

DDA Intro ^{PLUS}

*In Compliance with Standards Mandated by the
Maryland Department of Health and Mental Hygiene
Developmental Disabilities Administration*

Learner's Copy

Developed and Presented by

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This training is designed to meet the requirements of the following regulations:

COMAR 10.22.02.11.

- (C) The licensee shall develop and implement staff and careprovider training and ensure through appropriate documentation that, prior to being assigned independent duties:
 - (2) All staff and careproviders successfully complete the Administration's approved training to meet the specific needs of the individuals they serve and to carry out their assigned duties, such as training in:
 - (b) Principles of behavior change,
 - (c) The aging process and the special needs of the elderly; and
- (D) All staff and careproviders shall receive Administration approved training within 3 months of hire in the following:
 - (1) Community integration and inclusion,
 - (2) Individual directed, outcome oriented planning for individuals,
 - (3) General characteristics and needs of individuals served,
 - (5) Fundamental rights of individuals with developmental disabilities,
 - (7) Supporting individuals and families in making choices, and
 - (8) Communication skills.

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SELF-DETERMINATION AND SUPPORTING INDIVIDUALS AND FAMILIES IN MAKING CHOICES

People with developmental disabilities and their families are seeking supports that reflect their felt needs as well as their values and concerns. Market forces of consumerism and cost effectiveness enhance the individual as a purchaser and educated consumer of services. People are looking for results (outcomes).

Self-determination is highly valued in our society. People who are self-determined make choices based on their preferences, beliefs and abilities, take control over and participate in decisions which impact the quality of their lives, take risks and assume responsibility for their actions, and advocate on behalf of themselves and others. Self-determination is one marker of adulthood, and self-determined people are viewed as worthy of respect and valued by others.

Many people with mental retardation have not had the opportunity to become self-determined or to learn the skills and have the daily experiences that will enable them to take more control and make choices in their lives. Instead, they often experience overprotection and segregation, are not included in decisions that impact their lives, and have limited opportunities to make choices as well as limited options from which to choose.

Many people assume that people with mental retardation cannot become self-determined. However, research and practice has shown that, when given adequate support, learning opportunities and experiences, people with mental retardation can learn to become more self-determined, to assume greater control over and responsibility for their lives, and can improve their quality of life. The lack of such supports, learning opportunities and experiences is, in essence, denying people with mental retardation the right to become self-determined, valued, and respected members of our communities.

GENERAL CHARACTERISTICS AND NEEDS OF INDIVIDUALS SERVED

A developmental disability in the State of Maryland is defined as occurring prior to the age of 22 and anything which seriously limits the person ability to live and function on his or her own. The most common developmental disabilities are mental retardation, cerebral palsy, epilepsy and autism.

The History of Developmental Disabilities in the United States

Starting in 1820 and continuing to the present, Trent describes the development of American cultural concepts about retardation and its treatment. He focuses on the history of specialized institutions and their philosophies, although throughout this entire period most people with mental disabilities lived at home. For greater effect, he uses the words appropriate to each historical period in describing his subjects. "Idiot," "imbecile," "feeble-minded," "defective," and "moron" have evolved to become "persons with mental retardation," "persons with developmental disabilities," or "persons specially challenged," but Trent argues that our "long history of condescension, suspicion, and exclusion" continues to inform our views of such people.

Until the middle 1800s, most people with retardation either lived with their families or in foster families who received money from the town for their care. Some, who were labeled "moral imbeciles," ended up in jail. The first institution to accept "idiots," in 1847, was Samuel Gridley Howe's school for the blind in South Boston. Howe believed that "idiots" could be educated, using a new method developed by Edward Seguin in France, and returned to useful work in the community.

However, because of economic conditions institutions soon began to plan to keep people for a lifetime. They established farm colonies that employed inmates and helped the institutions become self-supporting. They used the brighter inmates to care for those worse off, recognizing that often inmates gave better care than paid attendants. Sometime in the late 1850s, medical doctors rather than educators became superintendents and began to model institutions after the "lunatic asylums" where many of them had served.

In order to get state funds for their institutions, superintendents constructed "feeble-mindedness" as a social problem. In the early 1900s, it would be labeled a "menace." Throughout much of their history,

institutions incarcerated boys and girls whom we would now call "delinquents." Women were considered in special danger, because they might pass their "feeble-mindedness" or "moral degeneracy" to their children.

Parents were generally reluctant to have their children come home for visits, especially when institutions considered such visits harmful, and over time, most families lost contact with their institutionalized members.

Mental Retardation

According to the new definition by the American Association on Mental Retardation (AAMR), an individual is considered to have mental retardation based on the following three criteria: intellectual functioning level (IQ) is below 70-75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less) (AAMR, 1992).

The new definition includes ten adaptive skills: communication, self-care, home living, social skills, leisure, health and safety, self-direction, functional academics, community use and work. Adaptive skills are assessed in the person's typical environment across all aspects of an individual's life. A person with limits in intellectual functioning who does not have limits in adaptive skill areas may not be diagnosed as having mental retardation.

Cerebral Palsy

Cerebral Palsy usually involves difficulty in muscle movement throughout the body. It may also involve mental retardation depending on the extent and nature of the brain injury.

We do not know the cause of most cases of cerebral palsy. That is, we are unable to determine what caused cerebral palsy in most children who have congenital CP. We do know that the child who is at highest risk for developing CP is the premature, very small baby who does not cry in the first five minutes after delivery, who needs to be on a ventilator for over four weeks, and who has bleeding in his brain. Babies who have congenital malformations in systems such as the heart, kidneys, or spine are also more likely to develop CP, probably because they also have malformations in the brain. Seizures in a newborn also increase the risk of CP.

Epilepsy

Epilepsy is a neurological condition that from time to time produces brief disturbances in the normal electrical functions of the brain. Normal brain function is made possible by millions of tiny electrical charges passing between nerve cells in the brain and to all parts of the body. When someone has epilepsy, this normal pattern may be interrupted by intermittent bursts of electrical energy that are much more intense than usual. They may affect a person's consciousness, bodily movements or sensations for a short time.

These physical changes are called epileptic seizures. That is why epilepsy is sometimes called a seizure disorder. The unusual bursts of energy may occur in just one area of the brain (partial seizures), or may affect nerve cells throughout the brain (generalized seizures). Normal brain function cannot return until the electrical bursts subside. Conditions in the brain that produce these episodes may have been present since birth, or they may develop later in life due to injury, infections, structural abnormalities in the brain, exposure to toxic agents, or for reasons that are still not well understood. Many illnesses or severe injuries can affect the brain enough to produce a single seizure. When seizures continue to occur for unknown reasons or because of an underlying problem that cannot be corrected, the condition is known as epilepsy. Epilepsy affects people of all ages, all nations, and all races. Epilepsy can also occur in animals, including dogs, cats, rabbits, and mice.

Autism

The following are the major signs of autism. A person is considered to have autism if they display a number of these.

Qualitative impairment in social interaction, as manifested by at least two of the following:

- marked impairment in the use of multiple nonverbal behaviors such as eye to eye gaze, facial expression, body postures, and gestures, to regulate social interaction.
- failure to develop peer relationships appropriate to developmental level.
- a lack of spontaneous seeking to share enjoyment, interests or achievements with other people e.g.: by a lack of showing, bringing or pointing out objects of interest.
- lack of social or emotional reciprocity.

Qualitative impairments in communication as manifested by at least one of the following:

- delay in, or total lack of, the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime.
- in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others.
- lack of varied, spontaneous, make-believe play or social imitative play appropriate to developmental level.

Restricted, repetitive and stereotyped patterns of behavior, interests and activities, as manifested by at least one of the following:

- encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
- apparently inflexible adherence to specific nonfunctional routines or rituals.
- stereotyped and repetitive motor mannerisms e.g.: hand or finger flapping or twisting, or complex whole body movements.
- persistent preoccupation with parts of objects.

Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years:

- social interaction
- language as used in social communication
- symbolic or imaginative play

FUNDAMENTAL RIGHTS OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

People with mental retardation have the same basic legal, civil and human rights as other citizens. Fairness and justice dictate the need for additional legal protection to enable people with mental retardation to exercise such basic rights. These rights, as for all citizens, should never be limited or restricted without compelling state interest and due process.

People with mental retardation who need supports, services and protection to fully exercise their rights and responsibilities should have them. Individuals with mental retardation have the right to be protected from decisions made by parents or guardians when these decisions threaten their health, safety, lives or general well-being.

All legal mechanisms constitutional, legislative, administrative, and judicial, which protect children and adults with mental retardation, should be vigorously and promptly pursued.

Maryland State law is very specific about the fundamental rights of persons with developmental disabilities. These are delineated in the Code of Maryland Regulations (COMAR)

Health General Title 7 of the Annotated Code of Maryland (The Developmental Disabilities Law) states that individual with developmental disabilities should:

- (1) Be treated with courtesy, respect and full recognition of human dignity and individuality;
- (2) Receive treatment, services, and habilitation in the least restrictive environment that is available, adequate, appropriate, and in compliance with relevant laws, rules, and regulations;
- (3) Be free from mental and physical abuse;

- (4) Be free from chemical restraints except for minimal restraints that a physician authorizes, in writing, for a clearly indicated medical need and made a permanent part of the record.
- (5) Be free from physical restraints except for minimal restraints that are authorized in writing and made a permanent part of the record by a physician or qualified developmental disabilities professional and which are clearly indicated for the protection of the individual with developmental disability or others;
- (6) Receive respect and privacy in an individually developed program;
- (7) Worship as the individual chooses; and
- (8) An accounting of all funds belonging to the individual that are held or otherwise administered by the licensee.

Some important reminders about fundamental rights and behavioral issues:

You ***may never*** use aversive conditioning techniques. This includes using any form of pain or unpleasant stimuli. Law and regulation strictly prohibit all forms of aversive conditioning. Seclusion is also prohibited. Seclusion means placing or encouraging a person to into a locked or restricted area.

The appropriate agency committee/s must first approve all non-positive forms of behavior modification. The appropriate agency committee/s job is to make sure that behavior programs are well written and address the behaviors of concern. The committee/s makes sure that these plans do not unduly infringe on a person's rights.

As a general rule of thumb, if you have any doubts or questions about what you are doing, see a supervisor immediately.

PRINCIPLES OF BEHAVIOR CHANGE AND PROGRAMMING

People with mental retardation must have access to the same range of mental health services available to all citizens, including behaviorally oriented supports.

The acceptability of any behavior intervention must be based on the consideration of: (1) its proven effectiveness; (2) potential secondary effects and risks associated with the intervention; (3) legal, social and ethical implications; and (4) ease and practicality of implementation.

In addition, behavior intervention programs should be:

- designed in a person-centered process and applied in a caring manner respecting individual dignity with informed consent;
- systematic in their approach, based upon a formal functional analysis or assessment, as well as a thorough assessment of each individual's unique abilities and contributions, and using the least restrictive strategy described in a written plan;
- based on procedures adequately documented in the clinical/educational research literature and take into account previous interventions;
- intended to replace challenging behavior with adaptive and socially productive behavior;
- implemented in positive and socially supportive environments, including the home;
- carried out by individuals (staff, family members and others) who have been trained and are qualified to effectively apply these approaches;
- monitored systematically. This ensures that the approach is consistent with individual needs and successful in achieving established goals and changed in a timely fashion if success is not evident or occurring at an appropriate rate.

Observing Behavior

The goal of any behavior modification program is to change behavior - replacing inappropriate or undesirable behaviors with appropriate or desirable ones. One key to success is to define behaviors, develop appropriate alternatives, and check that those target behaviors are realistic. One way to do this is to observe the behaviors and record them. By actually counting the instances of specified behaviors, you can gain valuable information and begin to introduce the idea of behavior modification.

Positive Reinforcement

One very effective way of increasing desired behaviors is through positive reinforcement. Here the individual receives recognition for behaving in the appropriate manner or meeting a goal. Giving a positive reinforcement consistently and repeatedly does change behavior and eventually the reinforcer is not needed. Remember that a reinforcer is anything that increases the targeted behavior.

COMMUNICATION SKILLS

A key to communicating effectively with people who come for supports is knowing something about your own value system. This sets the stage for understanding how your personal values affect: (1) your behavior; (2) your relationships with others; and, (3) your communication. An effective support coordinator must develop the ability to work with an individual, family and friends without being overly influenced by his or her own personal value system.

Cultural differences affect your communication. For example, in some cultures, a child with a disability lives with the family and extended family as long as they are alive. Consider the following situations as they are affected by your own culture and experience and how they might affect your communication:

Awareness is a key to successful communication. Our culture and life experience can be either a bridge or a barrier to effective communication. In order to be an effective communicator, it's important to:

1. *Recognize that each of us is a walking system of values.* We must try to be aware of how those values affect us daily in both the way we experience life and the way we communicate those experiences to others.
2. *Be aware of our personal biases.* One useful tool (Brill) is to become sensitive to the use of the term "they." This is a term that often implies a personal bias toward someone for a belief or value that is different from our own. Awareness of these biases can help overcome barriers which affect successful communication.
3. *Strive to respect the differences of others.* Each person receiving services deserves to be treated with an understanding of their background and a respect for their personal beliefs and values.

Creating A Positive Communication Climate

The following are strategies for creating *climates* of positive communication:

- *Avoid making assumptions.* Avoid drawing conclusions before meeting with an individual or a family based on written information. Read only what you need to ask informed questions.
- *Avoid jargon and explain technical terms.* Use conversational language with individuals and families, and explain any technical terms. Service coordinators should refer to service agencies by name as opposed to initials, and explain terms such as behavioral intervention, authorizations, etc.
- *Recognize differences in the way people acknowledge and understand information.* Explain information to people using a variety of aids (e.g., drawings, pictures) if necessary. Allow time for processing information, and answering questions.
- *Respect cultural differences.* Ask the focus person who ought to be invited to meetings. This will likely vary from person to person and family to family.

Pay attention and respond to nonverbal cues. Be aware of body language of all parties.

Active Listening

Active listening is listening constructively, with interest and acceptance, focusing an understanding of the other person's feelings; putting yourself in his/her shoes. It is hearing the other out, asking questions only to clarify or to draw the other person out. It is letting the other person make his/her own point (not finishing his/her sentences.) It is accepting and appreciating the silences. It is respect for the other person.

Type of Statement	Purpose	To Achieve Purpose	Examples
ENCOURAGING	To convey interest	Don't agree or disagree. Use noncommittal words with a positive tone of voice	"I see," "Uhuh," "That's interesting"
RESTATING	To show that you are listening and understanding; to let the person know you grasp the facts	Restate basic ideas, emphasizing facts.	"If I understand, your idea is," "In other words this is your decision"
REFLECTING	To show that you are listening and understanding; to understand how feels	Reflect basic feelings	"You feel that," "You were pretty disturbed by this..."
SUMMARIZING	To pull important ideas, facts, etc., together; to establish a basis for further discussion; to review progress	Restate, reflect and summarize major ideas and feelings	"These seem to be the key ideas you have expressed," "If I understand you, you feel this way about the situation"

THE AGING PROCESS AND THE SPECIAL NEEDS OF THE ELDERLY

Physical fitness must be defined with consideration for an individual's age and lifestyle. For a younger person, physical fitness is defined as a physical condition that allows an individual to work without becoming overly fatigued, perform daily chores, and have enough energy left over to engage in leisure activities. Physical fitness is extremely important for the older population because as a person ages, there is a higher level of fatigue and often pain resulting from arthritis, low back problems, or other ailments. As these conditions worsen over time, many older people become more sedentary thinking that if they rest they will get better.

On the contrary, when older people rest and become more inactive, they feel increasingly tired because they have decreased their physical fitness. Thus, it is a vicious cycle: disability and pain cause decreased movement, and decreased movement results in less fitness and a higher level of dysfunction. A good physical fitness level-regardless of the disability-helps older people maintain their quality of life and can reduce their dependence on others to help with activities of daily living.

A moderate to high level of fitness reduces the incidence of "hypokinetic" diseases. Hypokinetic basically means a lack of movement or too little movement. When the body doesn't move enough, it slowly deteriorates and becomes vulnerable to disease. In essence, a sedentary lifestyle can contribute to or increase the severity of such problems as hypertension (high blood pressure), obesity (excess fat), adult-onset diabetes, osteoporosis (brittle bones), depression, and low back pain.

There are four parts to physical fitness:

- Muscle strength and endurance
- Flexibility
- Body composition (body fat)
- Cardiovascular endurance (the ability of the heart, lungs and blood vessels to transport oxygen to working muscles)

Do people with mental retardation have problems in these areas?

Yes. Research indicates that people with mental retardation have very low levels of cardiovascular endurance. A lack of cardiovascular endurance often means the individual is unable to sustain long

workdays or participate in leisure-time activities (e.g., hiking, swimming, biking) without becoming fatigued. A poor cardiovascular fitness level also translates into a higher risk of disability and death.

Perhaps the most disturbing findings pertain to the fitness levels of adults with mental retardation in regard to their body fat levels. Whereas a third of all Americans are overweight, close to one-half of all people with mental retardation are overweight. When we separate women from men, we find that many more women with mental retardation are overweight compared to men with mental retardation. The high levels of obesity (excess fat) found in people with mental retardation expose them to a higher risk for many different types of diseases that are associated with high levels of body fat. These include Type II diabetes, hypertension, heart disease, stroke, arthritis, respiratory diseases, and cancer.

Adults with mental retardation are at risk for all kinds of hypokinetic diseases that result from physical inactivity. One researcher went as far as saying that people with mental retardation are a "population at risk" because of their sedentary lifestyle.

The body goes through several changes as we age. First, there is a loss in muscle tissue and a gain in fat tissue. Unfortunately, this is a negative change because fat does not perform a function like your muscles that contract in order to move the body. Therefore, fat just adds to our body weight, making it more difficult to move.

Bones start to lose their mineral content (calcium and phosphorus) as we grow older. This leads to one of the biggest health problems in the elderly, osteoporosis. Osteoporosis causes compression fractures, which are small cracks in the bones. This usually occurs in three areas: the hips, vertebrae (bones in the back) and wrist. When osteoporosis gets progressively worse, a hip fracture can occur.

Our cardiovascular system, which consists of the lungs, heart and blood vessels, takes a heavy toll as we grow older. A great deal of the deterioration to the cardiovascular system has to do with lifestyle. There is an accumulation of plaque (calcium, cholesterol, fats) inside the blood vessels which over time can lead to a blockage or a ruptured artery. When this occurs, a person will sustain a heart attack or stroke. The number one cause of death in this country is due to cardiovascular disease.

The last thing that slowly starts to deteriorate is the central nervous system. Our reflexes and reactions become slower, and we lose speed in doing things that require agility. Catching ourselves from a slip or fall becomes more difficult.

Developmental Disabilities and Alzheimer's Disease

Alzheimer's disease is a slowly progressive, degenerative disorder of the brain that eventually results in abnormal brain function and death. The disease was first described in 1907 by a German physician, Dr. Alois Alzheimer.

Alzheimer's disease is a disorder marked by a gradual decline in brain function that gets worse with time. It used to be assumed that this change was a normal part of aging that we called "senility." Some persons develop this condition when they are as young as 40 years of age. However, the disease is most common in persons over the age of 65. It is estimated that approximately 10 percent of persons over 65 years of age may have Alzheimer's disease and that in persons over the age of 85, up to 50 percent may be affected.

Alzheimer's disease is not a normal part of the aging process. It is not "hardening of the arteries." It is not contagious, and it is not known how it can be prevented. While the physical changes in the brain are very similar among different people, the behavioral and psychological symptoms that result are complex and may differ from person to person. These symptoms lead to a form of "dementia" which is the loss of mental skills and abilities, including self-care capabilities. As Alzheimer's disease progresses, these losses will result in total dependency for even the simplest activities.

What are the symptoms of Alzheimer's disease?

The early symptoms of Alzheimer's disease in the general population often include:

- Language problems. The person cannot find the right word or name for a familiar person, place or object. This is not the same as taking longer to recall a word. It is far more than the "occasional" slip of a name that everyone experiences.
- Loss of recent memory. The person may forget that he or she just had breakfast or has left something cooking on the stove, or may check and recheck that the bed has been made. However, recall of events from the distant past is often unaffected.
- Loss of a sense of time and place. The person may become more and more confused about what day it is, or forget the route to well-known places.
- Decline in activities of daily living. The person may exhibit an unexplained loss of activities of daily living (ADL) skills. What once was an easy task for the person may now be difficult.
- Personality changes. These may be so slight that, at first, they are difficult to notice. Some people become more quiet and withdrawn. In other cases, they may become more and more restless. Some persons may start to get angry over little things or have sudden changes of mood for no apparent reason.

The General Course of Alzheimer's Disease?

First (or onset stage):

The initial symptoms often appear very gradually. There may be some minimum memory loss, particularly of recent events. The individual may experience difficulty in finding the right words to use during casual conversations. Work performance may begin to deteriorate and changes in behavior may start to become obvious. These changes may last for a period of up to five years.

Second (or progressive stage):

The symptoms noted during the onset stage now become more obvious. There may be distinct problems with language abilities--this is typically the most obvious sign of movement to this stage. Persons affected may have difficulty naming objects or with maintaining a logical conversation. They may also have difficulty understanding directions or instructions. They often become easily disoriented with regard to what day it is (time), where they are (place), and who they are with (person). Confusion and the resulting frustration are often evident. Memory losses become even more pronounced. They may also begin to experience loss of self-care skills, including the ability to use the toilet (incontinence). Severe changes in personality may begin to become obvious, and their social behavior may be marked by suspiciousness (paranoia) and delusions. These changes may last for up to about twelve years.

Third (or terminal stage):

Persons affected now experience substantial dysfunction. Basic skills such as eating or drinking are forgotten. Because of eating problems, many persons may experience a substantial loss of body weight (up to 2-30 percent). They may eventually lose their ability to maintain balance and walk. Their ability to recognize other persons and their environment is gone. Both long- and short-term memories are lost. At this stage, persons affected require complete 24-hour care and often become bedridden and inactive. Because of this, they are at increased risk for any infection, especially pneumonia, and consequently are far more likely to die. These changes, leading to death, may last for three or more years.

Down Syndrome, Aging And Alzheimer's Disease

People with Down syndrome may experience health problems as they age that are different from those experienced by older persons in the general population. The presence of extra genetic material found among persons with Down syndrome may lead to abnormalities in the immune system and a higher susceptibility to leukemia, seizures, cataracts, respiratory illness, and heart conditions. Persons with Down syndrome also experience premature aging--that is, they show physical changes related to aging some 20 to 30 years ahead of persons of the same age in the general population.

With increased age, persons with Down syndrome may experience "typical" hearing loss and vision changes that are "expected to accompany being older," but will do so 20 to 30 years before other persons in the general population. Vision problems may be mostly due to cataracts. There may also be problems with motor abilities and changes in the skin, nerve, muscle, digestive, and urinary systems. Compared to

age peers, people with Down syndrome have higher rates of Alzheimer's disease. This may be another example of age-related changes occurring earlier in persons with Down syndrome than would be expected in persons in the general population. Adults with Down syndrome are often in their mid to late 40s or early 50s when symptoms may first appear, while symptoms first appear in persons in the general population beginning in the late 60s.

INDIVIDUAL PLANNING

The Planning Process

Person centered planning is one way of figuring out where someone is going (life goals) and what kinds of support they need to get there. Part of it is asking the person, their family, friends and people who work with him or her about the things she or he likes to do (preferences) and can do well (strengths and capabilities). It is also finding out what things get in the way (barriers and needs) of doing the things people like to do. If people can't talk for themselves, then it's important to spend time with them and to ask others who know them well.

Program Centered vs. Person Centered Planning

<p>Planning <u>for</u> Talking about you Doing things to you Following your program You live where you "fit" We are in control Starting with what's wrong Issues of health and safety dictate where you live We "let", "allow", and "place" We set your goals Your team decides the next developmental step Dead Plans Updated annually</p>	<p>Planning <u>with</u> Talking with you Doing things with you Having a life You choose with whom & where you live We share control Starting with what is important Issues of health & safety are addressed where you want to live We "support", "assist", "help" We suggest, you decide We figure out together what you want and help you to get it Living Plans Change with the person</p>
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COMMUNITY INTEGRATION AND INCLUSION

The way we talk about people with disabilities has seen positive progress since the late 1960's. In the 60's and 70's we talked about "normalization." This means that people with disabilities should have a rhythm of life just like everyone else. They got up, ate and slept at the same times that most people in society did these things. They weren't pointed out as different but we able to more easily fit in.

In the 70's and 80's we began to talk about "social role valorization." This was just a fancy way of saying that people with disabilities needed to not only have normal lives but that they needed to be valued by society. That is, they needed to have valued social roles.

Now in the late 1990's and 2000's we have taken this one step further and said that people with disabilities not only need a normal life and valued social roles but they need to become real and active members of their community.

The Principles of Supported Living

It is crucial to those people who are assisting others to find a home and to access needed supports to get to know these individuals, their desires and preferences, the people in their lives who care about them, and what an ideal living situation would look like for each of these people. Once this information is

gathered, the people who care about the person get together regularly to develop a plan for getting as close as possible to the ideal living situation.

Use of connections Our traditional residential services relied predominantly on system solutions to concerns and problems. By relying only on system solutions a whole wealth of potential resources is ignored. One of the components of supportive living is eliciting the assistance of all who want to and can help. Therefore, people who care about the individual along with the individual should continually ask, "Who do we know who can help?" "Who do we know who will help us think about it?" and "Who will ask for their assistance?"

Focusing on what people can do Traditional residential programs focused predominantly on what people could not do and tried to offer a treatment plan designed to teach people how to do what they could not do. Supportive living focuses on what people can do, provides support for things people cannot do, and provides opportunities for them to learn how to do the things they want to do.

In summary, supportive living is not a model, the answer, or some new magic. It is, however, a way of viewing people and assisting them in ways that enable these individuals to receive the support they need and to live in a home they want.

Inclusion

"Segregation is the way in which society tells a group of human beings that they are inferior to other groups of human beings in that society." (Testimony of: Kenneth Clarke, Brown V. Board of Education, 1956.)

Many people with mental retardation are still separated from people without disabilities. They are being denied the opportunity to participate in, benefit from, and enrich the daily life of their communities. Inclusion is bringing people with and without disabilities together throughout their lives.

All people, with or without mental retardation, have the right to be fully included in their diverse communities.

Children with mental retardation should:

- live in a family;
- grow up enjoying nurturing adult relationships both inside and outside a family;
- learn in their neighborhood school in a regular classroom that contains children without disabilities;
- play and participate with children, with and without disabilities, in community recreation and other leisure activities.

Adults with mental retardation should have the opportunity to:

- have maximum control over their own lives;
- have adult relationships ranging from acquaintances to friends to life partners;
- live in a home;
- engage in meaningful work and be paid fairly for it;
- enjoy recreation and other leisure activities;
- practice spiritual life if desired.

Supports and services needed by people with mental retardation should be given to them in their home communities as they live, learn, work and play with non-disabled people.