# Division of Developmental Disabilities
# QIDP Curriculum

## Presenter's Introductory Modules Guide

### Your Role as a QIDP Trainer

You have been selected by your organization to prepare new QIDPs to assume their roles and/or to assist existing QIDPs in improving their skills. This curriculum has been designed to involve you in a combination of activities. These activities will include classroom presentations, modeling of best practice, evaluating scenarios, and processing the reflections of the QIDP trainees. As the QIDP trainer you may also be the person responsible for submitting the necessary paperwork to the Bureau of Quality Management for approval of your organization's training plan and QIDPs.

The QIDP Orientation Curriculum has been divided into nine modules. They are:

Module 1– An Introduction to the World of the QIDP
Module 2– Leadership and Communication
Module 3– Assessing and Enhancing Quality Outcomes
Module 4– The Planning Loop
Module 5– Record Keeping
Module 6– Community Relationships and Resources
Module 7– Environmental Health and Safety
Module 8– Medical Issues
Module 9– Applying Rules and Regulations

Each module consists of a QIDP Notebook and Presenter's Supplementary Information for that module. The presenter would, therefore have a combination of the QIDP Notebook and the Presenter's Supplementary Information and would maintain them together in their training binder. To differentiate presenter information from the trainee's information the presenter's information should be printed on colored paper. These pages are then inserted into the QIDP Notebook just before the corresponding QIDP Notebook page. Presenter page numbers are followed by a letter. For example, Presenter's Supplement page 4A would be inserted in the QIDP Notebook before page 4. If more than one presenter's supplement page is needed for a particular QIDP notebook page, the following pages would be designated 4B, 4C, etc.

The Presenter's Supplements are provided to assist the presenter with additional information pertinent to the topic being discussed. These supplements also contain instructions on activities, facilitation exercises, answers to quizzes, cues to appropriate times to distribute additional materials, etc. Other materials for presenter use are included in the Presenter Supplement, or can be found at the DHS training website.

***Agencies are encouraged to supplement both the general information provided in each module with agency specific information and the presenter's supplements with guidance, exercises and other information developed by agency trainers to meet the specific needs of their agency.***

## Training Guidelines

### Materials:

- **Sign-In Sheets -** (these should be maintained and available for review by Department Staff; they should include the following components: module/class name, Class date, Class times, Instructor signature and Trainee signature)

- **QIDP Notebooks** - (1 for each Trainee)

- **QIDP Notebooks <u>with</u> Presenter Supplements** – (1 for each presenter)

Background reading materials for each module are listed at the beginning of each module. As a trainer, you should be sure that these materials are available for trainees. The background materials can be accessed from a variety of sources, including on-line sources such as www.Amazon.com .

Other materials needed that are specific to the module being trained are listed in the Presenter's Supplement at the beginning of each module. In addition to these course specific materials, the presenter may wish to have the following equipment available to facilitate presentation of each module:

- Markers
- Flipcharts
- Laptop/LED projector

## Preparing for QIDP Training:

- Read over the entire module;
- Gather additional agency-specific information and reference materials;
- Determine which videos and reference materials to incorporate into which module and when the best time is to introduce each;
- Make sure all information is current and up-to-date;
- Anticipate questions and prepare appropriate responses;
- Develop relevant examples to reinforce the points in the modules;
- Duplicate materials for each trainee
- Try to make the training fun, informative, interactive and as unlike a classroom setting as possible.

### Training Implementation Strategies

Introduce your agency's background, goals, philosophies, service population, services offered, facilities, structure, personnel, policies and procedures.

***Presenter should be prepared to modify or supplement any materials that are needed for the specific needs of your agency. For example, home based service facilitation.***

As the training begins, stop after each main point to determine if the trainees have understood the material or have questions. You may also want to take time to answer questions as they arise.

# PRESENTER – Materials Needed for Module 1

- **Agency QIDP Job Description**
- **Agency Mission Statement**

## PRESENTER – Agency QIDP Job Description

Presenter should be prepared to distribute agency QIDP job description to trainees. Discuss the job description as it relates to the Agency' Mission and core values and principles.

**10A**

# PRESENTER - DEVELOPMENTAL DISABILITY DEFINITIONS

It is important that you understand the difference between, and the criteria for, both developmental and intellectual disabilities. However, as a QIDP, it is unlikely that you will actually be assessing people for the purpose of making a diagnosis. Most children and adults who are receiving services from you agency will have already been diagnosed.

# PRESENTER – Cerebral Palsy

**Cerebral palsy** is an umbrella term used to classify conditions that impair motor coordination caused by brain damage. Cerebral palsy is caused by brain damage occurring before, during, or after birth. Any brain damage inflicted up until approximately the age of three can result in cerebral palsy. The part of the brain that is damaged is the determining factor on how the condition affects the patient.

A type of cerebral palsy, called spastic cerebral palsy, occurs when the brain damage occurs in the cerebral cortex, the outer layer of the brain. Spastic cerebral palsy is the most common form of cerebral palsy, affecting 70 to 80 percent of patients. Spastic cerebral palsy has varying forms depending on the areas of the body it affects, whether its one side of the body or just the legs.

**Spastic cerebral palsy** refers to the increased tone, or tension, in a muscle. Normal muscles work in pairs. When one group contracts the other group relaxes, allowing free movement in the desired direction. Due to complications in brain-to-nerve-to-muscle communication, the normal ebb and flow of muscle tension is disrupted. Muscles affected by spastic cerebral palsy become active together and block effective movement. This causes the muscles in spastic cerebral palsy patients to be constantly tense, or spastic. Spastic cerebral palsy patients may have mild cases that affect only a few movements, or severe cases that can affect the whole body. Although spastic cerebral palsy is not thought to be a progressive disorder, as brain damage does not get worse over time, spasticity in muscles can increase over time. This increased muscle tone and stiffness in spastic cerebral palsy can limit the range of movement in the joints. The effects of spastic cerebral palsy may increase with anxiety or exerted effort, leading to excessive fatigue.

Treatments for spastic cerebral palsy vary depending on the severity of the symptoms in the individual. Oral medications, such as Valium and baclofen, have been tried but the general consensus is that they do not reduce spasticity. Baclofen infusion, however, a relatively new procedure, has been slightly more effective in spastic cerebral palsy. Using a pump inserted in the abdomen, baclofen is distributed to muscles, reducing spasticity. However, when baclofen treatment is stopped, spasticity returns. Risks associated with baclofen include overdose, meningitis, and other complications, and since it is a relatively new treatment, long-term affects are currently not known.

**19A**

Botox injections placed in the muscles of spastic cerebral palsy patients are also a relatively new treatment. When injected into affected muscles, botox weakens the group of muscles, reducing spasticity. Botox injections usually last 3 to 4 months and side effects appear to be minimal.

Orthopedic operations are also used for the treatment of spastic cerebral palsy. Orthopedic surgery usually involves lengthening tendons and muscle release to improve range of motion. Surgery will not reduce spasticity directly, but does reduce the consequences of it.

**Spastic diplegia cerebral palsy** tends to affect the legs of a patient more than the arms. Spastic diplegia cerebral palsy patients have more extensive involvement of the lower extremity than the upper extremity. This allows most people with spastic diplegia cerebral palsy to eventually walk. The gait of a person with spastic diplegia cerebral palsy is typically characterized by a crouched gait. Toe walking and flexed knees are common attributes and can be corrected with proper treatment and gait analysis.

In many cases the IQ of a person with spastic diplegia cerebral palsy may be normal. However, other side effects like strabismus are common. Strabismus, the turning in or out of one eye, commonly called cross-eye, affects three quarters of people with spastic diplegia cerebral palsy. This is due to weakness of the muscles that control eye movement. In addition, these individuals are often nearsighted. If not corrected, strabismus can lead to more severe vision problems over time.

**Ataxic cerebral palsy** is caused by **damage to the cerebellum**, which is in the base of the brain. The cerebellum is the control center for balance and coordination and coordinates the actions for different groups of muscles. Ataxic cerebral palsy therefore affects coordination of movement. Ataxic cerebral palsy usually affects all four limbs and the trunk. In addition, ataxic cerebral palsy is characterized by poor or low muscle tone, also known as hypotonic.

Ataxic cerebral palsy can affect an individual in several ways. A person with ataxic cerebral palsy will usually have a wide-based gait, or walk. Because of their poor sense of balance they tend to walk with their feet unusually far apart. In appearance, a person with ataxic cerebral palsy will look very unsteady and shaky. This is due to low muscle tone where the body is constantly trying to counter-balance itself.

**19B**

The most significant characteristic of ataxic cerebral palsy is tremor, especially when attempting quick or precise movements, such as writing or buttoning a shirt. Also known as intention tremor, this symptom of ataxic cerebral palsy worsens when attempting a voluntary movement. For example, when reaching for an object, such as a book, the hand and arm will begin to shake. As the hand gets closer to the object the trembling gets more severe, increasing the completion time necessary for the task.

Athetoid cerebral palsy is a form of athetonia, which is marked by slow, writhing involuntary muscle movement. A mixed muscle tone where some are too high and others too low also characterize **Athetoid cerebral palsy**. Damage to the basal ganglia, located in the midbrain, is the cause of athetoid cerebral palsy. Approximately 25 percent of cerebral palsy patients are affected by athetoid cerebral palsy. Athetoid cerebral palsy can also be referred to as **dyskenetic cerebral palsy**.

The slow, writhing movements associated with athetoid cerebral palsy usually affect the hands, feet, arms, or legs. In some cases, athetoid cerebral palsy can affect the muscles of the face and tongue, causing grimacing and drooling. The involuntary and uncontrollable muscle tone fluctuations sometimes affect the whole body. The movement caused by athetoid cerebral palsy often increases during times of heightened emotional stress. Symptoms usually tend to disappear completely during sleep.

Several difficulties are common with athetoid cerebral palsy. The main cause for these problems is the muscles alternating between floppy and tense. Unwanted movements may be small or big, rapid, irregularly repetitive, random, or jerky. Athetoid cerebral palsy can also cause a person to appear restless and constantly moving, only being still when fully relaxed and sometimes only when asleep.

People with athetoid cerebral palsy often show a lot of movement in their face. **Athetoid cerebral palsy can also affect speech**. This condition is known as dysarthia. Speech is affected to a degree in every case of athetoid cerebral palsy because of difficulty controlling the tongue, breathing and vocal chords. Similarly, the person may experience difficulties with eating and drooling.

**19C**

A person with athetoid cerebral palsy can also have difficulty holding onto an object, like a pencil or eating utensil, because of the mixed tone of muscles. Athetoid cerebral palsy can make a person work and concentrate harder than usual to get their hand to a certain spot, like scratching their nose. This is also concurrent with big, involuntary movements and is found through the entire body rather than being restricted to a certain area. The treatment of athetoid cerebral palsy varies on the concentration of symptoms. For those suffering from dysarthia, (Dysarthria is a disorder caused by paralysis, weakness, or inability to coordinate the muscles of the mouth). Speech therapy can help improve swallowing and communication. A speech therapist also can work with the child to learn to use special communication devices like computers with voice synthesizers.

The most common combination of mixed cerebral palsy involves both spasticity and athetoid movements, but other combinations are also possible. The least common mix is athetoid and ataxic cerebral palsy, however any mix of types may occur. It is possible to have a mix of all three types of cerebral palsy: spastic, athetoid and ataxic.

Mixed cerebral palsy with **spastic and athetoid cerebral palsy** is the most common type of mixed cerebral palsy, accounting for nearly 10 percent of mixed cerebral palsy cases. Spastic cerebral palsy causes one or more tight muscle groups, which limit movement in the patient. Children with spastic cerebral palsy have stiff and jerky movements. They often have trouble moving from one position to another and have a difficulty holding and letting go of objects.

Mixed cerebral palsy with athetoid characteristics are caused by damage to the cerebellum or basal ganglia. These areas of the brain are responsible for processing the signals that enable smooth, coordinated movements as well as maintaining body posture. Injury to these areas may cause a child to develop involuntary, purposeless movements, especially in the face, arms, and trunk.

# PRESENTER - Epilepsy - Symptoms

Seizures are the only visible symptom of epilepsy. There are different kinds of seizures, and symptoms of each type can affect people differently. Seizures typically last from a few seconds to a few minutes. You may remain alert during the seizure or lose consciousness. You may not remember what happened during the seizure or may not even realize you had a seizure.

Seizures that make you fall to the ground or make the muscles stiffen or jerk out of control are easy to recognize. But many seizures do not involve these reactions and may be harder to notice. Some seizures make you stare into space for a few seconds. Others may consist only of a few muscle twitches, a turn of the head, or a strange smell or visual disturbance that only you sense.

**20A**

**Partial seizures**

Partial seizures begin in a specific area or location of the brain. The most common types of partial seizures are:

- **Simple partial seizures.** Simple partial seizures do not affect consciousness or awareness.
- **Complex partial seizures.** Complex partial seizures do affect level of consciousness. You may become unresponsive or may lose consciousness completely.
- **Partial seizures with secondary generalization.** Partial seizures with secondary generalization begin as simple or complex partial seizures but then spread (generalize) to the rest of the brain and look like generalized tonic-clonic seizures. These two types can easily be confused, but they are treated differently. Most tonic-clonic seizures in adults begin as partial seizures and are caused by partial epilepsy. Generalized tonic-clonic seizures are more common in children.

**Generalized seizures**

Seizures that begin over the entire surface of the brain are called generalized seizures. The main types of generalized seizures are:

- Generalized tonic-clonic seizures (grand mal seizures), during which the person falls to the ground, the entire body stiffens, and the person's muscles begin to jerk or spasm (convulse).
- Absence seizures (petit mal seizures), which make a person stare into space for a few seconds and then "wake up" without knowing that anything has happened.
- Myoclonic seizures, which make the body jerk like it is being shocked.
- Atonic seizures, in which a sudden loss of muscle tone makes the person fall down without warning.
- Tonic seizures, in which the muscles suddenly contract and stiffen, often causing the person to fall down.

People may refer to seizures as convulsions, fits, or spells. But seizure is the correct term. Convulsions, during which the muscles twitch or jerk, are just one characteristic of seizures. Some seizures cause convulsions, but many do not.

**20B**

# Signs and Symptoms of Autism Spectrum Disorder (ASD)

ASDs begin before the age of 3 and last throughout a person's life, although symptoms may improve over time. Some children with an ASD show hints of future problems within the first few months of life. In others, symptoms might not show up until 24 months or later. Some children with an ASD seem to develop normally until around 18 to 24 months of age and then they stop gaining new skills, or they lose the skills they once had.

A person with an ASD might:

- Not respond to their name by 12 months
- Not point at objects to show interest (point at an airplane flying over) by 14 months
- Not play "pretend" games (pretend to "feed" a doll) by 18 months
- Avoid eye contact and want to be alone
- Have trouble understanding other people's feelings or talking about their own feelings
- Have delayed speech and language skills
- Repeat words or phrases over and over (echolalia)
- Give unrelated answers to questions
- Get upset by minor changes
- Have obsessive interests
- Flap their hands, rock their body, or spin in circles
- Have unusual reactions to the way things sound, smell, taste, look, or feel

From Centers for Disease Control Website at http://www.cdc.gov/ncbddd/autism/facts.html

# PRESENTER – Mental Health

Many people with developmental disabilities have spent much of their lives in institutional-type settings and thus have become dependent on others for decision-making. This can be stressful for them when they are suddenly asked to make choices and advocate for themselves in this person-centered world.

# Mental Illness

***Presenter's Script***

*It is important to understand that mental illness and developmental disabilities* ***are not the same.***

- Mental illnesses are disorders of the brain in which behavior, mood, thought processes, relationships and ability to cope with life stressors are disturbed or outside the norm.
- Mental illnesses CANNOT be overcome through "will power."
- Mental illnesses ARE NOT a reflection of choice or character.
- MI in the DD population is often hard to recognize. It is important to note that
- Signs/symptoms of mental disorders cause clinically significant distress or impairment in social, occupational, or other important areas of functioning. (Just being a little weird" or eccentric doesn't necessarily mean you have a mental disorder).

## MI Causes and Treatments

- Mental illnesses are biologically-based brain disorders, NOT result of personal weakness
- Causes are largely unknown, but can include:
    - Imbalance of neurotransmitters
    - CAT scans reveal physical differences
    - Mental illnesses are treatable, not "curable", with goals of symptom reduction and return to prior level of functioning

# An Overview of the Major Mental Illnesses
# Thought Disorders:

## Schizophrenia is:

- ❖ a disorder characterized by disorganized thought processes
- ❖ Means "split mind" NOT "split personalities" or "multiple personalities"
- ❖ Emerges in late teens, twenties

**Symptoms of Schizophrenia include:**

- Disorganized thoughts/speech
- Inappropriate or flat emotions/affect
- Avolition, lack of motivation
- Lack of insight into illness
- Hallucinations (seeing, hearing, smelling, feeling things that aren't there)
- Delusions (believing things others don't believe)
- Paranoia
- [Symptoms can come and go in cycles]

**Differentiating Schizophrenia. . .**Use caution with:

- Developmentally appropriate self-talk
- Imaginary friends/fantasy play
- May be confused with hallucinations or delusions, in particular with clients with
- Downs Syndrome or ASD

# Mood Disorders:

Mood Disorders are disorders characterized by:

- Longer periods (than normally experienced) of marked shifts in emotional state
- Significant impairment in functioning
- Components of mood disorders are depression and/or mania:

## Depression

Symptoms include:

- Feeling excessively down, sad
- Tearfulness
- Trouble sleeping/sleeping too much
- Not eating/over-eating
- Loss of interest/pleasure in everyday activities
- Trouble concentrating
- Lack of goal-directed behavior
  Irritability

Anxiety Disorders are disorders characterized by:

- Avoidance of certain stimuli
- Autonomic arousal (feeling "hyper," "anxious," "shaky")
- Excessive motor activity
- Agitation

## Bipolar Disorder

- Periods of depression alternating with periods of mania.
- Sometimes longer, slower and sometimes more rapid, drastic swings.
- Presentation varies greatly.

## Mania

Symptoms include:

- Feeling unusually high, elated
- Very fast, pressured speech
- Trouble staying on task, in one place
- Excessive motor activity
- Increased risk-taking, impulsive behaviors
- Irritability and/or aggressiveness
- Hyper sexuality

## Differentiating Bipolar Disorder.

Some things can be difficult to attribute to Intellectual disability, bipolarcondition, or just a bad day:

- Poor judgment
- Distractibility
- Excessive activity

The key is to compare current behavior with previous functioning. Look for deviations from what was previously exhibited.

**25C**

# Anxiety Disorders:

## Obsessive-Compulsive Disorder (OCD)

Obsessive, intrusive thoughts (sometimes relieved only by engaging in ritual)
Repetitive, ritualistic behavior (only temporarily relieve anxiety)
Overwhelming need to have things a certain way

Symptoms may include:

- Hand washing
- Cleaning/fear of germs
- Hoarding
- Touching in patterns/or number of times

## Other Anxiety Disorders

### Phobias

A phobia is a type of anxiety disorder. It is a strong, irrational fear of something that poses little or no actual danger. There are many specific phobias.
People with phobias try to avoid what they are afraid of. If they cannot, they may experience:

- Panic and fear
- Rapid heartbeat
- Shortness of breath
- Trembling
- A strong desire to get away

**Generalized Anxiety Disorder** has the following symptoms:

- Excess anxiety and worry that is out of proportion to the situation
- Difficulty controlling the worry
- Restlessness or feeling keyed up or "on the edge"
- Being easily tired
- Difficulty concentrating
- Irritability
- Muscle tension -- shakiness, headaches
- Sleep disturbance (difficulty falling or staying asleep; or restless, unsatisfying sleep)
- Excessive sweating, palpitations, shortness of breath, and stomach/intestinal symptoms

**PTSD (Post Traumatic Stress Disorder)**
Post-traumatic stress disorder (PTSD) is a real illness. You can get PTSD after living through or seeing a traumatic event, such as war, a hurricane, rape, physical abuse or a bad accident. PTSD makes you feel stressed and afraid after the danger is over. It affects your life and the people around you.
PTSD can cause problems like:

- Flashbacks, or feeling like the event is happening again
- Trouble sleeping or nightmares
- Feeling alone
- Angry outbursts
- Feeling worried, guilty or sad

PTSD starts at different times for different people. Signs of PTSD may start soon after a frightening event and then continue. Other people develop new or more severe signs months or even years later. PTSD can happen to anyone, even children.

**Personality Disorders:** Enduring patterns of inner experience and outward behavior that deviate markedly from the expectation of the individual's culture. This isn't people just being "odd" or "difficult," it is:

- Maladaptive
- Disruptive to social, occupational, relationships
- Pervasive & inflexible
- Stable over time
- Leads to distress or impairment

Symptoms vary widely depending on the specific type of personality disorder. Treatment usually includes talk therapy and sometimes medicine. There are many types of personality disorders. Some of them are listed below:

**Borderline Personality Disorder**
Symptoms Include:

- Affects mood, self-image, relationships
- Mood changes quickly, easily enraged
- Create a crisis or act out in a crisis to put focus back on them
- Impulsive behavior
- Self-injury/harm
- Manipulation
- Overly dramatic, hostile, friendly
- Moves into serious relationships very quickly, moves between relationships very quickly

## Avoidant

- ❖ People with avoidant personality disorder are preoccupied with their own shortcomings.
- ❖ They form relationships with others only if they believe they will not be rejected. Loss and rejection are so painful that these people will choose to be lonely rather than risk trying to connect with others.

A person with avoidant personality disorder may:

- Be easily hurt by criticism or disapproval
- Hold back too much in intimate relationships
- Be reluctant to become involved with people
- Avoid activities or occupations that involve contact with others
- Be shy in social situations out of fear of doing something wrong
- Exaggerate potential difficulties
- Hold the view they are socially inept, inferior, or unappealing to other people

## Dependent

- ❖ Dependent personality disorder usually begins in childhood. However, the cause of this disorder is unknown. It is one of the most common personality disorders, and is equally common in men and women.
- ❖ People with this disorder do not trust their own ability to make decisions. They may be devastated by separation and loss. They may go to great lengths, even suffering abuse, to stay in a relationship.

A person with dependent personality disorder may:

- Have difficulty making decisions without reassurance from others
- Have problems expressing disagreements with others
- Avoid personal responsibility
- Avoid being alone
- Feel devastated or helpless when relationships end
- Be unable to meet ordinary demands of life
- Become preoccupied with fears of being abandoned
- Be easily hurt by criticism or disapproval
- Be extremely passive in relations with other people

## Schizoid

A person with schizoid personality disorder:

- Appears aloof and detached
- Avoids social activities that involve significant contact with other people
- Does not want or enjoy close relationships, even with family members

## Anti-Social

The cause of antisocial personality disorder is unknown. Genetic factors and child abuse are believed to contribute to the development of this condition. People with an antisocial or alcoholic parent are at increased risk. Far more men than women are affected. The condition is common in prison populations. Fire-setting and cruelty to animals during childhood are linked to the development of antisocial personality.

A person with antisocial personality disorder:

- Breaks the law repeatedly
- Lies, steals, and fights often
- Disregards the safety of self and others
- Does not show any guilt
- To receive a diagnosis of antisocial personality disorder, a person must have shown behaviors of conduct disorder during childhood.

<u>People with antisocial personality disorder may have the following signs:</u>

• Anger and arrogance

• Capable of acting witty and charming

• Good at flattery and manipulating other people's emotions

• Substance abuse and legal problems

Submitted by Shannon Paul of Clearbrook with additions by Dr. Pat McGuire, Div. of DD

## Dual Diagnosis (MI/DD)

Someone who has both a developmental disability and a mental illness

**Note**: the same term ("dual diagnosis") can be used to describe someone with MI and a substance abuse disorder or MR and a substance abuse disorder.

# PRESENTER- A Day in the Life of the Other Guy

After trainees read the selection discuss in class. Be sure to emphasize the significant role that Direct Service Providers have in the lives of the people they help support.

# PRESENTER – Materials Needed for Module 2

- **Index Cards**

**3A**

# PRESENTER – Opportunities for Effective Communication

Effective business communication skills take some practice, but as with everything in life the more you use them the better these skills will develop. Communication skills require learning how and what to say in a way that will get a desired outcome for the people you help support. Many times we are unable to convey our thoughts properly and we end up sending mixed signals in our conversations. We know what we want to say but are unable to find the correct wording.

Brevity is the key to effective communication – both verbal and written. Plain and concise dialogue can be clearly heard/read and understood. Observing economy of words with a specific and goal-oriented approach not only saves time (which is of precious value in any organization) but also leads to clearer views, wise decisions and immediate end-results. As Thomas Jefferson once said, "The most valuable of all talents is that of never using two words when one will do!"

# Presenters Behavior as a Form of Communication

## EXERCISE

Write each of the following emotions on an index card. Pass one card to each trainee. You may duplicate the emotive card if there is a large class, or just let the others in class try to 'guess' the emotion.

The list may include:
Angry
Happy
Nervous
Confused
Worried
Frightened
Bored
Anxious

After the exercise, emphasize that behavior is also a form of communication. Understanding behaviors is a difficult task as some of us express emotions differently.

Discuss the importance of nonverbal communication and how one must be aware of facial expression and the large amount of communication that is contained in facial expression and body language.

**9A**

# PRESENTER 10 Words

***Presenter Script***

"This exercise helps you understand the difficulties people with limited vocabularies have communicating their choices.

First, find a partner. We are going to do a "Communication Exercise." Write 10 words on a piece of paper. Now tell your partner what you would like for dinner tonight using only these ten words."
(Allow 10 minutes)

Have your partner try and guess what the other person is trying to communicate.

Then emphasize that:

- Some persons with whom they will be working may not use the spoken word to communicate.

- Explain that they may use sign language, hand gestures, communication boards, pictures, electronic devices, etc..

- Discuss the importance of observation skills when persons served use facial expressions, body movements and behaviors to communicate their wishes.

- Explain that all behavior communicates something.

**9B**

# PRESENTER – Listening Effectively

According to A. Barbour, author of *Louder Than Words: Nonverbal Communication*, the total impact of a message breaks down like this:

- 7 percent verbal (words)
- 38 percent vocal (volume, pitch, rhythm, etc)
- 55 percent body movements (mostly facial expressions)

This breakdown indicates that effective nonverbal communication skills are essential. There is nothing worse than delivering a speech about how well your organization is doing while at the same time, shrugging, frowning and turning away from the audience. You would be sending mixed messages and based on the above scale no one in the audience will believe that the company is actually performing well.

Effective communication is the combined harmony of verbal and nonverbal actions. Nonverbal communication consists of body movement, facial expressions and eye movement.

Body Movement indicates attitude, conveys feelings serves as illustrators and regulators. Illustrators are nonverbal movements that accompany and illustrate verbal communication.

Regulators are nonverbal cues that monitor or control the speaking of another individual.

While listening to a person you nod you head to indicate that you understand and is in agreement with the speaker. You look away or yawn to indicate that you are bored or would like for the speaker to stop talking. You frown or raise your eyebrows to indicate to the speaker that you either don't believe them are that you don't understand.

Your posture also plays a role in your communication efforts. A slumped posture indicates that you have low spirits, are fatigued or that you feel inferior, whereas, an erect posture shows high spirits and confidence. If you lean forward it implies that you are open and interested. Leaning away shows disinterest or that you are defensive. Maintaining a rigid posture is interpreted by many to mean that you are defensive, while a relaxed posture translates to openness. Crossed arms and legs indicated a defensive, proactive position, while uncrossed arms and legs indicate a willingness to listen.

# PRESENTER – Listening Effectively

Direct eye contact is essential in our society to demonstrate a self-assured, honest personality. Most people find it difficult to look at someone in the eyes when they are talking to them. Direct eye contact can be anxiety-provoking and on occasion can cause some individuals to lose their train of thought. The solution is to focus your eyes somewhere else on the face. For example, you can keep your eyes glued to the person's nose, mouth, or ear. As long as your focus is within eight inches of the nose, the other person will not be able to tell that you are not looking him or her directly in the eyes.

# PRESENTER – Communication Functions

Some of the people that you will help to support may not use words to communicate or may have a limited number of words with which to communicate.

It is essential that you "listen" to the communication that is non-verbal in nature.

Let's look at the following chart to see what some common behaviors may communicate. Remember, these may vary from person to person.

In your role as QIDP, you may want to develop a chart similar to this, but based on each individual who I non-verbal. This is sometimes called a "Communication Dictionary".

# PRESENTER - Communication Functions Scenarios Optional Discussion Exercise

Read these scenarios with the class. Discuss the reason for the behaviors.

1. Sally, who does not speak, became angry at her roommate. First she started hitting and pinching her roommate. Then she bit her roommate. Finally, she threw things at her. Some staff were thinking that maybe she needed some medication to calm her down.

***After investigation, it was found that Sally's roommate had been stealing Sally's clothes. After the stealing stopped and Sally's clothes were returned to her, Sally stopped being angry, and her 'behaviors' stopped.***

2. One day Joe began throwing his food on the floor. At every meal at the group home, Joe's food ended up on the floor. When staff asked Joe why he did it, he replied "I don't know."

***After investigation, it was discovered that a staff person, who was new to the group home, began cooking foods which Joe didn't like. The staff person hadn't bothered asking Joe what he liked to eat. Joe was afraid that if he complained, the new staff person would get make at him and he would be punished.***

3. Alicia, who has epilepsy, began having seizures more often. Alicia is on a self medication program. Staff found that the correct amount of pills had been taken from her pill bottle. Staff was just about to make an appointment with Alicia's doctor to get her epilepsy medication increased when the DSP discovered that Alicia had not been taking her medications as she was supposed to.

***She had been flushing them down the toilet because she didn't like their taste.***

# PRESENTER - Communication Functions Scenarios Optional Discussion Exercise

## Idiom Activity

What is an idiom? It is a phrase that means something other than the direct translation of the words. For example, when we say "we are on the same page", it may mean that we are communicating effectively from a similar perspective. Some people, especially those with autism spectrum disorders do not understand idioms.

List some common idioms then generate other ways of saying those messages that would be clearer to persons who don't understand idiomatic phrases.

# Presenter Coaching Strategies

**Invest Attention in Employees**

- Communicate with employees on a regular basis
- Supervisors should participate in "hands on" work with staff and persons served
- Say "thank-you"
- Give credit where credit is due
- Take a person out for lunch

**Practice What You Preach**

Don't ask an employee to do something that you would not be willing to do

**Concentrate on Solutions (rather than on problems)**

**Communicate Effectively**

Communicating effectively means being a good listener and providing constructive feedback on a regular basis. Sometimes people do not communicate clearly or fail to communicate at all because they are afraid of what might happen, such as:

- Being blamed for the problem
- Hurting other's feelings
- Being misunderstood
- Offending the person
- Being rejected
- Being wrong

**Use Feedback Effectively**

Provide routine feedback by:

- Memos and formal notes
- Supervisory praise statements
- Publicly posted feedback
- Say "thank you"

**Additional Strategies include…**

- Increase staff involvement in managerial actions
- Staff should participate in "quality assurance processes
- Provide opportunity in some aspect of the organizational structure of the agency to impact the management operation of the organization

**12B**

# PRESENTER – The Choice Making Process

The issues of choice and control over one's life are vital to the quality of life for people with intellectual disabilities.

Choice for people with intellectual disabilities has these components.

- The individual must have **experienced** the options from which to choose.

  For example, a choice between a recreational event in which the individual has participated and a proposed activity that has not been experienced may not be meaningful.

- Choice making should be done in a **graduated fashion**. That is, people should be exposed to and assisted in making small choices with limited risk before they are required to make big choices with significant risk.

**Remember, many individuals with intellectual disabilities have lived in environments where options for making choices were limited**

# PRESENTER – Assessing Behavior

## Positive Behavior Support

Positive Behavior Support strategies are an essential element in the work of professionals in the developmental disability field. Positive Behavior Support encompasses behavioral strategies to deal with a broad range of situations from teaching routine tasks and social skills to responding to acts of aggression and self-injury. The goal is to help people with developmental disabilities overcome problem behavior with positive, life-affirming strategies so they can lead quality lives.

The core values of positive behavior support include:

- Respecting the rights of all citizens
- Taking a person-centered approach that includes getting to know the individuals and their families
- Treating people with dignity
- Ensuring that individuals are not abused or neglected

Example of a behavior:

The statement, "John was upset and tried to hurt others" does not indicate how serious the problem is. A clearer statement would be, "John frowned, growled, stomped his feet, tried to pull the hair of staff and flipped over a peer's wheelchair from the side. Injuries to the peer in the wheelchair would have resulted if staff had not intervened."

# PRESENTER Functional Analysis

**Presenter may wish to use these scenarios to elicit discussion regarding the functions of these behaviors.**

1. Kate teases others, which gets them upset. Caregivers lecture her and tell her to stop, but the problem is getting worse:

   Here are some possible solutions
   - Determine the preferred kind of attention
   - Initially, give her lots of attention non-contingently
   - Provide attention only when she is behaving appropriately
   - Attention should never provided when she is exhibiting problem behavior
   - Teach her to obtain attention appropriately

2. Jon bangs his head and screams when his workshop becomes too loud and disruptive.

   Here are some possible solutions
   - Determine <u>what</u> he is escaping
   - Determine <u>why</u> he is escaping
   - Teach him a proper way to refuse or delay request, to leave the situation, or to obtain a break
   - Do NOT use timeout procedures in this situation

Generally, **replacement behaviors:**

- ❖ Increase independence
- ❖ Teach the person to control his/her own reinforcers
- ❖ Teach self-control
- ❖ Improve prosocial behavior
- ❖ Teach person to negotiate problematic environments successfully
- ❖ Bring behavior under control of naturally occurring reinforcers

# PRESENTER – ABCs (Functional Analysis)

Functional Behavioral Assessment (FBA) or Functional Analysis is a process for gathering information about the cause or "function" of challenging behavior that is used to develop efficient and effective behavioral interventions. The functional assessment process includes the use of questionnaires, rating scales, behavioral observation and systematic environmental manipulation when appropriate (i.e., functional analysis, treatment analysis) to determine the underlying causes for maladaptive behavior.

With a Functional Behavior Assessment you should:

- ✓ Define the problem behavior
- ✓ Devise a plan to collect data
- ✓ Compare and analyze the data
- ✓ Formulate the hypothesis
- ✓ Develop and implement a behavior intervention plan
- ✓ Monitor the plan

**Define the problem behavior**

A well-defined behavior is:

- Easily observed
- Countable
- Has a beginning and end
- Is repeatable

**For example** a statement such as "Amy is aggressive" is too vague.
Instead use "Amy pokes, hits or kicks other with her feet or hands before meal time."

**Devise a plan to collect data**
There are two basic methods**: direct and indirect.**

**Indirect methods** use written records, interviews, questionnaires or checklists to identify how others see the situation.

**Direct methods** are assessments to observe and record the problem events as they happen. Direct methods my include frequency counts, interval recording systems and **A-B-C charts.**

Remember to record only those things you see or hear, not you interpretation of the behavior.

The more data you collect, the more accurate a picture of the person's day-to-day behavior and events that surround it will become.

**Compare and analyze the data**
To see the big picture summarize the data
A summary could identify:

- Setting events
- Antecedents or triggering events
- The target behavior
- Consequences to that target behavior

Another summary could simply identify who, what, where and when

**Formulate the hypothesis**
Based on the data collected, give your best, educated guess to explain the function or reason for the behavior.

**Develop and implement a behavior intervention plan**

People respond best to Behavior Intervention Plans that use positive methods to encourage and teach appropriate, alternative behaviors. These methods may include:

- Modifying the physical environment
- Changing the antecedents or consequences of the behavior
- Teaching a replacement behavior that serves the same function

**Monitor the plan**

Regardless of the behavior intervention plan that is developed by the team, be sure to regularly monitor progress over time

Set review dates to ensure this will happen

# PRESENTER – Discovering Reinforcers

Positive reinforcement is one of the key concepts in behavior analysis, a field within psychology. Positive reinforcers are something like rewards, or things we will generally work to get. However, the definition of a positive reinforcement is more precise than that of reward. Specifically, we can say that positive reinforcement has occurred when three conditions have been met:

- A consequence is presented dependent on a behavior.
- The behavior becomes more likely to occur.
- The behavior becomes more likely to occur because and only because the consequence is presented dependent on the behavior.

Reinforcers lose their value if they are freely available. For example, if you offer a person a soda for completing work without displaying the target behavior, but they are given a soda by someone else or can have as many sodas as they want, then the person loses the incentive to earn the soda. Remember to offer a choice of reinforcers. Make sure the reinforcers is available if earned.

# PRESENTERS Types of Reinforcers

In operant conditioning there are **Primary Reinforcers and Conditioned (Secondary**) **Reinforcers.** Primary reinforcers are naturally reinforcing, i.e. there is no learning necessary for them to be reinforcing.

The conditioned reinforcer is learned. For example, many people bribe children with candy to clean their room or do their homework. If the parent continued to bribe their children with candy and also had them put a checkmark on a job chart, after a while the parents could stop giving candy and only have the child make the checkmark and it would still be reinforcing. In this situation, the parent taught the child to be reinforced by making checkmarks. Marking the checkmark is the conditioned reinforcer because it had to be learned. In contrast, the candy is a primary reinforcer because it did not have to be learned.

# PRESENTER – *"The Dignity of Risk"*

Former practices with regard to people with developmental disabilities stressed "protection" to such an extent that individuals never got the chance to explore various life experiences and options. People with developmental disabilities should be given the opportunity to make graduated choices with staff assistance and training. People should first learn to make small choices with limited risks. They can then go on to make bigger choices with more risks as they learn and grow. It is possible for a person to have a support plan which enables them to manage identified risks and to live their lives in ways which best suit them.

# PRESENTER- Least Restrictive Environment

The courts have determined that people with developmental disabilities must be provided service in the least restrictive environment. Courts have ruled that states must create new services if existing programs do not provide the least restrictive setting for any individual.

The concept of least restrictive alternative means that services should be presented tin the most typical setting possible while still meeting the person's needs.

A setting without supports could be very restrictive for some people.
For example, a person who uses a wheelchair requires a residential setting with special adaptations: wide doors, grab bars in the bathroom, lowered kitchen appliances, etc. Without these supports the setting would be considered very restrictive and in fact, dysfunctional

However, you should not provide more supports than necessary

Least restrictive environment has two meanings:

- It must be the most typical or characteristic environment
- It must meet the particular needs of the person

## Remember…
## Least Restrictive Environment does not mean a program without supports and specialized services

# PRESENTER – Materials Needed for Module 4

- **Completed Agency ISP Document (redacted)**
- **Copies of People First Language Exercise (in Presenter Supplements)**

# Presenters – Intro to the IDT Process

All individuals receiving funded services are required to have an individualized plan of care or individual service/support plan (ISP). Individual Service Plans provide the opportunity for enhancing the quality of life of each person by outlining his or her individualized services and supports

The individual and their team are responsible for developing the individual plan of support. ISP teams are composed of people who care about and know the individual. The team may also ask specialists, consultants or specific provider staff to contribute to the plan by completing evaluations, or by observing and collecting information that is basic to the preparation of the plan.

The ISP team is ultimately responsible for assessing and documenting each person's:

- Personal choices and preferences.
- Significant health care, mental health or behavioral needs and related maintenance needs.
- Safety and financial skills.

The ISP teams translate this information into goals and objectives, which are then contained within the written plan. The plan results in outcomes that maintain or change services or supports to reflect what is most important to and most important for the individual in their daily life.

# PRESENTER - ACTIVE TREATMENT

## Presenter may wish to include the following:

**What is active treatment?**

"Active treatment" is a term used to describe the process of teaching independent living skills to people with disabilities. It includes specialized and general training as well as services and supports to assist a person to gain the skills and behaviors necessary to function with as much self-determination and independence as possible.

**What does an "active treatment provider" do?**

The short answer – "TEACH". The best active treatment providers approach all of their interactions with persons receiving services as an opportunity to teach a new skill or expand on a skill previously acquired.

**When is active treatment done?**

Active treatment should be occurring throughout the day, at all times. Active treatment is not an isolated event. It is the result of all the therapeutic interactions and training done throughout the day. To be most effective, active treatment should be happening all the time and occurring in all areas of life.

Active treatment includes implementation of **formal**, written programs.

Active treatment also includes **informal** activities in the areas of leisure, communication, social skills, community travel, money management, activities of daily living, as well as many other aspects of independent living.

Remember that actions/behavior is forms of communication. When persons use actions to communicate, be sure to **use the verbal label** that goes along with the desired response.

Example - Person served pulls on staff's arm for attention. Staff responds by saying (labeling) "*Help. Would you like help with your coat*"?

Remember that you don't need to use these techniques one by one. You can combine them and use several at the same time.

Example - incorporate naming (naming objects) while you are doing self-talk (describing your actions as you perform them).

## Teaching Activities Should Be…

- **Functional** - teach new skills.
- **Meaningful** - Real tasks. There is dignity and purpose in the task. Test: *If the person who is engaged in the activity wasn't doing it, would someone need to be paid to do it for them?* Minimize "busy work" that is discarded when the activity is completed.
- **Follow normalized rhythm** - teach skills at a time/place where they would be used. Use natural cues as the prompt of when to do something. Consider the daily routine and what would typically happen next within the "normal rhythm of life."
- **Age Appropriate** - Use materials and activities that adults without disabilities would use/do.
- **Emphasizes group participation** - work with group and have all persons participating. People can learn from each other.

**Opportunities for Active Treatment include the following:**

- **Example**: Let's say groceries have just been purchased and now need to be put away. Instead of the DSP putting the groceries away while the person stands in another part of the room watching, active treatment can be incorporated into this activity by the DSP explaining what they are doing while they are doing it ("self-talk") and perhaps asking the person to assist by organizing the items in boxes and helping with transferring the items to the shelves or drawers.
- **Example:**
  If a person has a formal goal to grasp a toothbrush, staff should also support the person to use this skill as the opportunity arises (grasping a fork, grasping a hairbrush, etc.). Informal goals don't necessarily have data collected.

# PRESENTER - The Importance of Leisure

- Leisure time choices that people make give us information on which to build future options for choice making. The process begins by staff providing a variety of leisure activities and assists each individual to participate in those of his or her choice.

- Many times people with developmental disabilities have a vast amount of "free time" which makes leisure activities very important

- Leisure time activities can help reduce inappropriate social behaviors. Behaviors like body rocking, aggression, self-stimulation can result from empty free time. People engaged in individualized leisure activities find it difficult to engage in dysfunctional behaviors at the same time.

- Leisure time activities can help with teaching social and communication skills

- Leisure time activities can help promote health and wellness along wit helping to reduce stress and anxiety

- Leisure activities should be provided through integrated community programs

- Individualization, choice and a range of options are needed for leisure programs. (A daily schedule that provides for a crafts class between 7 and 8 P.M. for 6 people living in a CILA does ***not*** place that class in the range of leisure activities.

# PRESENTER – Goals and Objectives

## Introductory Points

**Why developing goals and objectives is so important:**

- To assist persons served in the most systematic way possible to experience success while achieving their fullest potential.
- Establishing goals and objectives creates an environment where service providers must identify individual person's needs, wants, and desires and then developing training to meet these.
- Required by regulatory agencies who provide funding.
- Required by federal statute.

**Why are there specific ways to write goals and objectives?**

- So that we can answer this question: "What will this person be like if he/she goes through the training provided?"
- To give us a way to get empirical evidence to determine if the individual is improving
- To help us define the performance standards we expect each person to achieve as he/she progresses through training
- To help us determine what time and materials will be needed for the training

**Goals and Objectives are NOT the same thing!**
A goal is defined as: "the expected result or condition that involves a relatively long period of time to achieve, that is specified in terms of behavioral outcomes in a statement of relatively broad scope, and that provides guidance in establishing specific, short-term objectives directed toward its attainment."

# PRESENTER – Goals and Objectives

## Writing Goals

Determining goals for an individual may involve such activities as:

- Interviewing the person served, as well as persons closest to the person served; and staff who work most closely with the person

- Observing/investigating: make sure we know what the real goal for the person is:

  (***Provide an example from the instructor's experience; or use this example***: An individual indicated that he wanted to become a pilot. The QIDP took the person to the local airport, but the individual was not much interested in the airplanes. The Q noticed that he spent a lot of time talking to anyone he saw who was wearing some kind of uniform. Upon further investigation, the QIDP discovered that the individual was really more interested in acquiring a job where a "uniform" was required. His limited experience made him think that the only way to do that was to be a pilot! )

- Do not forget that people's interests change over time; it is necessary to continually be sure to review the goal with the individual to be sure that this is the path they wish to continue to take.

- Sometimes counseling may be involved; there may be certain realities that may need to be faced; like overcoming a health or mobility issue before progressing on to achieving another skill or ability.

- Think about who shall be responsible for monitoring the goal achievement (usually this is the QIDP but it does not have to be).

- Determine what steps will be needed to achieve the goal, see if they can be established in a logical chronology; however, remember that more than one step (or objective) can be worked on simultaneously.

- Set a deadline—choose a date when everyone agrees the goal can reasonably be attained.

**Other considerations:**

- There should be a correlation between the individual's needs and desires and the number of goals developed. This may require some prioritization of goals. Medical needs, for example, are usually of high priority. Depending on the individual's current status and level of functioning, some goals may become more important. For example, for one individual, learning to develop independence in self-care skills may have to take precedence over developing academic skills.

- Learning to develop independence in self-care skills may have to take precedence overdeveloping academic skills. However, that is not to say that with some individuals, some goals can be concentrated upon simultaneously.

- Use your knowledge of growth and development to know where the person falls in his attainment of developmental milestones. You can be assisted in this regard with standardized evaluations of developmental levels approved for use.

- Goals should be reviewed at least annually, and based upon fact-based assessment, readjusted as needed.

# Behavioral Objectives

- A behavioral objective is an attempt to define clearly the successful completion of behavioral change. Objectives are measurable intermediate steps between the person's present level of performance and the desired level as stated in the goal.

- Qualities of a well written objective are that they be:
  - Sequential
  - Relate directly to a goal
  - Are measurable
  - Behavior to be changed is observable
  - Are singularly stated—no compound objectives

**How to write good behavioral objectives**

A behavioral objective is one sentence, which is composed of five parts: in this order:

- Conditions
- Person
- Behavior
- Performance
- Timeline

## The five parts explained and defined:

## Conditions:

Describes the things that have happened or are required to happen during the program; or the things the individual will be given to carry out the program.

Examples: "When presented with 10 addition problems…"
"Given the instruction 'John, look at me'….."
"Given a straight line drawn on the floor…"

## Person:

- Use the individual's name, not nickname, not "he" "she" or "you"
- The person should immediately follow the condition

Examples: "Given the instruction: 'John, look at me', John will….
"Given a straight line drawn on the floor, Sarah will…."

## Behavior:

Specify the one behavior that the individual will perform in measurable and observable terms. This means the behavior must be OVERT (sensed through one of the five senses, and able to be measured); not COVERT. Look at the differences between these terms:

| **COVERT** | **OVERT** |
|---|---|
| Distinguish | Draw |
| Conclude | Fill in |
| Concentrate | Underline |
| Think | Repeat out loud |
| Recognize | Point to |
| Be aware | Walk |
| Infer | Count out loud |
| Realize | Pick up |
| Feel | Place beside |
| Be curious | Circle |
| Solve | Name |
| Learn | Climb |
| Know | Repeat |
| Understand | Sort |
| Be able | Push |
| Like | Select |

## Performance:

Performance describes the degree to which the person will perform the task satisfactorily. This may be done by various methodologies:

- How many—i.e., the number of responses; ex.: "will walk a straight line 15 times"
- How long—i.e., time-related—for what length of time; ex. "will package plastic soap dishes into the box for 20 consecutive minutes"
- How often--# of responses that are time-related; ex.: " will make his bed four out of seven times in one week"
- How well—to what degree or at what level of accuracy; ex. "write down the sums of addition problems with 80% correct score or higher."

Some of the best performance criteria combine criteria together; for example: "write down the sums of addition problems with at least 80% correct score on 4 out of 5 addition assignments within a two week period." (how well, how many, how long)

## Timeline:

The timeline is the date which is set by which the performance criteria should be achieved. The timeline date must always include month, date, and year.

Now you should practice attempting to write some behavioral objectives (See Objectives Worksheet)

Presenter can choose options for the trainees to complete the Objectives worksheet. This can be accomplished by having trainees work individually, in small groups or as a large group.

**19A**

# PRESENTER - OBJECTIVES WORKSHEET

**Practice I: Underline the condition statement in each of the objectives below:**

1**. When shown a red colored card and asked "What color is this?", John will state out loud "red" nine times out of ten by May 14, 2012.**

**2. Given a bolt-grid and ten bolts of various sizes, Mary will place all ten bolts onto the corresponding bolt on the bolt grid nine times out of ten by June 4, 2011.**

**3. After using her toothbrush, Rachel will place the toothbrush in the holder two out of three times by February 28, 2011.**

4**. Before leaving the classroom, William will put on his coat nine days out of ten by March 30, 2010.**

**Practice II: In the spaces below, add condition statements to the beginning of each of the sentences below:**

1. **When Given the verbal prompt "Thomas, tie your shoes" Thomas will tie his shoes nine times out of ten by September 30, 2010**

2. **When handed a fork by staff Terry will place the fork to the left of the dinner plate four out of five times by May 6, 2011.**

3. **Upon handing Ellen a pen and her paycheck with endorsement side facing up, Ellen will write her name cursively on the endorsement section of her paycheck for the next five pay periods, by August 1, 2012.**

4. **When handed the condiment basket' Jan will select the sugar substitute packet for her cereal for ten consecutive breakfasts by October 31, 2012.**

**Practice III: Listed below are some statements which contain either overt or covert behavior. Place a C for Covert in the blanks before those statements expressing covert behavior and an O for Overt in the blanks for those statements expressing overt behavior.**

____**O**_ Mary will walk. . . . .
____ **O**_ John will catch a ball ……..
____**C**_ Henry will remember. . . . .
____ **O**_ Sarah will pick up . . . . .
____**C**_ William will indicate. . . . .
____**C**_ Harriet will be able to . . . . .
____**C**_ Jim will learn to . . . . .
____**O**_ Fred will make the sign. . . . . .
____**C**_ Summer will understand. . . . .

**Practice IV: Listed below are some statements that are objectives. Look at the objectives and circle whether the objective has overt or covert behavior. If you believe the behavior is covert, in the blank provided, write down how you would re-word the objective to make it overt.**

1. Given five coins of which one is a dime and the instruction, "point to the dime", Rosemary will point to the dime nine times out of ten by June 1, 2012.
COVERT OVERT Reworded?
_____

2. After using the bathroom, Sam will wash his hands with soap and water nine times out of ten by May 15, 2012.
COVERT OVERT Reworded?
_____

3. When at meals, Jerry will learn to lift his spoon from the plate to his mouth for ten consecutive meals by December 15, 2011.
COVERT OVERT Reworded?
***When at meals, Jerry will lift his spoon from the plate to his mouth forten consecutive meals by December 15, 2011***

4. When presented with a picture of a dog and asked "What is this?", Jerry will be able to sign "dog" nine times out of ten by January 1, 2012.
COVERT OVERT Reworded?
***When presented with a picture of a dog and asked "What is this?", Jerry will sign "dog" nine out of ten times by January 1,2012***.

**Practice V: In the objectives written below, the performance criteria for each has been omitted. In parentheses next to the blank will be indicated the type of performance criteria you should insert on the blank provided.**

1. Given the verbal prompt, "It is time to eat," Rachel will walk to the dining room (How Often) **eight out of ten times for one week** by January 1, 2012.

2. Given a drill and drill bit, Harry will insert the bit into the drill chuck (How Well) **with 90% accuracy (might also add: 8 out of 10 times)** by August 1, 2011.

3. Upon sitting at her work station, Marion will assemble battery packages (How Long) **20 consecutive minutes (might also add 4 out of 5 times)** by November 30, 2011.

4. Given fifteen double digit subtraction problems, Jason will write the answers (how well and how many) **with at least a score of 80%, 4 out of 5 times** by September 30, 2012.

Chuck Padget, Kreider Services.

## PRESENTERS – Task Analysis

## To view a 7 minute video on task analysis, go to: http://silo.hunter.cuny.edu/e8jdJbbt

Many of the day-to-day behaviors that we perform, without even attending to what we're doing, are really quite complex, comprised of many smaller, discrete, singular, specific sub-behaviors that we perform in a certain order.

Consider "one" behavior done easily even when you are tired and distracted: Brushing your teeth. When you think about it (which we rarely do), brushing is really a bunch of distinct simple behaviors performed one after another. Just analyze the task (Ah ha! Now you know where the name came from).

Brushing Teeth
Pick up the tooth brush
Wet the brush
Take the cap off the tube
Put paste on the brush
Brush the outside of the bottom row of teeth
Brush the outside of the top row of teeth
Brush the biting surface of the top row of teeth
Brush the biting surface of the bottom row of teeth
Brush the inside surface of the bottom row of teeth
Brush the inside surface of the top row of teeth
Spit
Rinse the brush
Replace the brush in the holder
Grasp cup
Fill cup with water
Rinse teeth with water
Spit
Replace cup in holder
Screw cap back on tube
Place tube back in toiletry/shave kit

While you may brush your teeth in a different order you get the idea. Others of you are already thinking: "Gee, each of those steps could have been 'broken down' or sub-divided into even smaller steps".

For example, the first step, "picking up the toothbrush" requires the behaviors of locating the toothbrush, reaching toward it, grasping it, turning the bristles upward, etc. How small you decide to make the steps will depend on your best guess as to how well the person will be able to remember, understand, and perform the T.A. process and the sequential steps. Some individuals will display the desired behavior after only 5 steps being provided for them to follow. Others would need 20 increments in order to become competent in that action.

Task analysis is used most often with those who have problems mastering complex behaviors (e.g., individuals with autism, people who have intellectual disabilities or have mental illness, young children).

The process of breaking a complex behavior (a chain of simple behaviors that follow one another in order) down into it's component parts takes a little practice, but soon you'll be able to construct behavior chains for the easier to analyze motor skills, followed by the more difficult to delineate academic and social behaviors.

How are the "links" in the chain of behaviors developed? What process do teachers go through in devising the list of sequential actions? There are a number of ways: You might just imagine the desired behavior and write down the possible "steps". Or you might engage in that behavior, noting the sub-behaviors that lead to the final product. You could brainstorm with a more experienced colleague who has probably taught the behavior before.

Once you have determined the sequence of the discrete links in the chain of a complex behavior, it's time to instruct the individual in joining them together. As you might suspect the process of teaching the links in the chain is called "Chaining".

## Tying shoes

(shorter version for people who need help with the first few steps)

Grab one lace in each hand.
Pull the shoe laces tight with a vertical pull.
Cross the shoe laces.
Pull the front lace around the back of the other.
Put that lace through the hole.
Tighten the laces with a horizontal pull.
Make a bow.
Tighten the bow.

## Tying shoes

(longer version)

Pinch the laces.
Pull the laces.
Hang the ends of the laces from the corresponding sides of the shoe.
Pick up the laces in the corresponding hands.
Lift the laces above the shoe.
Cross the right lace over the left one to form a tepee.
Bring the left lace toward the student.
Pull the left lace through the tepee.
Pull the laces away from one another.
Bend the left lace to form a loop.
Pinch the loop with the left hand.
Bring the right lace over the fingers and around the loop.
Push the right lace through the hole.
Pull the loops away from one another.

# PRESENTERS – Shaping and Chaining

## Shaping

If a behavior never occurs, we say that it is not in the person's repertoire. Shaping is a way of adding behaviors to a person's repertoire. Shaping is used when the target behavior does not yet exist. In shaping, what is reinforced is some approximation of the target behavior.

Approximation means any behavior that resembles the desired behavior or takes the person closer to the desired behavior. Successive approximations are steps toward the target behavior, the behavior you want to shape.

In playing "Hot & Cold", you reinforce any movement that takes the player closer to the prize. Each of those successive movements is a closer approximation of the desired behavior. If the prize is under the couch, and the player is moving toward the couch, every time the player takes a step toward the couch, you are yelling "hotter", and you are reinforcing the behavior. If the player moves away from the couch, you would yell, "colder" (non-reinforcing).

During a successful shaping program, prompts are *faded*. Fading refers to the gradual withdrawal of prompts that have artificially supported a behavior.

## Chaining:

The new behavior you want to build may be a series or chain of behaviors. A behavior chain is a series of related behaviors, each of which provides the cue for the next and the last that produces a reinforcer.

Practically any complex behavior we do in the way of operant behavior is part of a chain or a multitude of chains: eating, getting dressed, using the computer, counting, brushing your teeth, riding a bike, walking to school and so on. Behavior chains are very important to all of us; as is the procedure for building chains, which is called **chaining**.

Chaining is the reinforcement of successive elements of a behavior chain. If you are teaching your child the alphabet, you are attempting to build a chain, if you are teaching the tying of shoelaces, you are also attempting to build a chain.

There are two chaining procedures, forward and backward chaining.

**Forward Chaining:**

Forward chaining is a chaining procedure that begins with the first element in the chain and progresses to the last element (A to Z). In forward chaining, you start with the first task in the chain (A). Once the child can perform that element satisfactorily, you have him perform *the first **and** second* elements (A & B) and reinforce this effort. Do not teach "A", then teach "B" separately; "A" and "B" are taught together. When these are mastered, you can move to "A", "B" and "C". Notice they are not taught in isolation; hence the term 'chain'.

**Backward Chaining:**

This is often a very effective way of developing complex sequences of behavior. In forward chaining, you are teaching A to Z; in backward teaching, you are teaching Z to A. Backward chaining is a chaining procedure that begins with the last element in the chain and proceeds to the first element.

To illustrate backward chaining, consider the following example: I want to teach someone to complete a six-piece puzzle. The steps are:

1. put in first piece
2. put in second piece
3. put in third piece
4. put in fourth piece
5. put in fifth piece
6. put in sixth piece

To backward chain this task, I would follow steps one through 5 myself, presenting the task as completed except for the last piece. Then, I would (using whatever prompt level necessary) teach the individual to put in the sixth piece (step 6). When he/she can successfully do this a number of times, I will teach steps 5 & 6 (completing steps 1 through 4 myself beforehand).

Backward chaining this puzzle gave the individual the idea of what he/she was doing ahead of time (there weren't just a bunch of puzzle pieces laying there) and teaching in this way gives an even clearer clue of the next step. I would be reinforcing each step as I am teaching it, but once the individual learns step 6, I will only reinforce steps 5 & 6 together (next link in the chain).

# Foundations of Person-Centered Planning

**Directions**: Review a completed planning document. Read the whole plan and then reflect on the following questions. Write down your responses. Base your responses only on what you find on the written plan.

1. Do you know what is most important to the person? For example, do you know whom the person loves most in the world? Do you know his or her "pet peeves"? Why does this person get out of bed in the morning? What makes for a good day? What was the hardest thing this person has ever lived through? What is missing to really understand this person and the important events of his or her life?

2. Were the words used to describe the person and his or her goal the words you would use to describe your goals? For example, are words like "socially isolated" used to describe "lonely?" Are goals listed on the plan ones that a person would actually have for him or herself? For example, is a goal of "being to work on time 20 out of 30 trials" important to a person? Or is the goal of "keeping my job" more likely to be significant?

3. How many goals and objectives on the plan focus on valued social roles (NOT ridding the person of 'bad' habits)? How many were focused on contribution to community or enhancing relationships with unpaid people in his or her life? If this plan were successfully achieved, how would the person's life be better? How do you know?

4. Based on what you have read, was this a service-centered plan, a person-centered plan, or something in between? Why is this your response?

# PRESENTERS - What Is A Rights Restriction?

## Underlying Assumptions

- The use of restrictive practices is a major event in the lives of all concerned and should be employed only when positive supports are ineffective.
- Regular evaluation of the plan must take place. That can only be done accurately with the use of effective data collection techniques.
- Restrictions are presumptively viewed as temporary and must be coupled with training in the acquisition of positive behavioral skills.

**Restrictive Interventions which must be reviewed** (this is a descriptive, rather than exhaustive, list)

**All interventions with restrictive components, such as:**

Limitations on access:

- To personal possessions (money, mail, clothing, cigarettes);
- To personal or public space (locked areas, off limits areas);
- To food or drink;
- To activities;
- To friends, family, children, significant others, etc.;
- To community services;

Limitation on movement

- Bed rails;
- Mitts;
- Belts;
- Therapeutic holds;
- Escorts;
- Braces, helmets, splints for behavior control;
- Mechanical restraints

Medication

- Psychoactive drugs and medications used for behavior control

# PRESENTER – People First Language Instructions

Presenter will need to make copies of the following Exercise and distribute to trainees. During the Exercise, remember to emphasize how the language we use can shape attitudes of people around us.

Presenter may also want to discuss how language has changed over the years with regards to people with developmental and intellectual disabilities. Words such as "Feeble-minded", "moron", "idiot" were used as diagnostic terms.

Our language regarding Intellectual Disabilities continues to evolve. In February 1, 2010, the Division of Developmental Disabilities replaced the use of "**QMRP**" (Qualified *Mental Retardation* Professional with "**QSP**" (Qualified Support Professional).

Effective 1/1/2012, Public Act 097-0227, required all state agencies to replace the term "mental retardation" with "intellectual disability" or "intellectually disabled" in all rules, policies and procedures. This change required the Department of Human Services to now refer to QMRP or QSPs as "Qualified Intellectual Disabilities Professional or QIDPs.

It is the Division's belief that this new terminology is more respectful to persons with intellectual disabilities. It should be understood, however, that materials from the federal Centers for Medicare and Medicaid Services will continue to use the term "QMRP" until replacement language is adopted by that entity.

**61A**

# PRESENTER - People First Language

Please translate these statements into people first language:

| | | |
|---|---|---|
| He's a mongoloid. | | He is a person with Down's syndrome. |
| He's a quadriplegic. | | He has a physical disability. |
| Mary is non-verbal. | | Mary uses gestures to communicate. |
| Lilly is confined to a wheelchair. | | Lilly uses a wheelchair to get around. |
| Laura is autistic. | | Laura is a person with autism. |
| He had a behavior. | | He (stated what he did). |
| Adam is low functioning. | | Adam requires lots of assistance. |
| Connie is non-compliant. | Or | Connie likes to do things her own way.<br>Connie doesn't like to do what is asked. |
| Jane is a tube-feeder. | | Jane receives nutrition via G-tube. |

**61B**

# People First Language

Please translate these statements into people first language:

He's a mongoloid. _____

He's a quadriplegic. _____

Mary is non-verbal. _____

Lilly is confined to a wheelchair. _____

Laura is autistic. _____

He had a behavior. _____

Adam is low functioning. _____

Connie is non-compliant. _____

Jane is a tube-feeder. _____

# PRESENTER – Materials Needed for Module 5

- **Forms for Recordkeeping Exercise**
- **Copies of Agency Release of Information**

**3A**

# PRESENTER – Record Keeping

Documentation completed over a long period of time shows what has been going on in the individual's life and the types of supports s/he has been given. For example, if the person periodically demonstrates some serious challenging behavior, documentation over time may show a pattern or patterns regarding events that may trigger the behavior. Documentation can also indicate successful prevention strategies used in response to these episodes.

Documentation completed by different people can indicate whether each person is providing consistent supports. For example, notes in a health log can indicate if all DSPs respond in the same way when someone has a seizure. Or, if DSPs are all following the same techniques and treatments needed to prevent skin breakdowns on people who are at risk of/or who have already developed pressure sores or decubitus ulcers.

Documentation can provide a record of history. Therefore, any time information is unknown about the person's past, referring to thorough documentation can help fill in the blanks.

## RECORD KEEPING – SUPPLEMENTAL ACTIVITY

### Discussion on Types of Documentation

1. Identify five (or more) different areas of support in which it may be important to communicate through documentation. (Instructor lists class's comments on a marker board.)

2. Identify the information that should be included in each of the listed documentation categories.

# PRESENTER - Sections of Individual Files

Presenter should be prepared to discuss agency specific individual files. Various agency documents can be used for discussion regarding where they are to be filed in individual records. Sample of individual record may also be brought to class and used for discussion.

# PRESENTER - Record Keeping Application Exercise

**Presenter should be prepared with copies of Agency forms chosen to use with this Exercise. Sample of file folder also needed.**

**Partially prepare forms and have the QIDP fill in the remaining information.**

# PRESENTER – *Optional* Materials for Module 6

- **Copies of "Community Resources" List (In Presenter's Supplements)**
- **Copies of "Guardianship and Advocacy" (In Presenter's Supplements)**
- **Copy of Community Participation Planning Tool (PDF)**
- **Copy of "My Choice, My Future" (PDF)**

# PRESENTER - Community Resources, Supports & Technical Assistance

**Presenter may wish to copy the following list and distribute to trainees. Optional exercise would be to use laptop with projector and navigate through some of the online resources.**

# PRESENTER - Community Resources, Supports & Technical Assistance

Illinois Assistive Technology Program
www.iltech.org/

Illinois Centers for Independent Living
www.incil.org/locations.asp

Illinois Network Facilitators
http://www.dhs.state.il.us/page.aspx?item=48541

Illinois Offices for Rehabilitation Services
http://www.dhs.state.il.us/page.aspx?module=12&officetype=7&county=

United Cerebral Palsy of Illinois
www.ucpillinois.org/

Epilepsy Foundation of North and Central Illinois
http://www.epilepsyheartland.org/

Epilepsy Foundation of Greater Southern Illinois
http://efgreatersil.org/

Muscular Dystrophy Association
www.mdausa.org/

The Autism Program of Illinois
www.theautismprogram.org/

Illinois Department of Human Services
http://www.dhs.state.il.us/page.aspx?

Illinois Coalition Against Sexual Assault
www.icasa.org

# PRESENTER – Guardianship Supplemental Materials

**Presenter may wish to discuss or copy the following materials on Guardianship if desired.**

## GUARDIANSHIP AND ADVOCACY COMMISSION
## THE OFFICE OF STATE GUARDIAN

The Office of State Guardian advocates for the rights of over 5,300 disabled adults in Illinois. By law, the Office of State Guardian serves as guardian only when no other person is suitable and willing to serve. With nine regional offices, the State Guardian is active in virtually every county in Illinois. In addition to serving as guardian, the State Guardian offers guidance and advice to persons requesting such assistance. The Office of State Guardian encourages maximum self-reliance and independence. Where possible, alternatives to guardianship should be pursued.

### GUARDIANSHIP FACTS

Illinois has one of the most unique and progressive guardianship laws in the United States. Previously, people with disabilities were termed "incompetent" and "conservators" were appointed by Probate Court to care for the person with a disability's estate and finances. In 1979, the Illinois Probate Act was amended to provide statutory protection for people with disabilities. Entirely new forms of guardianship were established. Most importantly, new procedures for the appointment of guardians and for the supervision of people with disabilities and their estates were created.

**Guardianship is needed when a person is unable to make and communicate responsible decisions regarding his personal care or finances due to a mental, physical or developmental disability**. Without more, a mental, physical or developmental disability is not sufficient for the appointment of a guardian. The fact that a person is elderly, mentally ill, developmentally disabled, or physically disabled does not necessarily indicate a need for guardianship. The extent to which a guardian is allowed to make decisions for a ward is determined by the court based on a thorough clinical evaluation and report.

Two basic types of guardianship are "person guardianship" and "estate guardianship". A "guardian of the person" is appointed by the court when a disabled individual cannot make or communicate responsible decisions regarding his personal care. This guardian will make decisions about medical treatment, residential placement, social services and other needs. The court appoints a "guardian of the estate" when a person with a disability is unable to make or communicate responsible decisions regarding the management of his estate or finances. The guardian will, subject to court supervision, make decisions about the ward's funds and the safeguarding of the ward's income or other assets.

The Illinois Probate Act gives the court the flexibility to tailor guardianship to meet the needs and capabilities of people with disabilities. Depending on the decision-making capacity of the person with a disability, the court can appoint a limited guardian who is granted the power to make only those decisions about personal care and/or personal finances that the court specifies. The court can also appoint a plenary guardian who generally has the power to make all decisions about personal care and/or finances for the person with a disability.

In anticipation of emergencies, the Probate Act provides for specific remedies to temporarily safeguard alleged people with disabilities. A temporary guardian may be appointed by the court for the period between the filing of a petition for guardianship and the conclusion of the court hearing where the need for guardianship is decided. Temporary guardianship, which lasts no longer than 60 days, is a means to ensure that an alleged person with a disability receives immediate protection. It is intended only as a short term remedy and is utilized only where a demonstrated harm or emergency exists.

For the most part, any person 18 years of age and older who has not been convicted of a serious crime and who is of sound mind can serve as guardian, if the court finds the person suitable. A guardian must be a legal resident of the United States. Public and private not-for profit agencies also are eligible and encouraged to participate in the guardianship role. Only agencies providing residential services to people with disabilities residing in their facilities cannot serve as guardians.

Family members are not automatically named the legal guardian for their disabled relative. In all cases, the court will make a determination as to the need for guardianship and who should serve as guardian. A family member may petition the Judge to be named guardian or the person with a disability may express a preference as to his guardian. If the person with a disability expresses a preference, the Judge will give consideration to the person with a disability. However, the Judge appoints whomever will make the best guardian and act in the best interest of the person with a disability, regardless of the party's relation to the disabled.

## INITIATING THE LEGAL PROCESS

Guardianship is a court-created responsibility. In order for a guardian to be appointed, a petition must be filed in the court by an "interested person". The petition includes basic information, such as the name, date of birth and address of the person alleged to be in need of guardianship. A report must also be filed which includes a physician's description of the person's physical and mental capacity along with their relevant evaluations which would enable the Judge to determine the kind of guardianship needed.

Guardianship hearings are set within 30 days of a petition being filed with the court. The alleged person with a disability, or Respondent, must be served with summons and a copy of the petition. The Respondent may be represented by an attorney, have a jury trial and present evidence and cross-examine witnesses. Where appropriate, the court will appoint an attorney or lay person to serve as the guardian ad litem. The guardian ad litem acts as the "eyes and ears" of the court, and advocates for the best interest of the Respondent. Before the hearing, the guardian ad litem must interview the Respondent, inform him of his rights, and investigate the appropriateness of guardianship. If the alleged person with a disability opposes the opinions of the guardian ad litem, or disputes the need for guardianship, the court may appoint an attorney to represent the Respondent.

At the hearing, evidence about the Respondent's health, mental faculties, finances, housing and life style is presented. The guardian ad litem reports to the court as to the condition of the Respondent and may recommend the type of guardianship needed. The court reviews all the information presented, including the physician's report, the testimony of witnesses and the testimony of the guardian ad litem. Finally, the court either enters a limited or plenary guardianship order or finds that no guardianship is warranted.

An appointed guardian is responsible for overseeing a program intended to maximize the ward's self-reliance and independence. A person guardian also may be required to submit an annual report to the court concerning the services provided to the ward and the status of the ward's personal care. Estate guardians must file inventories of the ward's assets and periodic accounting of estate receipts and disbursements. All estate expenditures are subject to court review, and the guardian may be held accountable for estate assets improperly managed.

If a change in guardianship seems indicated at any time, or if the annual report recommends that guardianship be changed or revoked entirely, a petition for modification or termination of guardianship can be filed. Based on this, the Judge may then terminate the guardianship or modify the guardian's duties. A court may also appoint a successor guardian if a guardian is unwilling or unable to perform his duties.

Any party filing a petition for guardianship usually is required to pay fees for filing, sheriff's fees for the service of summons on the Respondent, and attorney's fees. Although it is not required, petitioners are generally represented by attorneys, particularly in contested guardianship cases. In some cases, the petitioner may pay fees for the services of the guardian ad litem or the physician who prepares the medical report. If the alleged person with a disability has funds, these may be used to pay costs and fees.

Guardianship can be costly and complicated. In many cases, alternatives to guardianship can and should be used. Guardianship should be considered a last resort, a mechanism by which a person's legal rights are taken away for a sound and necessary purpose. It should never be used in a retaliatory manner or as a convenience for a health care provider or a family member.

## PRESENTER – Community Resources
## CART/SST

CART is a clinical administrative review of a case that is done when an agency is having difficulty addressing issues with an individual. The review team is multidisciplinary and includes clinical representatives from the SODC for that region as well as the SST for that region. The disciplines involved can be any combination of social worker, psychologist, behavior analyst, QIDP, nurse, pharmacist, psychiatrist, network staff, and PAS agents. The agency can request a CART review for an individual from the network staff, PAS, or ISSA. The networks, PAS, and ISSA can also request that the agency present the case at CART if they feel the individual may benefit from a review. The CART members will then provide technical assistance and other pertinent recommendations regarding the case to the agency. The case is generally revisited with the agency at a future CART to assess if recommended interventions were effective in improving the situation.

The SST is a multidisciplinary service team that provides on site evaluation, observation, and technical assistance. These teams generally consist of QIDP, nurse, social worker, and behavior analyst with ready access to PT/OT, speech, medical and psychiatric consultations, among others. The team members work intensively with the agency to train staff and provide assistance with any number of needed services- behavior plans, behavioral data collection, behavior support programs, linkage to needed resources, and psychiatric assessment being just a few. These teams maintain involvement with the agency and assist them in implementing recommendations until the identified issues are managed or reduced. PAS, ISSA, BTS and network staff can ask for an SST referral, but decisions regarding final referral are made on a triage basis subject to need and available resources. The SST referrals generally involve a situation where the individual's challenges are threatening the ability for them to remain in their current community placement.

## PRESENTER - The Five Dimensions of the Principle of Normalization

***Presenter Introductory Script -*** *People with Developmental disabilities have not been fully accepted by society. They have been perceived as significantly different. This difference is negatively valued. The combination for being both different and devalued results in people being stigmatized.*

*The distinction between the terms different and devalued is important. Many individuals are different but not devalued. An absent-minded professor or the million-dollar athlete may act differently but they are not devalued. If you are valued and accepted by your friends, you can deviate from the norm in certain ways and your friends will still tolerate you. However, people who have developmental disabilities and are devalued are not allowed to act differently.*

*Society is not as willing to tolerate differences in people with developmental disabilities. For instance, you might not be admonished for playing your stereo too loudly on a Friday night, but the same behavior by a person with developmental disabilities may not be so easily tolerated. To be socially accepted, people who are negatively valued because they are different must act in a conservative manner.*

*The normalization theory suggests that you, as an employee of a human services agency, should minimize the perceived differentness of people with developmental disabilities. Human services agencies should attempt to reduce the stigma and deviancy associated with disability. The normalization principle does this by encouraging people with developmental disabilities to establish behaviors and experiences that are similar to those of other people. It also promotes the use of valued means to achieve goals. Both the means to the end and the end behavior or experience should be valued as typical of the norm.*

## PRESENTER _ Community Presence

The first dimension of the normalization principle is community presence. This means that both the programs and the people themselves must be situated in the community. Community presence can be considered as physical integration.

Services and activities should be provided in local neighborhoods and communities. Isolation should be avoided.

Residence in a neighborhood or community provides a sense of belonging or ownership. People residing in a group home outside the neighborhood cannot make the same claim on services or activities as people on your block. Access to the services and activities also influence community presence, speed of transit and convenience influence access. Public transportation, parking, traffic congestion and physical safety determine ease of access. A supervised apartment program in a high crime area does not promote community presence. Similarly, a work training program distant from public transportation prevents some people from making full use of the training opportunity.

Residential options for people with developmental disabilities should also consider the distance and access to the same resources commonly used by persons without disabilities.

### Community Participation

Community participation, the second dimension of the normalization principle, is a measure of the extent to which people are socially integrated into the community. This includes both impersonal and personal interactions. The impersonal interactions take place, for example while purchasing an item at the neighborhood “Dollar” store, while ordering a meal in a restaurant, and during work or work training. Public attitudes and the behavior and appearance of people with developmental disabilities should be positive.

Community participation also involves person interactions, including the opportunity for meaningful relationships with friends and family.

Both personal and impersonal interactions are influenced by how services are provided by an agency. Services for people with developmental disabilities in any community should be comprehensive. All needed services should be available in the community, but no single agency or organization should provide all of the services. The residential program should be separated from the recreational program. Vocational and work training programs should take place apart from the residential program.

## Skill Enhancement

The third dimension of the normalization principle implies that people should perform according to the expectations of the culture for a particular age range. Firm expectations should be set for people with developmental disabilities.

Human services agencies should be committed to helping each person achieve greater independence.

One common obstacle to growth and development is physical and social overprotection. This occurs when programs unnecessarily lower the person's exposure to normative dangers, risks, and growth and learning challenges. All people learn through making a series of mistakes. The series moves in the direction of increasing complexity and danger. If people do not learn from minor failures they are ill prepared to make more important decisions and may face potentially dangerous consequences. Overprotection prevents people from learning.

Social overprotection takes place through rules, commands, role expectations, and peer pressure. Unnecessary restrictions on the use of community resources, prohibitions on certain recreational or leisure time activities, and dress codes are examples of social overprotection.

**Programs that serve many** people with developmental disabilities are frequently forced to set up extra rules and procedures in order to control large numbers of people. Unfortunately, this approach results in group management practices that ignore individual needs. In addition, the rules and procedures are usually designed for those persons with the most needs. As a result, those with fewer needs and supports must accommodate themselves to the overprotected environment. Instead of designing programs around the person with the greatest needs, human services agencies should allow each person with a developmental disability the dignity of risk and opportunity to learn from mistakes.

## Image Enhancement

Human services programs should assist people with developmental disabilities to project positive images. There are two reasons why a positive image is vital. First, it is human nature to treat people as they are perceived; thus a person who projects a negative image is treated in a negative manner. Second, a person who is treated in a negative fashion starts to act accordingly. The self-fulfilling prophecy occurs as the person with a developmental disability begins to act out the negative expectations.

Enhancing the image of people with developmental disabilities exerts a direct and positive influence on the public's perception. Improvement of their self-image and personal appearance and the development of skills and behaviors in these individuals contribute to a more positive public perception. The public's expectations are increased, and the self-fulfilling prophecy yields positive results.

The public perception is frequently confused because of the age-inappropriateness of programs for people with developmental disabilities. Developmental services for adults are frequently offered in old school buildings. Transportation is provided by the yellow special education bus, and the interior decorations of facilities are associated with childhood. Similarly, adults sometimes dress in a childlike fashion. This is particularly evident in grooming, dress, hairstyle and mannerisms. The issue of age-appropriate possessions is similar to that of dress and fashion. The staff can have a direct influence in these instances. Although you may have little control over transportation to the vocational center, you can encourage a person to have and value those appearances appropriate for his or her age. Age appropriate labels and forms of address should be used. You can refer to children by their first names, but adults should be introduced and Mr. Ms. Or Mrs.

## Autonomy and Empowerment

The final and most important component of normalization is autonomy and empowerment. In one sense, these issues are related to legal rights. People of all ages have basic rights. Due process, equal protection of the law, freedom from abuse, and the right to medical treatment are rights accorded all people regardless of age. Other rights are acquired gradually with age. The law often sets forth specific ages at which adolescents gain specific rights. The legal age of maturity generally corresponds to the time period when people attain greater autonomy.

Autonomy and empowerment, however, have important meanings quite apart from the legal sense. Autonomy and empowerment mean transferring power and control to people with developmental disabilities. Responsibility for making decisions rests with each individual, regardless of developmental disability.

People with developmental disabilities often become dependent on the service provider to make decisions for them. Advocacy efforts and consumer-driven service coordination programs are designed to focus the decision-making responsibility on the individual.

Human services agencies should periodically review policies and procedures concerning rules or restrictions placed on people with developmental disabilities. Limitations with regard to smoking, drinking, choice of residence or roommates, and leisure-time activities should be clearly justified.

The autonomy of people with developmental disabilities can best be ensured by making them the key to developing the individualized service plan. They should be present at their individualized service plan meetings and reviews, even if the staff question their ability to understand or contribute.

Participation of people with developmental disabilities in their individualized service plan meetings can be enhanced by the following methods:

1. Simulated team meetings can teach people their roles and responsibilities.
2. An advocate or service coordinator can assist the person with developmental disabilities with his or her role and responsibility.
3. All questions concerning likes, strengths, and needs should be first directed toward the person with a developmental disability. The staff should contribute to the meeting only after that person has spoken or if he or she cannot respond to the question.

Finally, the person with a developmental disability should determine what services are provided and the manner in which they are provided. The question of what is best for that person should resume a secondary position to the more important question of “What does the person choose to do?” The responsibility of the staff is to teach and assist people with developmental disabilities to make responsible decisions.

# PRESENTER - KEY PRINCIPLES TO COMMUNITY-BASED INTEGRATION

**The instruction is individualized and focuses on those specific skills needed and wanted by the person for a desired life**
The skills chosen as priorities, then, are based on what each person desires for his or her community life. While there are some areas that are predictably important for community life, it is important to prioritize them according to the wishes of the person. If someone cannot cook, for instance, but has a number of support strategies to get around that issue, and also has little interest in learning to cook, then cooking should not be a major focus.

Some questions to ask about this might be:

- What are the interests of the individual?
- What are the person's gifts?
- What goals and dreams does the person have regarding community life?
- What are the life priorities for the next few years?
- What community places does the person desire to access?
- What skills will the person need to function successfully in his or her desired lifestyle?
- What are the support needs of the individual?
- What are the available resources in the community?
- Which resources will lend themselves to meeting the needs of the person?

**The instruction is provided in a variety of actual settings where individuals want to be competent or will need to utilize life skills**
The community provides lots of potential setting where competencies can be explored based on interests. For example, libraries, grocery stores, department stores, hair salons, coffee shops, discount stores, movie theaters, fast food restaurants, sit-down restaurants, and post offices all offer places to learn, interact and make new friends.

**Instruction focuses on participation in functional activities rather than just performing an isolated skill** Instruction should focus on attainable skills in a reasonable time frame, and alternative strategies should be made for non-mastered skills. If repeated practice is needed on a particular area, such as counting change, setting up rehearsal opportunities should be effective, but not to the exclusion of fully participating in the community activity.

**Varied instruction combined with supports natural to a setting are used to help individuals generalize skills.**
Once the individual masters a skill in one setting, introduce new skills so the person can continually experience success. Generalization also can be done with different materials, times or situations.

Whenever possible look for support and learning experiences that can become self-sustaining, rather than those dependent on outside assistance. As natural supports are built up over time, the trainer's presence becomes less and less necessary.

**Instruction takes place at the time of day at which the task is usually performed.** If an individual wants to learn or prepare lunch, return a book to the library, or make a bank deposit, instruction should occur at the natural time that event would typically occur. It should also occur in the natural setting to promote learning.

**Whenever possible, instruction comes from the natural environment from those with the skills and experience who are in the setting where the skills will be utilized**
For instance, a bank teller, if asked, might be willing to offer someone support on using a checkbook. A neighbor might help with teaching to cook, using the bus, or operating a dishwasher. To find out where these types of people resources are, though, you will need to map out the assets of a community.

Source: Community-Based Instruction, Dale DiLeo, 2005.

*Often, people with very significant disabilities may spend most of their time in the same places with the same people. Staff may believe that some people they serve have disabilities that are so severe that they do not notice their environment. It is sometimes difficult to be sure how much a person understands and feels if they have communication and/or physical challenges. However, it is an unfair assumption to believe that people do not notice or experience their environments in any meaningful way. Think how much you enjoy being outdoors on a warm spring day, feeling the warmth of the sun and the breeze on your face as compared to a day spent confined to a room indoors. Even if people cannot act or speak for themselves, it does not mean they are not affected by things or that they do not enjoy new sights, sounds, and experiences.*

# PRESENTER – *Optional* Materials for Module 7

- **Copy of "How to Be Fire Safe" Curriculum (Link in Presenter's Supplements)**
- **Copies of Risk Assessment Tools(PDF)**
- **Copies of MSDS Sheets(Link in Presenter's Supplements)**
- **Copies of "Small Group Activity"(Link in Module)**

# PRESENTER - A Quality Home Activity

*You may do this activity individually or in a small group. If you decide to do it in a small group, follow the instructions listed below.*

1. *Divide trainees into groups of 3-5.*
2. *Ask group members to follow the instructions in their notebooks.*
3. *Ask each group leader to give the characteristics their group used to describe a quality home.*
4. *Note those that are related to environmental health and safety.*
5. *Responses should suggest that a quality home:*
   - *involves appropriate choices;*
   - *provides shelter;*
   - *is free from hazards;*
   - *meets individual needs (e.g., mobility)*
   - *etc.*

**6A**

# PRESENTER - Accommodations

We all have a role in making sure that all individuals have quality homes to live in. It cannot be a quality home unless it is environmentally safe and appropriate to the needs of the individual.

What may be safe for one individual may not be safe for another. Environmental accommodations may be needed to make a living situation appropriate.

What might these accommodations include?

*Hold a brief discussion on this question.*

*Possible responses include:*

- ***ramps***
- ***silent alarms***
- ***wider door frames***
- ***hand rails/grab bars***
- ***automatic door openers***
- ***roll-in showers***
- ***plumbing adaptations to allow for cutouts; toilet/sink adaptations***
- ***cabinet/shelving adaptations***
- ***lighting modifications (visual impairments)***
- ***acoustic treatments such as acoustical ceiling tiles, wall hangings to decrease reverberation (hearing impairments)***

# Universal Sign for Emergency

***The following information is based upon (National Council on Disability) NCD's 2009 report entitled Effective Emergency Management: Making Improvements for Communities and People with Disabilities***

For individuals who are deaf-blind, receipt of an emergency message often involves diverse communication needs. Large-print and tactile cues are preferred when available. Communication with individuals who are deaf-blind can range from sign language near the person's face to sign language in the palm to words written on the palm with a finger.

**The universal symbol for an emergency is a tactile symbol "X," "drawn" on the back of the deaf-blind individual by an individual who is alerting him or her**.

This symbol is understood to mean that an emergency has occurred and that it is imperative for the individual receiving the message to follow directions and not ask questions. However, few preparedness materials or trainings include this information

# PRESENTER Fire Safety

Supplemental Material

This curriculum is designed to teach people with disabilities about home exit plans and smoke detector maintenance so that they can respond independently to fire emergencies in their homes. The *Fire Safe* curriculum has been pilot tested in California, Minnesota and North Dakota with measurable success. All of these training materials are currently accessible and can be downloaded to use for training.

- Fire Assessment
- *How to Be Fire Safe*
- *How to Be Fire Safe - Trainer's Guide*
- *How to Be Fire Safe - Visual Guide; Snow*
- *How to Be Fire Safe - Visual Guide; Rain*
- *How to Be Fire Safe - Visual Guide; Sunny*
- *How to beFire Safe, Part II*

http://www.seedseducation.org/firesafety.htm

**Presenter may wish to copy one of the curricula above to discuss in class regarding safety programs that may be developed for individuals supported.**

# Presenters MSDS

- **Presenter should explain where MSDS sheets are located at each building or residence**
- **Explain scope of duties at your agency for maintaining current MSDS sheets at each location**
- **Print and make copies of an MSDS sheet and discuss in class**

**A blank MSDS can be found at:**

**http://www.ehso.com/images0407/msds%20form%2016-section.pdf**

# Presenters Carbon Monoxide Detectors

***Effective January 1, 2007, every Illinois home is required to have at least one carbon monoxide alarm in an operating condition within 15 feet of every room used for sleeping purposes. Homes that do not rely on the burning of fuel for heat, ventilation or hot water; are not connected to a garage; and are not near a source of carbon monoxide (as determined by the local building commissioner) are not required to install carbon monoxide detectors. (Public Act 94-741)***

# PRESENTER Know the Person's Risk Management Plan

Knowing the risk management plan for potential behaviors would entail some form of a functional assessment to help understand the individual's behaviors. These behaviors maybe to escape, avoid, or to obtain something, most behavior intervention plans stem from the knowledge of why an individual has maladaptive behavior and should be based on a functional assessment.

**Presenter may wish to discuss agency risk assessment tool or use handouts of sample risk assessment tools.**

# PRESENTER MAY USE THE FOLLOWING OPTIONAL ACTIVITY

**Presenter will need to ensure a sufficient number of copies are provided for the small groups.**

Small group activity for use with "Food Safety Guidelines" Section

## PRESENTER'S Small Group Activity (Presenter copy)

Your group home has decided to invite several people over for Thanksgiving dinner. You have a large kitchen and dining room, so this will work out well. Including individuals, families, friends, and staff, there will be approximately 27 people at this get together. The individuals in your group home have chosen the following foods to comprise the menu:

Turkey
Stuffing
Giblet gravy
Ham
Candied Sweet Potatoes
Fresh Green Beans
Cranberry Sauce
Rice
Hot Dinner Rolls
Butter
Iced Tea

Banana Cream Pie
Pumpkin Pie
Coffee

Six individuals live in your group home and you will assist three of them in purchasing the foods while the other three will assist in food preparation.

Using the principles of food sanitation and safety, identify important principles in the preparation of this meal. Discuss food purchasing, preparation and storage of leftovers.

## Here are the facts which you need to consider in your groups:

You purchase frozen turkeys. Discuss storing and thawing as well as cooking the turkey you purchased.

**Frozen Turkey**

Keep frozen until you're ready to thaw it.

Turkeys can be kept in the freezer indefinitely. However, cook turkeys within 1 year for the best quality.

**Thawing Your Turkey**

There are three ways to thaw your turkey safely:

**Thawing in the Microwave Oven**:

Check your owner's manual for the minutes per pound and the power level to use for thawing.

Remove all outside wrapping.

Place on a microwave-safe dish to catch any juices that might leak.

Cook your turkey immediately after thawing in the microwave.

Do not refreeze.

**Thawing in the Refrigerator:**

Keep the turkey in its original wrapper.

Place it on a tray to catch any juices that may leak.

A thawed turkey can remain in the refrigerator for 1 to 2 days.

If necessary, a turkey that has been properly thawed in the refrigerator may be refrozen.

| Thawing in the refrigerator | Time to thaw (allow 24 hours for every 4 to 5 pounds) |
|---|---|
| 4 to 12 pounds | 1 to 3 days |
| 12 to 16 pounds | 3 to 4 days |
| 16 to 20 pounds | 4 to 5 days |
| 20 to 24 pounds | 5 to 6 days |

**Thawing in Cold Water:**

Wrap your turkey securely, making sure water is not able to leak through the wrapping.

Submerge the wrapped turkey in cold tap water.

Change the water every 30 minutes.

Cook the turkey immediately after it is thawed.

Do not refreeze.

| Thawing in cold water | Time to thaw (allow 30 minutes per pound) |
|---|---|
| 4 to 12 pounds | 2 to 6 hours |
| 12 to 16 pounds | 6 to 8 hours |
| 16 to 20 pounds | 8 to 10 hours |
| 20 to 24 pounds | 10 to 12 hours |

## (Answer Key)

1. John, who lives in the group home, is assisting with cooking this dinner. He has cooked about three times the amount of rice needed. Discuss storage of the left over rice.

***You can store cooked rice for about 6 days in the refrigerator or up to 6 months in the freezer. To reheat it, add 2 tablespoons of water for each cup of cooked rice and put it over very low heat in a covered pan on the stove or reheat it in a microwave oven.***

***There is a form of bacteria (bacillus cereus) that occurs naturally in many samples of uncooked rice. It can survive the cooking process and multiply to harmful levels if the rice is allowed to cool for an extended period without refrigeration. Leftover cooked rice should be placed in a shallow container to allow it to cool quickly, and stored in the refrigerator for up to a week or in the freezer for half a year or more.***

2. Martin lives in the group home and his mother has insisted on stuffing the turkey the night before. She always does that with her turkeys and bakes them early in the morning. That way, she says the oven is free for other baking. She just called you and is on her way over to the group home to stuff the turkey. She won't take no for an answer. What would you recommend?

***The USDA does not recommend buying retail-stuffed, uncooked turkeys from a store or restaurant. DO NOT THAW a commercially pre-stuffed frozen turkey before cooking. If this product has been placed in the refrigerator, and it has completely thawed, discard both the turkey and the stuffing***

***If you plan to prepare stuffing using raw meat, poultry, or shellfish, you should cook these ingredients before stuffing the turkey to reduce the risk of food borne illness from bacteria that may be found in raw ingredients. The wet ingredients for stuffing can be prepared ahead of time and refrigerated. However, do not mix wet and dry ingredients until just before spooning the stuffing mixture into the turkey cavity.***

***<u>If stuffing is prepared ahead of time, it must be cooked immediately and refrigerated in shallow containers. Do not stuff whole poultry with cooked stuffing.</u>***

***Cook Immediately! Immediately place the stuffed, raw turkey in an oven set no lower than 325 °F.***

3. Instead of making iced tea as the dinner menu calls for, Bob decided to make lemonade and he poured it into an unlined decorative copper pitcher rather than the plain glass pitcher which you had asked him to use.

***Acid can cause the metal to leach out into the liquid and contaminate the food.***

4. The gravy was made two hours ago and left in a covered pot sitting on the kitchen cabinet. Is the gravy safe to serve?

***No, unless it was kept heated to 140 degrees during that time.***

5. Tim's aunt came for dinner and brought macaroni salad. She said that she came directly from her daughter's home where she was for about 3 hours and left the salad in her car feeling that it was cold enough. The high temperature today was 37 degrees F and it was very sunny. Should you serve the salad? You wonder did it get warmer than 37 degrees in the car.. You hate to hurt her feelings by not serving the salad.

***Leftovers should be stored in the refrigerator within 2 hours after cooking is completed. Why just 2 hours? Because bacteria that cause food poisoning can multiply to undesirable levels on perishable foods left at room temperature for longer than that.***

## *The "Danger Zone"*

***Bacteria, or other germs, need time, food and moisture (or wetness) to grow; but they won't grow when the temperature of the food is colder than 41º F or hotter than 140º F. The temperatures in between 41º and 140º are in the "Danger Zone." Keep potentially hazardous foods out of the "Danger Zone!" For example, when food is left in the "Danger Zone", bacteria can grow fast, and make poisons that can make your customers and family very sick.***

6. Most of your dinner guests ate the pumpkin pie. By the time food was put away, that banana cream pie had been out of the refrigerator for 1 ½ hours. Do you think that it will be safe to eat tomorrow?

***Yes since less than 2 hours. Refrigerate immediately.***

7. You just noticed an empty, opened can of green beans in the wastebasket. The can is severely dented and soiled. You asked did someone just open the can and Harry says that he did and added the contents to the fresh green beans because he didn't think there would be enough beans for all of the guests. Are the beans safe to eat?

***The number one way to tell if a can is potentially dangerous is to push on the top and bottom of the can. If the top or bottom of the can moves in any way or makes a popping sound, the can's seal has been broken and air has made its way inside. Popped cans should be discarded or returned to the store where they were purchased for replacement. On the other hand, if the can does not make a noise or move, it is most likely safe to eat despite any dents***

***Another way to tell if a can is safe to eat is by simply looking at the can. If the can is bulging and bloated it is most likely unsafe. Cans will bulge and bloat when bacteria begins to produce gasses which push the can outward. You can also tell by looking at the dented can if it rusting. Rust can weaken the integrity of the can and allow air and bacteria to enter it.***

8. The ham which you purchased for this dinner is a canned ham and you bought it in the refrigerated section of the meat counter. The can says "refrigerate" till used. Unbeknownst to you, when Mark was unpacking the groceries, he put the ham on the pantry shelf. You went shopping two days ago. Is this ham going to be safe to use?

***There are two kinds of Canned Ham. One that can be stored on a shelf (aka shelf-stable), and one that must be stored refrigerated. The shelf-stable one is good for up to 2 years on a shelf, at room temperature. It is sterilized in the can during processing. It is usually packed for family-size in what the industry calls "pear-shape cans" (the ones that are flat at the bottom, rounded on top), but for institutions, they may be packed in larger cans called "pullman cans."***

***The ones that must be stored refrigerated are good unopened for 6 to 9 months. They are pasteurized, but not sterilized. Often ham packed in "pullman cans" requires refrigeration.***

## Small Group Activity (Trainee copy)

Your group home has decided to invite several people over for Thanksgiving dinner. You have a large kitchen and dining room, so this will work out well. Including individuals, families, friends, and staff, there will be approximately 27 people at this get together. The individuals in your group home have chosen the following foods to comprise the menu:

Turkey
Stuffing
Giblet gravy
Ham
Candied Sweet Potatoes
Fresh Green Beans
Cranberry Sauce
Rice
Hot Dinner Rolls
Butter
Iced Tea

Banana Cream Pie
Pumpkin Pie
Coffee

Six individuals live in your group home and you will assist three of them in purchasing the foods while the other three will assist in food preparation.

Using the principles of food sanitation and safety, identify important principles in the preparation of this meal. Discuss food purchasing, preparation and storage of left overs.

**Here are the facts which you need to consider in your groups:**
You purchase frozen turkeys. Discuss storing and thawing as well as cooking the turkey you purchased.

1. John, who lives in the group home, is assisting with cooking this dinner. He has cooked about three times the amount of rice needed. Discuss storage of the left over rice.
2. Martin lives in the group home and his mother has insisted on stuffing the turkey the night before. She always does that with her turkeys and bakes them early in the morning. That way, she says the oven is free for other baking. She just called you and is on her way over to the group home to stuff the turkey. She won't take no for an answer. What would you recommend?
3. Instead of making iced tea as the dinner menu calls for, Bob decided to make lemonade and he poured it into an unlined decorative copper pitcher rather than the plain glass pitcher which you had asked him to use.
4. The gravy was made two hours ago and left in a covered pot sitting on the kitchen cabinet. Is the gravy safe to serve?
5. Tim's aunt came for dinner and brought macaroni salad. She said that she came directly from her daughter's home where she was for about 3 hours and left the salad in her car feeling that it was cold enough. The high temperature today was 37 degrees F. and it was very sunny. Should you serve the salad? You wonder did it get warmer than 37 degrees in the car.. You hate to hurt her feelings by not serving the salad.
6. Most of your dinner guests ate the pumpkin pie. By the time food was put away, that banana cream pie had been out of the refrigerator for 1 ½ hours. Do you think that it will be safe to eat tomorrow?
7. You just noticed an empty, opened can of green beans in the wastebasket. The can is severely dented and soiled. You asked did someone just open the can and Harry says that he did and added the contents to the fresh green beans because he didn't think there would be enough beans for all of the guests. Are the beans safe to eat?
8. The ham which you purchased for this dinner is a canned ham and you bought it in the refrigerated section of the meat counter. The can says "refrigerate" till used. Unbeknownst to you, when Mark was unpacking the groceries, he put the ham on the pantry shelf. You went shopping two days ago. Is this ham going to be safe to use?

# PRESENTER – Materials Needed for Module 8

- **2010 Update Psychotropic Drugs (PDF)**

# PRESENTER - Use of Medications by People with Developmental Disabilities

Approximately 35 to 50% of people with DD receive psychotropic medication 65% of psychotropic medications prescribed are antipsychotics.

www.iidc.indiana.edu/training/

The most common types of medications prescribed for people with developmental disabilities include: antipsychotic, anti-anxiety, antidepressant, stimulant, and antiepileptic drugs.

### Antipsychotic and Antianxiety Drugs

Antipsychotic and antianxiety drugs are medications most frequently prescribed for people with developmental disabilities. They may be prescribed for conditions associated with aggressive, destructive and/or self-abusive behaviors. Antipsychotic drugs are generally strong or major tranquilizers. Antianxiety drugs refer generally to minor tranquilizers. Antipsychotic drugs are generally prescribed more often than antianxiety drugs.

### Antidepressant Drugs

Antidepressant drugs are frequently prescribed for the treatment of depression in adults. This is especially true when the symptoms include psychomotor disabilities, sleep disorders, loss of appetite, weight loss, and constipation. They may be prescribed for conditions associated with behavioral problems such as hyperactivity and aggression.

### Stimulant Medications

These are generally prescribed to treat minimal brain dysfunction, hyperactivity and attention deficit disorders. The intended outcome is to improve the attention span of the individual. They may be prescribed for individuals who demonstrate short attention spans, aggression toward others, impulsiveness, and restlessness.

## Antiepilepsy Drugs

Antiepileptic drugs are sued in the treatment of seizure disorders. People with developmental disabilities have an increased incidence of epilepsy. The percentage of individuals with developmental disabilities who also have epilepsy increases with the severity of disability. Antiepileptic drugs can be successful in the treatment of epilepsy; however only 50% of people can achieve complete seizure control through use of these medications. The nature and unpredictability of the side effects associated with the drugs also require that they be closely monitored.

# PRESENTER - Ten Medication Tips to Remember

A drug is a chemical substance used in the medical treatment of a person. When taken in prescribed or recommended dosages, the chemical is designed to benefit the person using it by relieving symptoms or curing an illness.

Two major classifications of drugs are prescription and non-prescription. When taken with a prescribed medication, non-prescription drugs may alter the effect of the prescribed medication. For this reason, it is critical that you consult the physician or pharmacist when using non-prescription drugs if a prescription drug is already being used.

Taking any medication poses some potential risk. These risks are referred to as side effects.

# PRESENTER - Assistive/Corrective Devices & Prosthesis

### What is a TTY?

A TTY is also known as a TDD (Telecommunications Device for the Deaf)

**HOW IT WORKS**: This device 'rings' via flashing light or the more recent vibrating wrist band that resembles a watch. The TTY consists of a keyboard, which hold somewhere from 20 to 30 character keys, a display screen, and a modem. The letters that the TTY user types into the machine are turned into electrical signals that can travel over regular telephone lines. When the signals reach their destination (in this case another TTY) they are converted back into letters which appear on a display screen, are printed out on paper or both. Some of the newer TTYs are even equipped with answering machines.

**WHO USES IT**: The TTY has 4 million users nationwide. 3 million of these users are hearing impaired and the other 1 million have severe speech impairments.

**ADVANTAGES:** Without a means of Telecommunication, the deaf were, in a sense, isolated from many people and services. Life without a telephone substitute involved many miles of driving to deliver and relay messages. (Which was very time consuming and frustrating.) The TTY gives deaf people the luxury of just being able to pick up the phone and chat. It also provided an easier way to connect to police and fire stations in case of emergency. And with the later creation of MRCs (message relay centers) the TTY users could connect to any phone anywhere in the world.

**DISADVANTAGES:** TTY users must know how to type. The alarmingly high spelling error rate of 5-6% (10% of which is TTY machine related as in the malfunction of a key) sometimes causes a problem in communication. One half million of TTY users communicate using ASL (American Sign Language) or which there is no written counterpart. ASL also has a grammatical system which differs greatly from that of Standard English. If a TTY user is especially "chatty", the other party must just sit quietly until the "chatty" person sends the message, which they must then read and respond to. A conversation such as this would end up taking much longer than the average phone call.

# PRESENTER - Assistive/Corrective Devices & Prosthesis

**Illinois Relay Center**
phone: 1-800-526-0857
TTY: 1-800-526-0844
web: www.itactty.org

Illinois Relay Center enables people who have speech impairments or who are deaf or hard of hearing who use a TDD/TTY to contact persons without a TDD/TTY, and vice-versa, at no cost. Operates 24 hours a day, seven days a week

**Video Relay Service**
Video Relay Service (VRS) is a form of Telecommunications Relay Service (TRS) that enables persons with hearing disabilities who use American Sign Language (ASL) to communicate with voice telephone users through video equipment, rather than through typed text. Video equipment links the VRS user with a TRS operator – called a "communications assistant" (CA) – so that the VRS user and the CA can see and communicate with each other in signed conversation. Because the conversation between the VRS user and the CA flows much more quickly than with a text-based TRS call, VRS has become an enormously popular form of TRS. For more information about other forms of TRS, see the FCC's consumer fact sheet at www.fcc.gov/cgb/consumerfacts/trs.html.

**Orthotics**
An orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body.
**AFO - Ankle Foot Orthosis**; orthotic device for the lower limb that encloses the ankle and foot and does not extend above the knee. Cervical - a rigid plastic orthosis that encircles the neck and supports the chin and the back of the head. KAFO - Knee Ankle Foot Orthosis; orthotic device for the lower limb that extends from above the knee to the ankle and foot. LSO - Lumbosacral Orthosis; spinal orthosis that encircles the body in the lumbosacral region


Photo Phone

The Photo Phone allows you to dial a number simply by pressing a picture. It has a built-in amplifier and large, easy-to-see keypad.

# PRESENTER - Assistive/Corrective Devices & Prosthesis

## Adaptive Eating Devices

### Seating

- Proper positioning is essential not only to successfully developing and practicing eating skills, but also for safety. People with oral motor or swallowing difficulties are at greater risk of aspiration, which is food or drink getting into the lungs. They need to be seated so the food doesn't slip back in their mouths before they are prepared to swallow. Their hips, knees and ankles should all be at a 90 degree angle during the meal. The eating surface should be flat and stable.

### Plates

- High-edged plates help people with fine motor skill deficits scoop up food more easily by allowing them to push the utensil against the edge of the plate. High edges are also helpful to people with visual impairments, giving them tactile feedback through the utensil so they know where the edge of the plate is. Plates should be made of durable materials such as plastic so they don't break if they are knocked off the eating surface.

### Eating Utensils

- People who find it difficult to grip normal silverware can get utensils with built-up handles which make them easier to grip, or get adaptive sleeves which can be put over normal spoons and forks. If the person cannot grip at all, utensils with Velcro can be strapped directly to the person's hand.

  Weighted spoons and forks provide extra tactile feedback, which may be necessary for certain neurological disorders. Angled spoons require less wrist movement, so they may be appropriate for people with limited wrist mobility.

### Cups

- Mugs with built-up handles can be gripped better than normal handles. Lightweight plastic cups are easier to lift than ceramic or glass vessels and won't break if dropped. Sippy cups won't spill as much if knocked over. For older children or adults who don't want to drink from a cup made for toddlers, sport cups serve the same purpose, though they may not have the handles sippy cups do.

### Mats

- Non-skid mats placed under dishes keep them from sliding around, making it easier for the person to find the plate when needed and reducing the chance of messes. The same mats can be put on the chair seat to prevent slippage.