UNIT ONE

Introduction to Human Services and Meeting Special Needs

MORC

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AND MEETING SPECIAL NEEDS

Introduction; "The trainee will"

- Identify types of developmental disabilities, mental illnesses and substance use disorders.
- Identify the challenges people with developmental disabilities and substance use disorders face.
- Identify and demonstrate communication and relationship skills with a person diagnosed with a developmental disability, mental illness and/or substance use disorder.
- Define and identify types of dual diagnoses.

Philosophy; "The trainee will"

- Recognize that personal values, attitudes and beliefs directly affect how we partner with others.
- Recognize that all individuals have the right to make life choices that fit them personally such as lifestyles, friends, careers and living arrangements.
- Identify those values, attitudes and beliefs that promote positive support and growth.
- Identify the journey mental health services have taken and the destination of positive life experiences.
- Identify your responsibility to promote recovery and self-determination through person and family centered approaches.
- Identify types of trauma and the range of effects.
- Identify trauma informed strategies.
- Describe the recovery model.
- Explain how trauma informed strategies support the recovery model.
- Demonstrate that persons receiving services will experience more positive living environments.

- Show how support systems can provide encouragement and opportunities for individual to improve their quality of life.
- Support people to be full participants in their services and recovery.
- Identify staff role as change agents with individuals and communities.

Person Center Planning; "The trainee will"

- Define person centered planning, its concepts and principles.
- Assist the person to explore their community and engage in activities that will help in the discovery of interest and preferences.
- Identify connection between a person's interests and preferences which lead to dreams and desires to be reflected as goals and objectives in the plan.
- Demonstrate good listening skills.
- Provide meaningful choices for individuals.
- Direct support staff will perform the elements of the person centered plan that pertain to them.
- Involve the person in the implementation of objectives in a person centered plan so that it is carried out by and with them and not for them.
- Identify the Person Centered Plan as the person's plan for services that staff is obligated to provide.
- Help the individual understand person centered planning including but not limited to: The role of direct support staff, The role of natural and community supports, The role of the person.
- Provide examples of how Person Centered Planning is being successfully implemented.

Documentation; "The trainee will"

- Identify what is appropriate to put in a person's record.
- Identify what information needs to be reported to the appropriate location with the person's record or other reporting mechanism.
- Identify what is required to document; do so clearly and concisely and in a format that is professional.

UNIT 1:

INTRODUCTION TO HUMAN SERVICES

AND MEETING SPECIAL NEEDS

INTRODUCTION: This training session introduces you to mental health services in the State of Michigan. It covers different mental health conditions and your very important role. How you fulfill your role and perform your duties contributes greatly to the quality of life for those you serve.

VALUES, ATTITUDES and BELIEFS: Our values, attitudes and beliefs have an important influence on how we approach our job and our relationship(s) with those we serve. These values, attitudes and beliefs contribute to how the individual feels about him or herself, as well as how they feel toward us.

CAREGIVERS: There are many different job titles used, to describe your role: care giver, direct support staff, direct care staff, direct care worker, residential assistant, personal care assistant, training specialist, direct support professional and many others. No matter what job title is used in your organization, this part of the training will provide you with the terms and information you will need in order to serve people in the best way possible.

MENTAL HEALTH SERVICES in MICHIGAN: The **Michigan Mental Health Code** (Public Act 258) guides the way of mental health services in Michigan. The law states:

   a. A person with a mental health condition has the right to receive service suitable to his or her condition
   b. Services must be provided in a safe and sanitary environment and in the least restrictive setting
   c. Someone receiving services must always be treated with dignity and respect.

There are many other laws from the Federal Government and county mental health organizations that provide specific rules. Your own organization or employer also has policies and rules for providing services.

MENTAL HEALTH CONDITIONS: What are the conditions for which we provide services? In general they are developmental disabilities, mental illnesses and substance use disorders. We will cover each of these categories in detail. It is important for you to know what a person's disability is, in order to provide the best care possible. You will learn the different types of conditions and the challenges these pose to the person. You will also learn exactly how you can help a person to live the best possible life.

DEVELOPMENTAL DISABLILITIES

As the term "*developmental disabilities*" implies, these are conditions which are diagnosed during the developing stage of a person's life. Under the Michigan Mental Health Code, these conditions are intellectual disabilities (commonly known in the past as "*mental retardation*"), epilepsy, cerebral palsy, autism spectrum disorders and developmental delays. About 6.5 million people in the United States have a developmental disability. For someone to be diagnosed with a developmental disability, these conditions have to apply:

- The disability occurs before age 22
- It is due to a mental or physical condition or a combination of these
- It is likely to be a life-long condition
- The condition shows that a person needs services that are individually planned and delivered
- It limits the person's life in three or more of the following areas:
  - Taking care of oneself
  - Being able to communicate and to understand communication
  - The ability to learn
  - Mobility
  - Being able to live independently
- It affects the person's potential for becoming economically self-sufficient

CAUSES OF DEVELOPMENTAL DISABILITIES

There are many causes of developmental disabilities. These causes can be roughly divided into two categories: *physical causes* and *social causes.* An exact cause cannot be determined for a large number of people with developmental disabilities.

Physical causes of developmental disabilities include the following:

- Pregnancy of an older mother
- Certain problems with a father's sperm
- Infections that affect the brain
- Lack of oxygen during or after birth
- Physical injury to the brain
- Exposure to some chemicals that affect the health or development of the brain
- Abnormalities in the person's chromosomes
- Exposure to lead in older paints, older water pipes and plumbing, or high levels of lead in the soil or water sources

Social causes of developmental disabilities:

These can be more complicated. In most cases these could have been prevented. If a mother drinks alcohol during pregnancy, the development of the baby could be affected. Drinking during the early months of the pregnancy can result in physical problems and deformities. Drinking during the later months of pregnancy can cause emotional and social problems associated with developmental disabilities.

Another social cause is the lack of an environment in early life that stimulates the growth and development of a child's brain. In order to develop normally infants and children need stimulation in activities, a pleasant physical environment, and being touched, cuddled and talked to by parents and care givers. At different times in growing, the brain needs to be exposed to things that allow the child to learn. If certain abilities are not learned at the right phase of development, later learning becomes more difficult.

INTELLECTUAL DISABILITIES

Intellectual disabilities are sometimes called **cognitive disabilities**. These were called "*mental retardation*" in the past, a term that is recognized by most people in the community. The term *"mental retardation"* is no longer used to describe those with an intellectual disability due to the negative stereotypes and prejudices associated with the term. An intellectual disability means that a person has an intelligence quotient (IQ) score below 70 or 75. The ARC of the United States estimates that between one and three million Americans have an intellectual disorder. The most common intellectual disabilities are autism, Down syndrome, Fragile X syndrome and Fetal Alcohol Spectrum Disorder.

DOWN SYNDROME

Down syndrome is a condition resulting from having an extra 21st chromosome. This is a condition that sometimes occurs when the birth mother is older than usual.

The physical appearance of someone with Down syndrome is normally recognizable. The nose is flatter and the mouth is smaller. The tongue may be unusually large and may stick out much of the time. The eyes often have a fold at the inner corner. The fingers may be short and thick. In general someone with Down syndrome will have a noticeably stocky appearance.

People with Down syndrome are at risk of some other physical problems. The ear canal may be very narrow causing hearing problems and ear infections. People with this condition are at greater risk of heart problems and for some kinds of leukemia. An adult with Down syndrome has almost a one hundred percent likelihood of developing Alzheimer's disease at an early age.

FRAGILE X SYNDROME

Fragile X syndrome is caused by a problem in the structure of the X chromosome. This chromosome makes a protein that is important for the development of the brain. This condition can be passed from parent to child even if the parent did not have the condition. Because boys have only one X chromosome, the syndrome is normally more serious. Girls have two X chromosomes.

Males with fragile X syndrome typically have a serious intellectual disability. The physical appearance may include large ears, a long face and large testicles. Many of the characteristics of autism, attention deficit disorder or attention deficit hyperactivity disorder may also be present.

Physical characteristics and the other elements of fragile X are very often less serious in girls. The majority do not have a serious intellectual disability. Some females show no characteristics of the syndrome but are able to pass it on to children.

FETAL ALCOHOL SYNDROME and FETAL DRUG SYNDROME

Fetal alcohol syndrome results from a mother drinking alcohol during pregnancy. The alcohol passes from the mother's bloodstream into the unborn child's bloodstream. Because the unborn child is so tiny even a small amount of alcohol has an extremely greater effect on the baby than on the mother. It makes no difference whether the alcohol is beer, wine or distilled spirits. Health professionals cannot identify any amount of drinking that is safe during pregnancy. This is the one cause of developmental disabilities that is completely preventable.

Fetal alcohol can cause physical problems, intellectual disability, learning difficulty, problems with vision and behavior problems. The effect can vary greatly from one child to another. The results cannot be cured or reversed. Some of the characteristics of fetal alcohol syndrome are:

- Small eyes, a thin upper lip, a smooth surface between the nose and lip
- Deformed joints, limbs and fingers
- Slow growth before and after birth
- Problems with seeing or hearing
- A small head (microcephaly)
- Heart defects
- Learning problems
- Attention problems
- Intellectual disability

Fetal drug syndrome is similar to fetal alcohol. This condition is caused by using illegal drugs or misusing legal medications during pregnancy. Many over-the-counter and prescription medications should not be used if a woman is pregnant or plans to become pregnant. Women who are pregnant or plan to become pregnant should also not come in contact with certain medications for men.

Many of the physical problems of fetal alcohol syndrome can also be seen in fetal drug syndrome. This condition can also cause life-long learning and behavior problems or intellectual disability. Depending on the drug used or misused, a baby can be born with an addiction and may experience the extreme difficulty of withdrawal.

AUTISM and AUTISM SPECTRUM DISORDERS

Autism is the fastest growing developmental disorder with 1 in 68 children being diagnosed. Autism is a neurodevelopment disorder characterized by:

- Social impairments
- Cognitive impairments
- Communication difficulties
- Repetitive behaviors

Because autism is a spectrum disorder, it can range from very mild to very severe and occur in all ethnic, socioeconomic and age groups. Males are four times more likely to have autism than females. Some children appear normal before age 1 or 2 and then suddenly "regress" and lose language and social skills they previously gained.

Some typical characteristics of autism and autism spectrum disorder are:

- Difficulty playing with other children

- Not responding to their name (the child may appear deaf)

- Difficulty with pretend or imaginary play

- Avoid eye contact

- Give unrelated answers to questions

- Have difficulty understanding, or showing understanding, of others feelings or their own

- Repeat words or phrases over and over (echolalia)

- Get upset by minor changes

- Have obsessive interests

- Flap hands, rock their body, or spin in circles

- Displaying over or under sensitivity to the way things sound, taste, smell, look or feel
- Avoid or resist physical contact
- Demonstrate little safety or danger awareness

Each individual with autism is unique. Many of those on the autism spectrum have exceptional abilities is visual skills, music and academic skills. About 40 percent have average or above average intellectual abilities. Indeed, many persons on the spectrum take deserved pride in their distinctive abilities and "atypical" ways of viewing the world. Others with autism have significant disability and are unable to live independently.

CEREBRAL PALSY

Cerebral palsy is a disorder of the brain caused by injury or lack of oxygen. This usually happens before or during birth. There are different kinds of cerebral palsy, depending on the part of the brain that has been affected. A person can have more than one type of cerebral palsy. Since cerebral palsy results from problems in the condition or development of the brain, a person might or might not have an intellectual disability. For many people, however, intelligence is not affected.

One type of cerebral palsy causes stiffness in the muscles of the body and makes movements very difficult or even impossible. This kind of cerebral palsy can affect one, two or all of the body limbs. Because of the rigid muscles, it can also make it very difficult for the person to speak and to be understood.

A second kind of cerebral palsy results in muscle movements that cannot be controlled. Arms, legs or the neck may wave or shake. The last type of cerebral palsy results in difficulty with coordinated movements of the body. A person with this type may have problems with balancing and walking as well as doing things that require good hand coordination.

EPILEPSY

Epilepsy is the condition of having seizures on a recurring basis. Any of us might experience a seizure at one time or another. The diagnosis is based on a pattern of seizure activity. A seizure is an episode of uncontrolled electrical activity in the brain. The brain controls all of the other actions and activities of the body. Because of that, the location of the seizure activity in the brain will affect the part or parts of the body controlled by that area of the brain.

Seizures can be classified as generalized or partial. A generalized seizure involves the entire brain in the seizure activity. A partial seizure involves only a specific location or part of the brain. Seizures can also be divided into convulsive or non-convulsive. Convulsive seizures, those

which include uncontrolled shaking of all or part of the body, are the kind most people in the community recognize as a seizure. Non-convulsive seizures do not have the shaking but can have a wide variety of symptoms, again depending on where in the brain the seizure activity located.

As with other mental disabilities, epilepsy can stem from a variety of causes. Some of these are injury to the brain, infections of the brain or some kind of problem with the structure of the brain. Also like other conditions, the specific cause of epilepsy often cannot be identified.

About 3 million Americans have epilepsy; however, most of them do not fit the criteria of having an intellectual or developmental disability. Epilepsy by itself does not affect a person's intelligence or general health. Because seizures have to do with the structure and workings of the brain, many people who have other disabilities of the brain may also have epilepsy. A later portion of the training course will cover the types, causes and treatment of epilepsy and different types of seizures.

DUAL DIAGNOSIS

The term "***dual diagnosis***" typically means that a person has a developmental disability as well as a mental illness. As mentioned previously, developmental disabilities are caused by a neurological difference in the brain or a physical problem of the brain. The same cause can result in more than one developmental disability. It has also been estimated that 30-50 percent of the individuals with a developmental disability also have a mental illness.

MENTAL ILLNESSES

A **mental illness** is a condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis. And while nearly 2,000,000 Americans live with a serious mental illness, many people do not understand the differences between mental illness and intellectual disabilities, and think that they are all the same thing.

MYTHS about MENTAL ILLNESS

The following list of myths about mental illness is adapted from the Substance Abuse and Mental Health Services website:

- **Myth:** There's no hope for people with mental illnesses.
- **Fact:** People with mental illnesses lead active, productive lives.

- **Myth:** I can't do anything for someone with mental health needs.
- **Fact:** You can do a lot, starting with the way you act and how you speak. You can nurture an environment that builds on people's strengths and promotes good mental health. For example:
    - Avoid labeling people with words like "crazy," "wacko," "loony," or by their diagnosis. Instead of saying someone is a "schizophrenic" say "a person with schizophrenia."
    - Treat people with mental illnesses with respect and dignity, as you would anybody else.
    - Respect the rights of people with mental illnesses. Like other people with disabilities, people with mental health needs are protected under Federal and State laws.

- **Myth:** People with mental illnesses are violent and unpredictable.
- **Fact:** People with mental illness are much more likely to be victims of violence rather than committing violence.

- **Myth:** An intellectual disability is the same thing as mental illness.
- **Fact:** The two are completely different conditions. A simple explanation might be that an intellectual disability affects intelligence and learning but does not directly relate to a person's thought or feelings. Mental illness does affect a person's thoughts and feelings but is unrelated to intelligence. Keep in mind that a person might have an intellectual disability and mental illness at the same time.

- **Myth:** Mental illnesses are brought on by a weakness of character.
- **Fact:** Any one of us might develop a mental illness at some point in our life. Mental illnesses are caused by brain chemistry, psychological, and social factors. Extreme life events such as loss of a loved one or a job, can also contribute. No one is one hundred percent immune to developing mental illness.

- **Myth:** People with mental illnesses cannot hold a job.
- **Fact:** Many people with mental illness are able to live productive lives and contribute to their communities.

- **Myth:** People with mental illnesses will never recover.
- **Fact:** Most people with mental illnesses get better, and many recover completely. Recovery means that a person's condition is able to live a fulfilling life in the community. For others it means that the symptoms can be controlled by medication or other therapies.

COMMON MENTAL ILLNESSES

DEPRESSION: Depressive Disorders are among the most common mental health disorders. They are characterized by a sad, hopeless, empty, or irritable mood, and sometimes somatic and cognitive changes that significantly interfere with daily life. People with this condition may have trouble focusing on work or doing even their ordinary daily activities. Although everyone may experience episodes of depression, when it interferes with a person's activities and quality of life, it may meet the criteria for a mental illness diagnosis.

BIPOLAR DISODER (formerly called "***manic-depressive***" disorder): A person with this condition experiences uncontrollable swings of mood from depression as described above to elation and unusually high energy (the "manic" phase). In this second phase, a person might go for long periods without sleep and might keep themselves extremely busy with activities, talking and moving around.

SCHIZOPHRENIA: This condition is actually a group of different disorders affecting a person's perception of reality. It may include hallucinations, delusions, and perception of being persecuted and disordered logic or thinking. Some of the types of schizophrenia are paranoid schizophrenia, catatonic schizophrenia, childhood schizophrenia and disorganized schizophrenia.

OBSESSIVE-COMPULSIVE DISORDER: A person with this condition is overwhelmed by continual thoughts or feelings. These ideas may cause them to carry out certain repetitive behaviors. Some examples of these behaviors might include excessive hand washing, organizing and reorganizing cabinets or closets, or following exaggerated and elaborate rituals in their daily activities.

POST-TRAUMATIC STRESS DISORDER: Some people who have experienced an extreme or a long-lasting stressful situation might not recover emotionally while others in similar circumstance do not develop this extreme anxiety disorder. In a person with PTSD, the body continues to release the hormones and brain chemicals even though the cause of the stress is long past. Some causes of PTSD are the experience of war, natural disasters, and auto or aircraft accidents, sexual or domestic abuse. The experiences that cause PTSD are not necessarily dramatic events; they might be the person's stressful experience over a long period of time. As with other conditions, when PTSD interferes with a person's quality of life and daily activities, treatment is needed.

SUBSTANCE USE DISORDERS

Substance use disorders are defined as a pattern of use of alcohol or drugs and medications (legal or illegal) that interferes with a person's responsibilities at work, home, school or in the community. The main categories of substance use disorders are drug misuse, illegal drug abuse and alcohol abuse. The person with the disorder cannot control the drive to obtain the effect of the substance. Drug misuse includes using legal drugs in a way that is different from or in excess of the intended purpose of the substance. The use may cause problems of safety (driving, working with machinery or home appliances), problems with relationships (family, co-worker, etc.). Another challenge of substance use disorders is the economic effect. Someone with this condition may spend more and more money on the substance. As a result, the person will not have sufficient money to pay bills or buy routine necessities like food, fuel or housing. The person may also suffer the consequences of losing employment, legal costs and fines and possible imprisonment.

The term, "*substance use disorder*" typically refers to an individual who uses substances (alcohol, drugs) and there is evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use or evidence of recurrent dangerous use.   The term "**co-occurring disorder**" typically means that a person has a substance use disorder and also a diagnosis of mental illness.

In our field, a "co-occurring" disorder is a developmental disability and any other co-occurring disorder including a mental illness, a substance use disorder, or a physical disability.

PROVIDING MENTAL HEALTH SERVICES

Care givers must be fully familiar with several principles in providing the best mental health services. These principles are Culture of Gentleness, Person-Centered Planning, Self Determination, the Recovery Model, Natural Supports, and Trauma-Informed Services. These six areas are not separate approaches to providing care but rather principles that all work together to aid the person in achieving the best possible quality of life and in cultivating healthy and meaningful relationships.

A CULTURE of GENTLENESS:

An important model in contributing to supporting values, attitudes and beliefs is the formation of a "Culture of Gentleness". The "Culture of Gentleness" recognizes that we all do better when we have healthy, positive, and supportive relationships around us to help navigate the difficulties of life.

This culture embraces the principles that all individuals need to feel emotionally and physically safe. We all long for the desire to be valued by those around us, and be offered the opportunity to demonstrate caring acts towards those that are important to us. In addition, we all want to be actively involved in setting the course for our own lives.

In order to position ourselves to teach those we serve, we must spend time establishing a trusting relationship with them. We as care givers must be committed to offering unconditional valuing to those who are often devalued by society.

These values are conveyed in what we call **"The Central Purpose"**

"The Central Purpose"

The purpose of our presence in the lives of others is to *nurture*, *teach* and *sustain* the experience of *connectedness*, *companionship* and *community*.

The tenants of a "Culture of Gentleness" will be covered more thoroughly in the "Working with People" segment of your training.

Person/Family Centered Planning

Person/Family-Centered planning (PCP) is a process mandated through the Michigan Mental Health Code for all individuals/families receiving publicly funded mental health services. The PCP process is intended to place individuals (and families with minor children) who receive supports in control of their outcomes, with assistance from advocates and allies, as well as providers of service. PCP is an open-ended process that is a continual discussion between the Supports Coordinator and the individual served on an ongoing basis. The PCP process lead to the development of the Individual/Family Plan of Service (I/FPOS).

The person/family-centered plan identifies goals and objectives established for the person's services. The plan is based on what the person/family wants in his or her life and what needs have been identified for the person. Areas covered in the plan include the person's nutrition,

housing, clothing, health needs, employment and/or education, legal needs, transportation, relationship and recreation needs. The goals and objectives developed are built on the strengths and gifts of the individual.

In simpler terms, the plan seeks to answer the following questions for the person:

- Where should I live?
- Whom do I want in my life (family, friends, housemates, care givers)?
- Whom do I need in my life (clinical professionals, therapists, service providers)?
- What am I able to do for myself and for what do I need to rely on others?
- How will I have a meaningful and purposeful life (education, training, employment, volunteering)?
- How can I control the money and resources that are available to me?
- How will I have a share in all that my community has to offer?
- How will I exercise good citizenship in my community?
- How can I enjoy myself and the company of others (entertainment, hobbies, recreation, and vacations)?

The input of the person/family whose plan is being developed is essential in this process. The entire team working on the plan must make sure that the person/family's needs and wants are realistically addressed so that the person's life is unfolding in the way he or she wants. We have to recognize that each person/family is entitled to make their own choices regarding services. For some people we may have to provide more support and assistance in identifying available choices. We might also have to help someone in making the best realistic choices.

The person/family supported chooses whom he or she wants to attend the meeting for the person-centered plan. These are people who know and care about the individual. They are also people whom the person/family supported, trusts and whose contributions to the plan he or she wants.

The plan is a flexible document. It must be changed as the person's needs and wishes change. It must also be changed if the person served is not satisfied with it. At least once each year, the goals and objectives are revised. It is the privilege as well as the responsibility for care givers and others contributing to services to honor the person/family's wishes, and do everything possible to enhance the quality of that person's life. Of course, it is the responsibility of the person/family supported to participate actively in the development of the plan and to work to achieve the goals and objectives.

SELF DETERMINATION

The history of mental health services has been that the person with a mental disability was under the complete control of care givers and professionals. The person with the disability had no voice in his or her treatment. The way we serve people has now turned to a system of self-determination.

Self-determination means that we give control back to the person, where it should be. It means that the person served has the right to participate in their services and to control the resources available to them. Some of the key principles of self-determination are:

- The development of peer support services; the contributions of others with mental disabilities in support and advocacy
- Education the person for self-management of his or her disability
- The dedication of an individual budget in order to meet the person's plan for rehabilitation and recovery
- The right of access to records and documents regarding the person and his or treatment plan
- Elimination of harsh , coercive treatments
- As in the principles of person-centered planning, the ability to live in and participate in the community
- Inclusion of others with mental disabilities in staffing mental health programs

An important aspect of managing one's own services is the control of the budget and resources. The dollars go directly to the person rather than to an agency or organization. An individual or organization known as a fiscal intermediary may assist the person in matters such as bill-paying, hiring staff, handling payroll, and locating support services in the community.

THE RECOVERY MODEL

This model is based on the belief that an individual with a mental disability can recover from mental illness or a substance use disorder can recover from their disability and return to a natural role in the community. The recovery model also means that someone with a mental disability can adapt to the disability and have a fulfilling life. The expectation is that beyond simply getting past the limits of the disability the person can actually thrive to a point that their life is better than it was before.

An effective program based on the recovery model includes the following elements:

- The person receiving services is an active participant in the process rather than a passive recipient of treatment the person has both the right and the responsibility to steer the recovery process
- The program is firmly based in optimism and encouragement of the person
- The process is directed by meaningful activities, participating in the community, a respect for cultural perspectives and the support of family, significant others, and a close circle support
- A trusting and respectful relationship between the person supported and care givers and others involved in providing services
- The process builds on the person's strengths; the process instills hope and encouragement in the person
- The individual and those supporting him or her develop a plan for the interventions and resources needed

NATURAL SUPPORTS

Some years ago John McGee, the author of **Gentle Teaching**, wrote that "every person longs to feel safe, loved and connected to others". Natural supports are all of the supportive connections, associations and relationships we enjoy in our own lives. They include our family and our friends, our neighbors, our co-workers, classmates, members of our church, our clubs, people whom we do business with in our community and all of the others we can rely on and who can rely on us. Most of us do not even have to think about these relationships. We simply take for granted that they are there for us.

We develop our relationships with others based on the direction we want our lives to take. Our lives also take direction from those with whom we associate.

For many people with mental disabilities these supportive connections are less available. The stigma of the disability may keep others at a distance. For some of those we serve, the most frequent interactions on a regular basis are either with other people with similar disabilities or with people who are paid to be in their lives (care givers, clinical staff, therapists, etc.).

Part of our responsibility in the lives of those we support is to teach them how natural relationships develop on a respectful and mutual basis. This, of course, begins with the nature of our relationship with those persons. If we can teach the people we support how to connect with us, we give them the ability to connect with others. Because their disability may limit their independent access to people in the community, we may need to create opportunities for them

to get to know others. At the same time we become role models for those in the neighborhood and in the community on how to relate to the people we support.

TRAUMA INFORMED SERVICES

A relatively new addition to providing mental health services is the concept of trauma informed services. It is believed that most individuals receiving mental health services have experienced substantial traumatic experiences in their life. SAMSHA (Substance Abuse and Mental Health Services Administration) defines trauma as events or circumstances experienced as physically or emotionally harmful or threatening, having lasting adverse effects on someone's functioning, and physical, social, emotional, or spiritual well being. They can be a single event or a series of events. They can overwhelm one's ability to cope, produce a sense of fear, vulnerability, and helplessness. They often will ignite the "fight, flight, or freeze" reaction.

 Traumatic events could include sexual, physical or emotional abuse or assault, neglect, serious accident, illness or medical procedure(s), victim or witness to domestic or community violence, school violence, bullying, natural or manmade disasters, forced displacement, war, terrorism or political violence, grief or separation of parents or primary caregivers, and system-induced trauma or retraumatization. "Secondary trauma" is trauma-related stress reactions and symptoms resulting from exposure to another individual's traumatic experience, rather than from exposure directly to a traumatic event. Secondary trauma can occur among behavioral health service providers across all behavioral health settings and among all professionals who provide services to those who have experienced trauma (e.g., direct support professionals, healthcare providers, peer counselors, first responders, clergy, and intake workers).

Symptoms of trauma may include:

- Headaches, backaches, stomachaches, etc.
- Sudden sweating and/or heart palpitations
- Changes in sleep patterns, appetite, interest in sex
- Constipation or diarrhea
- Easily startled by noise or unexpected touch
- More susceptible to colds and illnesses
- Fear, depression, anxiety
- Outbursts of anger or rage
- Emotional swings
- Nightmares and flashbacks- re-experiencing the trauma
- Difficulty trusting and/or feeling betrayed
- Self-blame or shame
- Diminished interest in everyday activities

Trauma triggers are events or circumstances that can remind someone of a pervious trauma and can invoke, fear, anger and frustration or physical/emotional discomfort or pain.

It is essential that we as caregivers understand the history of those we serve and more importantly if the history is unknown, assume that the individual you support has experienced trauma. Our goal is to understand the history of those we serve and to avoid retraumatizing those we support.

Some common trauma triggers in residential and work settings include (these can be triggers for both those served and those who serve):

- Loud noises
- Chaotic environment
- Restricted freedom of movement
- Yelling and emotional outbursts
- Loss of control
- Lack of personal space
- Unpredictable violence
- Threat of harm by others
- Imbalance of power and control

Caregivers need to understand that individuals we serve are often coping the best way they can. Our job is to build relationships built on trust and creating environments where we are sensitive to trauma and trauma triggers. Caregivers are essential in building residence and creating healing experiences through positive relationships and culture.

We will discuss trauma more, in the "Working with People" units of training, when we discuss the importance of one's histories and memories.

DOCUMENTING

An important responsibility for the care giver is recording various events and observations of the person served and actions taken by the care giver. The purpose of documenting is to communicate events and observations, collect and record data, and to report progress of someone you serve. Your documenting will show when goals are achieved, problems that a person is experiencing, and when actions or events required by the plan of service take place. Your documenting might also be the foundation for others to consider whether changes should be made in the plan of service.

The main instruments of documenting are:

- The Incident Report Form
- The Recipient Rights Complaint
- The Health Care Chronological
- The Medication Record
- The Personal Care and Community Living Supports Log

There may be other journals or data sheets specific to the needs of an individual served. Each of the documents listed above will be covered in detail in separate trainings but a brief description follows below.

INCIDENT REPORT FORM

The Incident Report Form records events and observations that have a bearing on the health, well-being and plan of service of the person supported. A few examples of what might be documented on an Incident Report Form include:

- Accidents
- Illnesses
- Injuries
- Medication Errors
- The occurrence of challenging behaviors
- Hospitalizations
- Adverse encounters with members of the community

Your own provider agency and the community mental health agency will have specific lists of events and observations that must be reported on an incident report.

RECIPIENT RIGHTS COMPLAINT FORM

This document reports observed or suspected instances of the violation of any of the rights of recipients that are listed in the Michigan Mental Health Code. The reporter does not have to be certain that a right has been violated, only a good faith belief that something has occurred. One of the responsibilities of the Recipient Rights Office is to investigate these allegations. Because this report serves to protect the individual served, the care giver must complete and submit it

immediately. A discussion of the specific rights listed in the Mental Health Code occurs during the separate Recipient Rights training.

HEALTH CARE CHRONOLOGICAL

The Health Care Chronological records information on changes and events in the person's health, health and medications interventions by the care givers, medical appointments, and instructions from health care professionals. Some events, such as accidents or injuries might have to be recorded on both the Health Care Chronological and on the Incident Report.

MEDICATION RECORD

This document records the administration of prescribed medications to the person supported. It can also be used to document certain health treatments. In the event a medication is refused, missed, or a medication error occurs, the event is recorded on the Medication Record and also on the Health Care Chronological and the Incident Report. The record lists medications given on a regular basis and medications given only as they are needed. Each time a medication is administered, the care giver makes a notation on the form.

PERSONAL CARE/COMMUNITY LIVING SUPPORT LOG

There are several versions of the Personal Care/Community Living Supports Log, designed for varying living arrangements. The purpose of the Personal Care/Community Living Supports Log is to document how an individual's plan of service is implemented on each shift. The form covers different aspect of daily life, for example: personal hygiene activities, meals and meal preparation, medications, housekeeping activities, and learning skills in the community. The form also has a space for a narrative description of activities of the plan of service.

GUIDELINES FOR DOCUMENTING

DESCRIPTIVE and EVALUATIVE WRITING

No matter which form a care giver is using to document, the writing should be very descriptive rather than evaluative. Descriptive writing relates what you have actually seen, heard or physically felt. Writing what you saw a person do (or perhaps what you looked for but did not see) is descriptive. Quoting what a person said to you is also descriptive. Descriptive writing also tells any actions you took and what you've said. It is important to keep your writing as descriptive as possible because social workers, psychologists, doctors and others make decisions and take actions based on what you have written. Writing your opinion of events and

the meaning you attach to what you have seen, heard, felt or done is evaluative. Sometimes it is important and perhaps even necessary to give your evaluation of events. In a case like that, it is important that you explain very clearly that this is your own opinion or your estimation.

RULES for DOCUMENTING

- What you write should always be clear, complete and accurate. Include all of your observations and the details of the event or situation you are documenting. If you are writing your documentation by hand rather than typing, it should be legible and large enough to be easily read.

- You should always document in permanent ink. Some places use different ink colors for different shifts but as a general rule, either dark blue or black is preferred. Never use pencil or erasable ink. If available, printing documentation from a computer is also acceptable.

- It should always be clear who the writer of the documentation is. Normally this is done by printing your name and your job title and also writing your signature. On some forms, you might also sign your initials if it is clear whose initials they are.

- When you are documenting in one person's record respect the privacy and protect the confidentiality of other people in the home. Never include the personal health information (PHI) of another individual.

- The first time you mention any other care giver or clinical person (doctor, nurse, therapist, etc.) in your writing; they should always be identified by full name and title. If you mention the same care giver or clinical person again in the same document, you can refer to them only by name if it is completely clear whom you are writing about.

- Any abbreviations you use should be only abbreviations that are recognized and understood by everyone or from a list of approved abbreviations. Never make up your own abbreviations.

- On forms that you are the only person who writes (the Incident Report, Recipient Rights Complaint), line out any blank space at the end of the area where you describe the events or actions with diagonal lines. On a form where several people might also

document (Health Care Chronological), only line out any extra space on the last line of your entry.

- If you make a mistake in your writing, no matter how small of a mistake, correct it as follows: line out the mistake with a single line through the word or words, write the word "error", write the date and your initials and then write the correct word or words.

- For example if you wrote the word "Tuesday" but you actually meant Wednesday, the correction would look like this: ~~Tuesday~~ ^{error ab 1/3/14} Wednesday.

- Anything you document becomes a part of the person's permanent record. Because of this, you should never change what someone else wrote and what you wrote should never be changed by anyone else. If the observations of two care givers differ, each should do their own documentation.

- Because of the requirements of privacy and confidentiality, documentation should never be left out where it can be seen by people who do not have a legitimate reason to read it.

- It is important to document as soon as possible, while all of the details are fresh in your mind. If you delay documenting, some important details might be forgotten or remembered incorrectly. If you delay, you might also not remember the right sequence of events – what happened first, what happened second, what you action you took, what happened next, etc.