brown, 1996) requires persistence and self-reflection, and we need to ponder what continuing challenging behaviour implies about how we interact with the person. If a person is “doing it to get out of demands” (a demand can be anything- tidying,

housework, getting up, going out etc) then respect this: is there a way of working out just what exactly about the 'demand' the person finds aversive, is there a way of making events or styles of interaction less aversive or demanding (we've often taught people to challenge by how we respond to them- how we structure services- how we impose our values upon how we think they should live their lives- how we speak to people), is the 'demand' something that the person wants to do? Likewise if the person is "doing it for attention" then perhaps we need to make sure the person gets the bloody attention in a way they prefer in the first place!

Such reflection is the hallmark of good positive behavioural support today. Behaviour analysis is about supporting the person and those around them to learn, respect, and achieve their goals and make real their values. We do this by being part of a team of people working towards supporting effectively and humanely fellow humans. We do this by working with others, not telling people what to do. As was once noted many hundreds of years ago, one cannot know without action. Reactive strategies are about humanely doing what we know can work.

References & Further Reading

- Adams, D., & Allen, D., (2001) Assessing the need for reactive behaviour management strategies in children with intellectual disability and severe challenging behaviour, *Journal of Intellectual Disability Research*, 45, 4, pp.335-343
- Allen, D. (2001) *Training Carers in Physical Interventions. Research towards evidence-based practice*. Kidderminster: BILD.
- Allen D., McDonald L., Dunn C. & Doyle T. (1997) Changing care staff approaches to the prevention and management of aggressive behaviour in a residential treatment unit for persons with mental retardation and challenging behaviour. *Research in Developmental Disabilities* 18, pp. 101-112.
- Baker P., LaVigna G. & Willis T. (1998) Understanding and responding to challenging behaviour: a multi-element approach. In: *Hallas's Caring for People with Learning Disabilities*, 9th edn, (eds W. Fraser, D. Sines & M. Kerr). Butterworths, Oxford.
- British Institute of Learning Disabilities (2001) *BILD Code of Practice for Trainers in the Use of Physical Interventions*. Kidderminster: BILD.
- Clements, J., Martin, N., (2002). *Assessing Behaviours Regarded as Problematic for People with Developmental Disabilities*, London, Jessica Kingsley Publishers
- Department of Health & Department for Education & Skills (2002) *Guidance for Restrictive Physical Interventions. How to provide safe services for people with Learning Disabilities and Autistic Spectrum Disorder*. London: DOH.
- Emerson, E. (2003) The prevalence of use of reactive management strategies in community-based services in the UK. In Allen, D. (Ed.) *Ethical Approaches to Physical Interventions. Responding to Challenging Behaviour in People with Intellectual Disabilities*. Kidderminster: BILD.
- Harris, J. (1996) Physical restraint procedures for managing challenging behaviours presented by mentally retarded adults and children. *Research in Developmental Disabilities*, 17, 2, 99-134.
- Harris, J., Allen, D., Cornick, M., Jefferson, A. & Mills, R. (1996) *Physical Interventions. A Policy Framework*. Kidderminster: BILD/ NAS.
- Hopton J. (1995) Control and restraint in contemporary psychiatric nursing: some ethical considerations. *Journal of Advanced Nursing* 22, pp.110-115.
- LaVigna, G.W. (1995) *Emergency management within a non-aversive framework*. Los Angeles: IABA.
- LaVigna, G.W., Willis, T.J., (1997) Severe and Challenging Behaviour: Counter-Intuitive Strategies for Crisis Management within a Nonaversive Framework, *Positive Practices*, 2, 2
- LaVigna G. W., Willis T. J. & Donnellan A. W. (1986) The role of positive programming in behavioural treatment. In: *Behavioural Approaches in the Treatment of Operant Behavior* (ed. E. Cipani), pp.59-83. American Association on Mental Deficiency
- Lehr, D.H., Brown, F., (eds) (1996) *People with Disabilities Who Challenge the System*, Baltimore, Paul. H. Brookes
- Paterson, B. et al (2003) Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey. *Journal of Psychiatric and Mental Health Nursing*, 10, 3-15.
- McDonnell A. (1997) Training care staff to manage challenging behaviour: an evaluation of a three day training course. *The British Journal of Developmental Disabilities* 43 (85), pp156-162.
- Sprent S., Lipinski D., Hill J. & Halpin M. E. (1986) Safety indices associated with the use of contingent restraint procedures. *Applied Research in Mental Retardation* 7, 475-481.
- Stilling L. (1992) The pros and cons of physical restraints and behaviour controls. *Journal of Psychosocial Nursing* 30 (3), pp.18-20.