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ABSTRACT

This instructor's manual, developed to assist the training instructor of a program entitled "The Aging and Aged Developmentally Disabled," provides information to enhance the skills of inservice and preservice caregivers and other professionals who work with the aging developmentally disabled. The objectives of the two training units, "Understanding the Client" and "Reaching to Community," are discussed and the organization of the 10 half-day training sessions which comprise the units is described. The need for individualization of the sessions according to the needs and skills of participants is emphasized. The layout of the instructor's and students manuals is given along with the class size, room arrangement, planning methods, use of materials, and evaluation process. For each of the sessions, an outline is presented, followed by a list of objectives and a step-by-step description of procedures and activities. Materials needed for each session are included and additional materials are provided in the appendix. Topics covered in this manual include facts about developmental disabilities and the aging process, basic needs of persons, environmental impacts, labeling persons, the caregiver role, and uses of community resources. (NRB)

WORKING WITH AGING AND AGED DEVELOPMENTALLY DISABLED PERSONS

TRAINING MATERIALS FOR CAREGIVERS

BY

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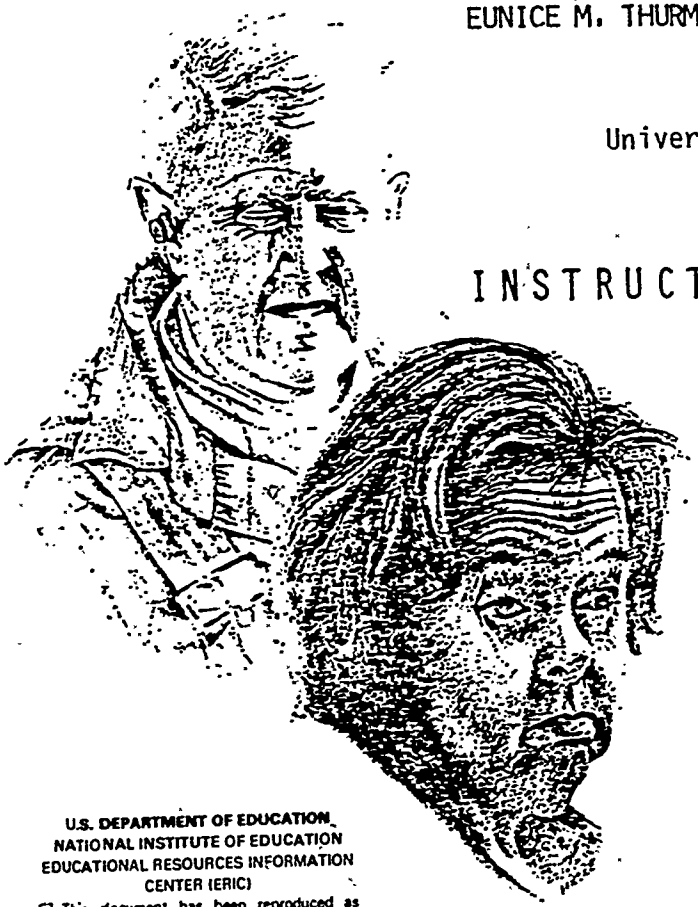
INSTRUCTOR'S MANUAL, VOL. I



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FOREWORD

The needs of the older developmentally disabled person are now being recognized. But recognizing needs is only the "tip of the iceberg." Solutions pose greater challenges that become visible only when we go forward to meet common needs within each person's unique life experiences.

This training manual will take each participant through an experiential process that will lead him/her to the realization that the universal aging process makes all of us - young or old, disabled or not - more alike than different. Then we can all join hands, celebrate our common humanity, and constructively meet the challenge of the aging and aged developmentally disabled person.

These materials are based on the following assumptions:

1. All persons, including developmentally disabled persons, have the right to a safe, fulfilled old age.
2. Personnel who provide servcies to AA/DD persons should support the client and his/her family by relating to the client in a manner appropriate to his/her age, thus breaking the patterns of infantilization and patronization.
3. Staff understanding and acceptance of developmental disabilities and the aging process are essential to staff development and are the best protection against mistreatment of the client by psychological, emotional, or physical neglect and abuse.
4. Humanistic treatment of the AA/DD person is morally and ethically supported by the expectations of this society for the treatment of the individual citizen.

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PREFACE

This training manual will supply assistance to the instructor as she attempts to enhance the skills of inservice and preservice caregivers and related professionals who work with AADD[1] persons. But the manual is only one of many types of resources that develop a meaningful learning environment. The unique strengths and experiences of the instructor must constantly impact on all the learning materials so that they "come alive" for each new group of trainees.

This complete manual is the result of information gained over many training experiences. Ranging from two to five days in length, these sessions were presented to direct caregivers, administrators, social workers, and volunteers. Due to their input and critical evaluations, the project staff[2] was able to incorporate suggestions in the completed training materials. Concurrently with the development of the manual, many hours were spent by project staff in direct service to, interviews with, and observation of, approximately 40 older, developmentally disabled persons.

All materials are based on direct experiences of the staff with the AADD person. Therefore he begins to speak about his own interests, needs, and concerns.

We wish to acknowledge Martha Perske's generosity in allowing us to use her prints in our materials. Special thanks goes to the Institute of Gerontology at the University of Michigan and the National Institute on Aging for allowing us to duplicate materials. We are grateful to both the Macomb Oakland Regional Center and the Institute for the Study of Mental Retardation and Related Disabilities for their continuing support of our project.

Thanks to all the project staff who have contributed to the manual over the two years: David Demetral, project assistant, spent many hours establishing a senior center, specifically for the AADD person. We have learned much from his experiences. Andree Naylor, project secretary, devoted her time by participating in

workshops, volunteering time with clients, offering constructive comments, as well as editing and typing. The support of the ISMRRD word processing unit--Linda Tucker, Jeanne Bright, and Gail Sonnett--resulted in a written format that enhanced the completed manual.

Martha Ufford Dickerson

Eunice M. Thurman

Ann Arbor, 1981

[1] This term will often be used to designate the aging and aged developmentally disabled person.

[2] The project is a cooperative effort between the Institute for the Study of Mental Retardation and Related Disabilities (ISMRRD) in Ann Arbor, Michigan and the Macomb-Oakland Regional Center (MORC), Mt. Clemens, Michigan. Its purpose is: 1) to develop cooperatively with MORC, a model, community-based service program for AADD; 2) to use that service program to develop and demonstrate a cooperative training program between a university and a community-based facility; 3) to develop and field test new service and training methods and materials; and 4) to disseminate materials on state, regional, and national levels.

GENERAL PROCEDURES AND TECHNIQUES

TRAINING SESSION

The training sessions are clustered into two units. The first unit (Sessions I-V) provides the students with precise information specific to the needs of the AADD. As participants learn more about the AADD person, they begin to appreciate how similar needs are across the life span. They become aware of themselves as active agents in effecting change, and learn to perceive the self-defeating roles society has mandated for older people generally, and the AADD persons specifically.

The second unit (Sessions VI-X) attempts to put participants into personally relevant situations where they begin to act both with and on behalf of the AADD person. Priority is constanty given to the self advocacy role of every person at any age.

TRAINING PROCESS

Each of the ten sessions has been designed as a half-day training experience (2 1/2 hrs). However, personal needs and skill levels of group participants should determine the length of time each trainer spends on any aspect of the sessions. All sessions should be individualized and applied to provide unique training experiences.

The training process utilizes a variety of teaching methods and group exercises. Thus, natural breaks occur and can be used as informal coffee or restroom breaks. However, regular breaks can be established without disrupting the flow of the session.

1. INSTRUCTOR'S MANUAL

Note that instructor manual (Vol. I) pages are numbered at the bottom of the page. Manual pages followed by an asterisk* are the instructors pages of the student manual. They often contain those pages where answers and suggested

responses are presented in *italic* type that the students should be copying into their materials. The trainer should refer to these pages during the training sessions.

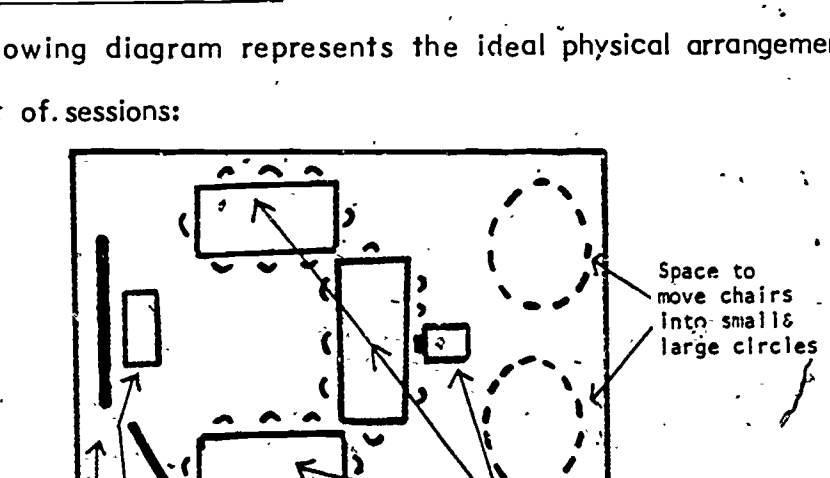
When a page in the manual is being referred to, it will be abbreviated MP. Manual pages, with asterisks *, coincide with pages in the student manual.

2. STUDENT MANUAL:

The separate student manual (Vol. II) is numbered at the top. This material is designed to allow the student to develop his own manual by completing sentences and/or outlines. Thus, even when material is presented as a lecture, participants must involve themselves. The instructor can use the blackboard, overhead viewer, or newsprint to present the material. Then key points and correct spelling are reinforced, and participants are recognized and acknowledged (This teaching design is effective in creating an informal learning atmosphere for adults.) When a page from the student manual is being considered, it will be abbreviated SP.

ARRANGEMENT OF CLASSROOM

The following diagram represents the ideal physical arrangement of the room for most of sessions:



This arrangement allows movement for lectures and visual presentations involving small and large group discussions. Since the ideal might not be available, it is more important for people to be able to move about. Therefore, a smaller room that contains chairs only, will allow flexibility to form small or large discussion groups. A table is useful for the initial registration and attendance procedures.

PLANNING FOR THE SESSIONS

The manual should be read and reviewed before the first training session. Since group cohesiveness is low at the beginning of all training sessions, the preparation of the instructor is crucial to the establishment of good procedures, and to get the sessions on the "right foot." The following check list (taken from Ingalls, 1973), should provide a reminder for you as you organize. You may wish to add to it as you plan for your unique situations.

- space
- lighting
- accoustics/outside noise
- temperature
- decor
- writing materials
- ash trays
- smoking arrangements
- restrooms
- audiovisual aid
- coat racks
- parking
- traffic directions
- name tags
- records/addresses, etc.
- restaurants
- picture/tape recordings

USING TRAINING MATERIALS

This material is designed for caregivers, or those workers in daily contact with

the AADD. It does not deal with the problems inherent in supervision and administration of programs for the client population. It has been our experience that learning can be enhanced for a group of individuals who share the same needs of skill development.

CLASS SIZE

Be flexible as you consider your specific group's needs. This will allow for discussion purposes. It is recommended that small groups be limited in size to 6-8 participants to allow for the maximum exchange of experience, expertise, and knowledge.

REGISTRATION AND ATTENDANCE

Registration and records of attendance must be conducted under the supervision of the sponsoring agency. This manual does not make recommendations in this area.

AUDIO-VISUAL MATERIALS

Not all trainers may have access to adequate audio-visual equipment. The Appendix includes supplementary materials that may be used.

EVALUATION PROCESS

An evaluation instrument is included at the end of Unit II. It can be used to evaluate the training experience in the following areas:

1. Relevancy of the content
2. Instructor's teaching skill
3. Instructor's use of group process
4. Pertinence of multimedia offerings

VIGNETTES

Many situations emerging from direct practice with the AADD form the basis for numerous vignettes, both within the training materials and as extra problem solving exercises. (See Appendix MP 174) These situations are extra materials to use if audio visual materials are unavailable. They can be used whenever the instructor feels they are appropriate.

Each of the vignettes is designed to raise obvious problems as well as more subtle issues that have emerged out of direct work with AADD individuals. The trainees should identify these concerns and then problem solve for possible solutions.

The issues in all the situations are real ones, and represent potential problems that could arise in any setting involving AADD persons. Names of individuals have been changed and recognizable information has been disguised.

SESSION I

AGING AND THE INDIVIDUAL

1. GREETING

2. TRAINING OVERVIEW:
   - Goals for Training
   - Outline and Process of Session
   - "Get the Most From Your Small Group Experience"

3. "THINGS WE TAKE FOR GRANTED" - Videotape

SUGGESTED COFFEE BREAK

4. FEELINGS ABOUT "YOUR DISABILITY"

5. IMPACT OF AGING
   - Small Group: Questions focusing on sensory change and adaptations
   - Large Group: Share-out

SESSION I

PURPOSES

1. Welcome the participants
2. Introduce training design
3. Encourage awareness of disabilities
4. Discuss the aging process

PROCEDURES

1. GREETING

(15 minutes)

Greet participants and distribute name tags.

Preparing name tags can provide an opportunity for participants to get to know each other. Have people design "creative" name tags, using different colored paper and magic markers. If coffee is provided also, it will allow for a natural socializing atmosphere. There are various ways of creating an informal climate for learning in addition to the use of name tags (see Ingalls, 1973).

Give each trainee SPP 1-3 and their disability grab bag. Instruct them to follow the directions in the bag.

Preparing the disability grab bag is not as difficult as it may appear initially. Presented here are the "disabilities" that we have used, and the supplies needed:

A. Hearing Loss

1. Hearing protectors.
   Reminder: Alcohol can be used to sterilize ear tips after each use.
2. Wet two pieces of cotton and place in ears.

B. Visual Limitation

1. Spray industrial glasses from the side with three thin coats of hair spray.

C. Cataracts

Eye Patch

D. Arthritic Fingers

Length of clear, vinyl tubing, used for drainage. (The widest diameter hose fits most size fingers. Take a hacksaw and cut the pipe into 1 inch lengths. These are slipped over the thumb and index finger).

E. Arthritic Hands

Cleaning gloves. (Ask trainee to put either glove on his writing hand).

F. Arthritic Joints

Strips of cloth two inches wide and three feet long. Two pieces of window lath, one inch wide and about one foot long. ("Sandwich" elbow or knee with two cloth strips.)

G. Non-Ambulatory or Partially Ambulatory

Wheelchair or Walker.

Put necessary items to simulate the disability (A-F) into a lun bag. Insert directions for the participants on a small piece of paper. The follow directions may be useful:

1. You have a significant hearing loss. Wear the enclosed hearing protectors.
2. You have a hearing loss. Wet the cotton and place it in each ear. Two cotton balls per ear should do the trick. Three might be better.
3. Your eyesight is failing with age. Wear the "glasses" that are enclosed.
4. You are losing sight from cataracts in one of your eyes. Wear the eye-patch on the same side as your writing hand.
5. You have limited mobility in your writing hand. Cov your thumb and index finger with the rubber hose.
6. Your writing hand is quite crippled with arthritis. Wear the enclosed glove.
7. Your right elbow has become stiff through increasing calcification of the joint. Please have someone assist you in immobilizing your elbow.
8. Your right elbow and right hand have been crippled with arthritis. Have someone assist you in immobilizing your elbow. Wear the glove.
9. Fingers on your right and left hand are hard to move and manipulate. Use the enclosed plastic hose pieces on your thumb and index fingers.

Direct participants to look briefly at the outline of Session I (SP 1) so they can note coffee breaks, lunch periods, and the general flow of the presentation. Specific information as to restroom, coffee, and restaurant locations should be provided.

Encourage group members to assume the assigned disability for a designated length of time. Trainees should be tolerant of the different comfort levels of the participants that may inhibit involvement in this exercise.

2. TRAINING OVERVIEW

(15 minutes)

Review the goals of the course and the topics covered as they appear on SP 2. Previous training experiences may provide rich and explicit examples. Restructuring, rephrasing, and repeating this material throughout the training sessions will help the trainee focus upon his own perceptions and expectations for the training process. Go on briefly to explain SP 3. Keep in mind that

this page conceptualizes the personal involvement of each trainee, and the personal investment she must make in order to get the most out of the learning experience. Using examples from personal experiences expands this information also. The trainer may choose to read, or let participants read, sections of this page aloud. Group discussion could then follow. Emphasize to students that they do not need to know a lot about aging and developmental disabilities. Besides the presented material, the information they gain from each other will be invaluable.

3. VIDEOTAPE

(30 minutes)

Show videotape, "Things We Take For Granted" (See Appendix MP 203 for this and other resources). Distribute the discussion guide (SPP 4-5) for the video tape as a summary. If time permits it may be used to enhance the group sharing.

4. "YOUR DISABILITY"

(30 minutes)

This discussion will be enhanced if participants have experienced a coffee break wearing their disability. The more opportunities the trainees have to explore the activities of daily living as a disabled person, the more quickly they will become sensitized to the unique problems of the disabled person. The problems participants will face as they attempt to walk, use their hands to open doors, stir their coffee, attend to toileting etc., will enhance the discussion.

Form a large group and encourage each trainee to share his experiences and feelings around the disability exercise. SP 6 should be distributed, and class members should be encouraged to record their experiences. You may refer to MP 13 for additional comments you could make.

5. IMPACT OF AGING

(1 hour)

Divide the large group into four smaller groups of 4-6 people. The trainer may let individuals choose group members they do not know, or count off by four, allowing ones to be together, twos to be together, etc.

Provide each group with a sheet of newsprint and magic marker. Once in small groups, the trainees should choose one person to record all participants' suggestions. Distribute SP 7 to all class members.

Four pieces of newsprint must be prepared beforehand, so each group can record on them. Large sheets of newsprint are needed to provide adequate writing space. Each page should be headed by one of the four following categories:

1. Bones
2. Appearance
3. Hearing
4. Vision

Each page should then be divided into four equal squares, each square consecutively should contain the following instructions:

1. How changes occur over time
2. How the environment must adapt to the change
3. What kind of supports (self image, prosthetics) can be used to cope
4. Ways others might help the older person adjust to his disability

Participants should respond to these instructions, and their remarks should be recorded on the newsprint sheets by the group recorder. Trainees must rely upon their personal experiences with aging relatives or friends, or on their own reading or academic courses. Remind each group recorder about the time limit, so all four categories can be considered within the time allowed.

Each small group should appoint a second individual to present its findings to the large group. This person will discuss material on the newsprint. Group members should make comments that expand on this information. As information is presented, supplement what is discussed with the added material found on your MPP 14, 15.

After the four presentations, distribute SPP 8,9. SP 8 should be discussed immediately as a review. Encourage participants to fill out the bottom of the page. MP 16 provides the instructor with appropriate responses. SP 9 provides a review for participants to supplement their personal notes.

HOW DOES IT FEEL TO HAVE A DISABILITY?

This exercise is an opportunity to learn how the activities of daily life are affected by a disability. List the feelings you experienced as a result of the simulation. Consider how your life would be different if you had been disabled since age 5. Use the space below, or on the back of the page, to make notes about the experiences other participants described.

Discussion may center around the manipulation that was used to get coffee or some other refreshment. For example, a participant with "arthritis" might have found it important to be especially nice to another student and get to know him/her so that s/he would have someone to get the coffee out of the coffee machine.

Problems around maneuvering in the washroom are common.

Since classmates may make excuses about not going to coffee break or avoid sitting with others, if they did go.

Participants will discuss making excuses for not doing something: "I can't do that because. . . ."

The concept of interdependence is important to stress. Although each of us share disabilities in this exercise, we can still assist each other with the abilities we still do have.

The pain of the disability.

People "staring" at your disability and the stigma you feel.

SOME OF THE INSIGHTS PARTICIPANTS MAY HAVE:

Communication becomes more limited and specific to another person (one-to-one interaction becomes critical).

Although all of us are dependent, some persons have to meet a greater degree of dependency everyday.

"Doing for" someone isn't always necessary, and frequently it is the least compassionate thing to do.

Impairments inconvenience us; however, we make them handicaps.

Caregivers are often responsible for client attitudes of over-dependency.

We are coping with a disability today. But how does the AADD individual learn to cope and adjust everyday?

IMPACT OF AGING

Your vision, hearing, appearance, bones and joints change with age. These changes often bring problems for the older person.

1. In what ways will the older individual compensate (make up) for this? Especially consider the areas listed on the newsprint. Also, keep in mind older people you know, and how they adjusted to the change.

2. How can others help the older person compensate?

3. Be sure you are prepared to present your findings to the group.

NOTES:

SOME RESPONSES MIGHT BE GENERALLY ACCEPTABLE FOR ALL GROUPS, NO MATTER WHAT DISABILITY THEY ARE CONSIDERING. GENERAL AND SPECIFIC RESPONSES PEOPLE MIGHT HAVE FOR EACH DISABILITY COULD INCLUDE THE FOLLOWING:

I. *HOW CHANGES OCCUR OVER TIME*

General: Gradual change; develop other senses to compensate; difficulty accepting the disability; depression; anxiety; slowing down of activities - person can't do as much, or can't keep up.

Bones and Joints: Gradual stiffness; abusing the body, i.e., lifting improperly; poor diet; chemical changes causing brittleness.

Hearing: Gradually lose high, then low tones; find you must listen more carefully; lose some hearing due to loud noises.

Vision: Find you must get bifocals, because your eyes don't adjust; glare bothers you more - sun or headlights.

Appearance: Wrinkles; grey hair; body scars; hair growth in "inappropriate" places; tooth decay; prosthetic devices (cane) causes people to "stare"; mastectomy (breast removal)

II. *HOW THE ENVIRONMENT MUST ADAPT TO THE CHANGE*

General: People of all ages must learn to slow down and accept the slower pace of the older person.

Bones and Joints: Move to a drier climate - Arizona; install humidifier/dehumidifier in home; construct barrier free building - no stairs, steps in home or public places; special barrier-free transportation.

Hearing: Speak slower and more distinctly; look at the person's face; tone down background noise.

Vision: Remove obstacles in the path; maintain the same furniture arrangement; add more light, but bulbs should be of a low wattage to eliminate glare.

Appearance: Relatives and friends must become sensitive to the changing physical appearance of the person, and "look past" it to the older person as an individual.

III. *KINDS OF SUPPORTS USED TO COPE (Prosthetics, Self-Image)*

General: Learning about the disability through classes, evluations of the problem, or formal therapy geared toward an acceptance of the disability.

Bones and Joints: Canes; bathroom supports; walker; dressing aids; bed boards; hospital bed; special shoes;

Hearing: Learning to feel comfortable in helping other people speak louder, more clearly and be acceptant of your difficulties; hearing aid; lip reading classes; supportive individual and group therapy; social service supports;

Vision: Glasses; contacts; talking books.

Appearance: Encourage use of cosmetics, wigs if the person feels good about using these items; encourage daily regimen around doing things that makes one feel good - beauty parlor, manicure, face lift, hot baths, etc.

IV. HOW OTHERS CAN HELP THE OLDER PERSON ADJUST TO DISABILITY

General: Learn to deal with disabilities as only one aspect of the older person. The older person has many more <u>strengths</u> than disabilities.

Bones and Joints: Redesign home for more easy access - bathroom, kitchen, etc.; self-sufficiency training; give positive feedback-exploring strengths; be aware of the needs of the disabled person for extra assistance and moral support for shopping, recreation, transportation.

Hearing: Take time to talk more slowly; encourage medical evaluation and treatment; be extra sensitive to include the person in social and family groups.

Vision: Reinforce interdependence i.e., the person might need someone to read small print to him, but <u>large type</u> books may be obtained from the library for independent reading. Encourage <u>interdependence.</u> Explain physical and social situations beforehand, i.e., directions to the washrooms, etc.

Appearance: Not valuing youth and beauty as if it is ultimate value: help person to continue to be useful and valuable to others; help person choose appropriate make-up and contemporary fashions/clothing.

THE PROCESSES OF AGING

"Grow old along with me!
The best is yet to be,
The last of life for which the first was made:
Our times are in his hand
Who saith, "A whole I planned,
Youth shows but half; trust God:
See all, nor be afraid."

Robert Browning, "Rabbi Ben Ezra"

Understanding the processes of aging goes beyond knowing about the changes that will occur. It is being aware that these changes will happen to you too. Aging and ultimately dying is a very personal process. And it is only through understanding our own aging that we will be able to understand the aging of older developmentally disabled persons.

Aging has a number of characteristics:

1. Happens to everyone, everywhere (universal)
2. Occurs over the years (gradual)
3. Takes place within the environment; is not caused by the environment.
4. Increases the chance of accident and disease (vulnerability)

The last factor increases our physical limitations through these normal processes of aging. What are these limitations?

1. *Less energy to do what needs to be done.*
2. *Less ability to recover from stress.*
3. *Loss in the ability of the senses to work well.*

Changes are especially significant in the following areas:

Vision, Hearing, Touch, Bones & Joints, Appearance.

SESSION II

SHARING COMMON NEEDS

1. TRUE - FALSE QUIZ

   - Lecturette/Discussion on the Concepts and issues of the AADD

2. IDENTIFYING COMMON NEEDS

   - Solo/Dyad Exercise: What do all people need when they age?

   - Large Group: "The Seven Basic Needs."

3. "HEY, LOOK AT ME" - Videotape

4. DISCUSSION OF BASIC NEEDS

   - Small Group: Consider the needs of the three AADD persons in the videotape Henry, Robert, Arlene.

SESSION II

PURPOSES

1. Clarify the special characteristics and concerns of the AADD person
2. Emphasize the commonality of needs
3. Develop skills in individualizing basic needs.

PROCEDURES

1. TRUE-FALSE QUIZ

(45 minutes)

As participants arrive, distribute SP 10 and the True-False Quiz, SPP 11, 12. About 20 minutes should be allotted for completing the quiz. Latecomers will have less time to complete the exercise; however, those participants who are punctual are not penalized. As you correct the exercises, (MPP 23, 24), add relevant comments not covered in Session I, and distribute SPP 13, 14.

The answers to the True-False Quiz are presented here in greater detail:

1. True: A recent (1978) study by the Institute for the Study of Mental Retardation and Related Disabilities at the University of Michigan, pointed out that approximately 12.8% of the AADD individuals do receive service. This reinforces the "invisibility" of AADD persons, and contributes to their special plight.

2. False: Nursing homes are institutions. No matter how well a nursing home is run, it is not a home. Although good nursing homes do provide nutritious meals, adequate health care, and a secure home setting, the nursing home cannot replace the warmth of family and friends. The same is true for the AADD person. After having been moved from one institution to another, the nursing home can only provide yet another sterile environment. This is especially demoralizing if the AADD person is well and able to enjoy her world.

3. True: However, money cannot be the complete answer. One must also be clear as to what the AADD person's needs really are. Otherwise money is wasted and ineffective services are fostered.

4. True: Both the aged and retarded have historically been socially devalued. This is also true of prisoners, children, and the mentally ill. Since these groups are usually impoverished also, a case can be made for AADD people being in "triple jeopardy": aging, retarded, and poor.

5. False: Traditionally, adult education has been successful for the white, middle class. For example, adult education supporters tried to provide effective "Americanization" classes for new immigrants to this country in the early [illegible]; they often failed. The courses did not meet the needs and realities of these persons. Therefore, community adult education must first of all recognize the needs of providing service to the AADD that go beyond supplying "busy work" which is comparable to work assigned children in the early elementary grades. These individuals have their unique needs and concerns which go far beyond those of a seven-year-old child.

6. False: Although the field of aging in general has been a popular area of research interest for the 20 years, this has not been true of the AADD. Research, though increasing, is sparse.

7. False: Just the opposite is true. Needs of the AADD population are long-term, often life-long, and increase over the age span. Gordon's (1978) study points out that there are service gaps in virtually every category of service. Among the greatest areas of unfulfilled need are special medical services (such as physical therapy), transportation, special living arrangements, and vocational and training services. The obstacles to service provision appear to be transportation, a lack of facilities, existing community bias, and a little long-range planning.

8. False: the real needs of the AADD person are often ignored in institutional settings. Because this person might be known only as a number to receive certain services, this does not imply the system knows him. Although adequate survival needs are sometimes met - food, clothing, shelter - the person is often not treated as a unique individual with interests, problems, and needs that go beyond survival concerns.

9. False: This type of attitude leads people to believe that a developmentally disabled person of any age is really like a child. To deny age differences is to deny the personhood of the AADD individual. Her needs are just as diverse, complicated, and unique as those of any aging person in general.

10. False: As age increases, so does the likelihood of disability, sickness, and chronic disease. Dependency also increases. Needs can only become more complex.

11. False: Small memory losses in old age can often be compensated for. Forgetfulness may have been a problem during a person's entire lifetime, but is considered "serious" only when he gets older. Memory lapses can be compensated for by writing down upcoming events and keeping a daily "To Do" list. When forgetfulness is a sign of depression, it is helpful to maintain daily routines, social contacts and physical activities. (See Appendix MPP 190, 191.)

12. False: See Appendix MPP 190, 191.

13. True: Treating the physical disorders of the body often involves getting to the root of emotional problems. Stress which results from living in a highly technological age where aging persons are often considered "extra baggage", places additional responsibilities on all medical and social service providers.

14. True: With age comes a decrease in the body's ability to withstand stress. This would include accidents, disease, changes in lifestyle, etc.

15. True: Some people argue quite convincingly that aging actually begins at conception, and there is evidence for this. Aging is a lifetime process that involves different "ages" (biological, phychological, sociological) and all of us don't age similarly on all these. For example, a 65-year-old person could go to college and learn as well as an 18-year old (psychological age). He may have illegally been denied a job because of his age (sociological age). He would still go out three times a week jogging while his pure white hair blows in the wind (biological age).

16. True: For example, an older person can have a bad heart which affects his mobility, but still have very good eyesight and no need for glasses.

17. False: A "trick" question. Closer to 75% of all the mentally retarded could live on their own if adequate social supports were provided. Recently it has become known that about 75% of all older persons in nursing homes could also live in the community if these services were available.

18. False: There is very little research to bear this out. Questions have been raised whether DD people begin aging earlier than their non-disabled peers because of the early onset of physiological and neurological impairments. In the past DD people have lived shorter lives, but modern medicine has decreased their mortality rate. Pregoria is a premature aging syndrome associated with Down's Syndrome. Also, it is known that pre-senile dementia or Alzheimer's Disease is present in some middle-aged persons with Down's syndrome.

19. True: Although participation in organized religion might decrease due to limited mobility to get to church, or general disinterest in specific religion, a person's interest in being remembered, or wanting to contribute to a universal purpose or good, increases. Sometimes, reminiscence is used to help bring unified purpose and meaning to an individual's life. By remembering the past, we put ourselves in perspective to other people and activities that were/are meaningful. Often this does include a firm belief in a particular religion.

20. True: Those who have the money and social resources to move out of the inner city frequently do. Some feel they don't want to move because the area has always been their home. Minorities, such as the elderly who have fewer resources and options, remain. Therefore, the complexities of urban life become the problem of the individuals who are left behind.

21. False: The ability to engage in sexual activity remains fairly constant over the life span.

22. True: Approximately 90% of people over 65, and 75% of the people between 45-64 have one or more chronic conditions. Some of the more common chronic disease conditions among older people include diseases of the heart, cancer, stroke, arthritis, influenza, (See Appendix MPP 194, 195), pneumonia, diabetes, hypertension (high blood pressure), and mental and nervous conditions.

23. True: Among people over 65 years of age, about 17% have hearing impairments and 10% have some visual impairment.

24. False: See True-False question number 9.

25. True: The loss of teeth has been shown to be a common cause of malnutrition in older people. They tend to shy away from foods that require chewing. In so doing, they eliminate essential food elements, from their diets (See Appendix, MP 200, 201). Clinical research reveals that tooth loss past the age of forty is most commonly due to gum disease, called pyorrhea.

26. False: Most would not need support if proper services were provided. Preliminary research indicates that when DD people are placed in the community, their level of stability and community adjustment increases over time. This would indicate that self-supervision becomes the norm for these persons.

27. True: Society treats older people as non-productive. Therefore, they are no longer "useful" in a society that demands productivity.

28. False: Transportation is one of the main concerns of all the elderly. It supplies the lifeline for necessary services and interpersonal needs. But deficits in transportation systems are not the only problem. Declining health and foot problems, as well as decrements in vision and hearing, seriously restrict mobility. These physical impairments make it difficult for the elderly to use transportation systems (if they exist) or gain access to friends and necessary services on their own. Although many developmentally disabled people in the community are provided transportation, the priorities for using it often remain basically those of the administration. A good transportation system provided for all citizens is the best way to guarantee that everyone will be able to use the personal and service resources in a community.

2. IDENTIFYING COMMON NEEDS

(45 minutes)

Step 1 (10 minutes)

Solo Exercise: Distribute one sheet of paper to each class member. Ask each person to think of an older parent, relative or friend. Trainees should reflect on their concerns about this person and write them on the paper. Comments might include:

- "My mother lives in Detroit and wants to move out. There have been many break-ins around the area."
- "Aunt Edna says she doesn't have enough money to get fresh vegetables."
- "My older friend, Ralph, is walking so unsteadily, he fell on the bus the other day."
- "Dad just will not get dentures. He says they cost too much."
- "All Mom does is sit in her rocking chair all day and talk about what she could have done with her life."

Step 2 (15 minutes)

Dyad Exercise: Participants should take their written remarks and find a person they don't know well. They should share their concerns and compare them with each other. Through this exercise, participants will find out how similar their concerns are.

Step 3 (20 minutes)

As the large group re-forms, have blank newsprint sheets or a blackboard available for the share-out. Trainees should be given an opportunity to share any concerns they wish. Allow input from only a few persons so that a limited number of examples can be written on the blackboard/newsprint as they are mentioned. The trainer could choose to have one person from each dyad share the concerns that were generated. The second person could expand on these concerns. Discussion is generated as class members see their concerns falling under seven basic needs.

Emphasize that all concerns fall under one of the following Seven Basic Needs:

1. Income/Money
2. Home
3. Health/Safety
4. Vocational Educational
5. Recreational/Leisure-time/Religion
6. Interpersonal Relationships
7. Assistance with Crisis

Use this list to direct the discussion with participants as they group their concerns in these seven areas. The numbers placed after the possible concerns listed below, represent the seven basic needs listed above. Other answers are possible. Trainees should begin to identify through this discussion how their concerns cluster in these categories. On the blackboard/newsprint, the instructor should group the concerns and summarize under the seven clusters. It is natural that many concerns overlap the various categories.

A. Muggings (3)

B. Heart Problems (3)

C. A relative expressing self-defeated feelings (3,4,6)

"I missed something in my life"
"I cannot wait till I die"
"I have failed my children"
"I have not accomplished my goals"

D. Loss of relatives, friends, spouse (6)

E. Worrying all the time (1,3,4,6)

F. Relative doesn't drive, but needs groceries or a doctor, etc. (3,7)

G. Relative being far away (3,7)

H. Relative not able to stay in her own home and must move, possibly to a nursing home (2)

I. Problems with paying bills (1)

3. VIDEOTAPE

(15 minutes)

Show videotape, "Hey, Look At Me" (See Appendix MP 203 for this and other resources.) Distribute the discussion guide (SPP 15,16) for the video tape as a summary. If time permits it may be used for group sharing.

4. DISCUSSION OF BASIC NEEDS

(45 minutes)

Step 1

Each trainee shold be given SPP 17, 18, 19 stapled together. Invite the participants to form three groups made up of individuals who do not know each other well. Each group will be responsible for discussing the options for meeting the needs of one of the three AADD persons in the film, Henry, Robert, and Arlene. If there is time, a group can consider the needs of the other two clients they have not been assigned. Encourage the trainees to use the pages distributed to record their comments.

Step 2

Re-assemble the large group and ask for each of the smaller groups to respond in turn. For example, Group One could share the thoughts generated in their discussion regarding Henry, and how the seven basic needs are met in his life. Group Two will describe their thoughts regarding Robert and Group Three, Arlene. All participants should be encouraged to make comments during any group's presentation.

It is important to assure participants that all answers were not supplied by the videotape, but must be "guessed at". These comments are subjected to the criticism of the small and large group, but there is no reason to think one answer is necessarily more appropriate than another.

WHAT DO YOU KNOW ABOUT THE AGING/AGED DEVELOPMENTALLY DISABLED (AA/DD) POPULATION

1.	About 90% of the AADD population who could use community services don't receive these services.	(T)	F
2.	The AADD people in nursing homes usually have their needs met there.	T	(F)
3.	Many people believe that the greatest obstacle to service delivery for the AADD is lack of money.	(T)	F
4.	The AADD are in double jeopardy because they are old and disabled.	(T)	F
5.	Many adult education programs exist in the community for the AADD.	T	(F)
6.	A lot of literature has been written on the needs of the AADD person.	T	(F)
7.	Community services for the DD increase as they get older because their needs increase.	T	(F)
8.	Since most AADD people have been institutionalized, more is known about their needs than the needs of the normal aging persons.	T	(F)
9.	Because the AADD persons needs are very similar, it is easier to meet these needs.	T	(F)
10.	Older people have fewer needs than younger people.	T	(F)
11.	Memory loss is always a problem for older people.	T	(F)
12.	All people when they get old become senile to some extent.	T	(F)
13.	Older persons who are ill need more than medical attention from health practitioners.	(T)	F
14.	Older people are more vulnerable is diseases and accidents.	(T)	F
15.	The process of aging starts at birth.	(T)	F
16.	Different parts of the body age at different rates.	(T)	F
17.	At the most 50% of the mentally retarded can become independent socially and economically.	T	(F)
18.	It is a fact that developmentally disabled people die sooner than the normal population because they age faster.	T	(F)
19.	Most people develop a greater interest in spiritual concerns as they grow older.	(T)	F

20. Many elderly persons live in urban areas. (T) F

21. The majority of all the aged no longer have sexual activity or desires. T (F)

22. Eight out of ten older Americans have one or more chronic diseases. (T) F

23. Visual and hearing problems are common among the elderly. (T) F

24. Unlike the normal aging population, the AADD are very much alike. T (F)

25. Approximately half of all the elderly have lost all their teeth. (T) F

26. All mentally retarded always need some degree of supervision as long as they live. T (F)

27. Both AADD and normal aging people have low status in our society. (T) F

28. Transportation is more of a problem for the normal aging person than it is for the AADD. T (F)

SEVEN BASIC NEEDS

The following exercise will help you recognize how the basic needs of an individual must be addressed in a differential manner.

	HENRY
1. Income Options	1. *Government subsidy - SSI, Social Security* 2. *Possibly some public assistance* 3. *Maybe some family inheritance, but if so some other income options might be cancelled*
2. Home Options	1. *Institutions* 2. *If another residential alternative was required it would be against Henry's wishes*
3. Health Maintenance	1. *Staff dependent* 2. *Taken care of on the institution's grounds* 3. *Basic needs taken care of, but no choices; limited options about personal priorities* 4. *Traditionally institutions are more concerned with younger clients.*
4. Vocational/ Educational Opportunities	1. *It doesn't appear as though Henry is interested* 2. *Henry is probably not even asked to be included because of his age*
5. Recreation/Leisure Time/Religion	1. *Stimulation to get involved seems limited - probably no age appropriate activities* 2. *Day dreaming, friends* 3. *Church*
6. Interpersonal Relationships	1. *A small group of close friends* 2. *The question arises as to Henry's preparation for the loss of these few individuals* 3. *Because of a dependent lifestyle, Henry may not reach out for others*
7. Assistance with Crisis	1. *All emergencies would be handled within the institutional milieu* 2. *Procedures are usually more important than feelings. If Henry's friend died, the burial would be organized; but Henry's feelings about the event could be completely ignored*

Seven Basic Needs (continued)

	ROBERT
1. Income Options	1. *All options open to any person are open to Robert*
2. Home Options	1. *Although Robert may be limited in purchasing his own home because of finanical limitations, (like many of us) he can choose freely within the community*
3. Health Maintenance	1. *Insurance* 2. *Community doctors and dentists* 3. *Possibly friends who advise him on health concerns* 4. *Henry can chose to eat fast foods or drinks; it is his choice*
4. Vocational/ Educational Opportunities	1. *Community adult education courses* 2. *All the community resources could be used*
5. Recreation/Leisure Time/Religion	1. *His "social club" -where he can enjoy others in the community who gather for drinks* 2. *Fishing* 3. *Close friends* 4. *All churches, if he choses to go to them*
6. Interpersonal Relationships	1. *Robert can choose his friends from anyone in the community. He has the skills/opportunities to call on them at any time.*
7. Assistance with Crisis	1. *Robert must make personal decisions about what an emergency is or is not. He can call on his friends to advise and all health organizations which deal with crises are open to him*

	ARLENE
1. Income Options	1. *Sheltered workshop/regular employment* 2. *Government subsidy that covers survival needs: room, board, food* 3. *Needs taken care of well, but Arlene is limited in personal choices and options.*
2. Home Options	1. *Arlene is presently in a sheltered group home* 2. *Arlene could consider a more independent situation - a sheltered apartment, or living with a friend*
3. Health Maintenance	1. *All needs are taken care of within the group home, although Arlene probably has some control over her own medication needs.* 2. *Nutritional needs are taken care of also, but personal choice would be limited to what others consider as "good nutrition"*
4. Vocational/ Educational Opportunities	1. *Sheltered employment* 2. *Could take part in regular adult education classes* 3. *Could to to reading improvement classes and possibly get into high school completion work* 4. *She could be challenged further than just stuffing envelopes.*
5. Recreation/Leisure Time/Religion	1. *Planned, group home activities* 2. *Good church life- opportunity to choose* 3. *Must depend on group home or public transportation to get around since she is not too mobile.*
6. Interpersonal Relationships	1. *Has church friends, and possibly friends at workshop and group home* 2. *Male relationships seem to be limited partially because complete involvement in the community is restricted by lack of experience, fear, limited mobility, and lack of staff creativity. Furthermore, Arlene may not be interested*
7. Assistance with Crisis	1. *Church can provide comfort with emotional crises, as well as the more "homelike" atmosphere of the group home Regimented life style would tend to alienate and possibly box Arlene in* 2. *Emergencies taken care of.*

SESSION III

PROBLEMS AND POTENTIALITIES OF THE AADD

1. "BOARD AND CARE" - Videotape

2. FACTS ABOUT MENTAL RETARDATION

   - Lecturette/Discussion using worksheets

3. SITUATION MANAGEMENT

   - Small Group: Problem solving
   - Large Group: Share-out

SESSION III

PURPOSES

1. Help participants define their values concerning rights of developmentally disabled people versus those of normal people.
2. Introduce factual information about mental retardation.
3. Develop problem solving skills.

PROCEDURES

1. VIDEOTAPE

(60 minutes)

SP 20 can be distributed to orient trainees to this session.

Show the videotape/film, "Board and Care". (See Appendix MP 203 for this and other resources.)

A discussion should provide additional information for focusing on particular issues and for leading a group discussion. "Board and Care" describes two young adults who want a special relationship. Both are retarded. Neither has the freedom to enjoy a normal man-woman relationship. This poignant drama highlights everyone's need for closeness. These are no easy answers to the pangs of emotional growth or the issue of rights of the retarded. Consider the following questions:

1. What do you perceive as the individual educational experiences of Rick and Lila as depicted in the film?

(Rick is underprivileged because of his father, resulting in understimulation and a lack of education. Lila is restricted by the system. She is not permitted to grow because of pressures to conform to others' perception of her.)

2. What are the dependence/independence roles of Rick and Lila in various situations?

(Out of ignorance, Rick remains dependent. He has never learned any differently. Lila, however, is "tantalized" into assuming "parts" of adult roles. As she was using her perfume in the bedroom, or getting groceries at the store, she was "expected" to perform adult roles. As she shared her lunch with Rick, others were supportive. But intense social pressure prevented the relationship to go further. The community would never have approved.)

3. How does the behavior of the father affect Rick? How does the behavior of the professional staff affect Lila?

(Both persons were patronized and restricted in different ways. The results were the same, however, because all persons' expectations for Rick an Lila were limited.)

4. To what extent should DD persons be encouraged to celebrate their sexual selfhood? What are the barriers to such experiences?

(We often "cut and paste" the DD person togefher according to our expectations for her growth, development, and sexuality. It is important to rethink personal assumptions and expectations.)

2. FACTS ABOUT MENTAL RETARDATION

(1 hour and 15 minutes)

The instructor should use the lecture method for the presentation of the material on developmental disabilities. The specific pages students will be filling in are on SPP 21-25, and separate teacher's pages are provided MPP 34-38. It will be helpful to write specific material on the blackboard as the lecture progresses. This gives the student an opportunity to instantly "review" what you just said by copying it down.

Sheets with the correct answers could be prepared ahead of time and displayed sequentially to correspond with the topic under discussion. Avoid displaying all answers at one time, as participants tend to spend their time copying instead of attending to the lecture/discussion.

The following bibliographic information can be used to supplement your lecture. However, you, as an instructor, must generate your own lecture. The references found in the Appendix can also enhance this presentation.

I. Historical Perspectives

Crissey, M., August, 1975. "Mental Retardation: Past, Present, and Future." American Psychologist, Vol. 30, No. 8, pp. 800-808.

Dickerson, M.U., 1981. Social Work Practice for the Mentally Retarded. New York: The Free Press.

Hutt, L., and Gibby, R., 1976. The Mentally Retarded Child: Development, Education and Treatment. 3rd ed., Boston: Allyn & Bacon.

Kirman, B., and Bicknell, J., 1975. Mental Handicap. New York: Churchill Livingston.

Levinson, A., 1965. The Mentally Retarded Child. New York: John Day Co.

II. Increasing Awareness In 1980

Braddock, D., 1977. Opening Closed Doors: The Deinstitutionalization of Disabled Individuals. Reston, Virginia: The Council for Exceptional Children.

Chinn, P., Drew, C., and Logan, D., 1979. Mental Retardation: A Life Cycle Approach. St. Louis: The C.V. Mosby Company.

Hungerford, R., DeProspo, C.J., and Rosenzweig, L., 1952. "Education of the Mentally Handicapped Child in Childhood and Adolescence." American Journal of Mental Deficiency, Vol. 57, pp. 214-228.

Menolasino, F., 1977. Challenges in Mental Retardation: Progressive Ideology and Services. New York: Human Sciences.

Nirje, B., 1969. "The Normalization Principle and Its Human Management Implications." In R. Kuegel and W. Wolfensberger (eds.), Changing Patterns in Residential Services for the Mentally Retarded. Washington, D.C.: President's Committee on Mental Retardation.

Provencal, G., 1981. "Issues and Social Policy" In M. Dickerson, Social Work Practice with the Mentally Retarded. New York: The Free Press.

III. Definitions, Causes and Classification

Attwell, A., and Clabby, A., 1971. The Retarded Child: Answers to Questions Parents Ask. Los Angeles: Western Psychological Services.

Grossman, H., (ed.); 1977, revised. Manual on Terminology and Classification in Mental Retardation. Washington: American Association on Mental Deficiency.

Kauffman, J., and Payne, J.; (eds.), 1975. Mental Retardation: Introduction and Personal Perspectives. Columbus, OH: Charles E. Merrill Publishing Company.

Leland, H., and Smith, D., 1974. Mental Retardation: Present and Future Perspectives. Worthington, OH: Charles A. Jones Publishing Company.

Neisworth, J., and Smith, R., 1978. Retardation: Issues, Assessment, and Intervention. New York: McGraw Hill Book Company.

Tymchuk, A., 1973. The Mental Retardation Dic-tion-ar-y. Los Angeles: Western Psychological Services.

SPP 26,27 may be distributed to provide a summary for trainees.

3. SITUATION MANAGEMENT

(60 minutes)

Once again, divide the participants into small groups. Assign a problem to each group (SP 28). Participants should be reminded to briefly read the other problems on the page to be familiar with them also. About 25 minutes of small group discussion should be adequate.

Reassemble the large group and discuss the issues again. Members of each small group should present their findings and then invite reactions from the entire group. Please refer to MP 39 for specific information around each situation.

The problem solving sessions help participants develop skills in identifying values, setting priorities, and seeking solutions. Individuals begin to see that there are no right answers, but that a group can come to better solutions by sharing feelings, concerns and ideas. Each participant begins to realize that his ideas/solutions are not necessarily acceptable to the rest of the group. Thus each person is faced with an individual decision about changing his opinion concerning different issues, or defending his point of view. The group members should uphold the right of every member to express his own beliefs. It is not the purpose of the training session to change a person's opinions. Referring each individual to SP 3, which describes how to get the most out of group discussion, will be helpful here.

FACTS ABOUT MENTAL RETARDATION

I. Historical Perspective

"Down through the centuries, there have been members of every population who were unable to adapt fully to the demands of the large society because of limited intelligence. As the civilization became more highly industrial and complex, the individual with limited intelligence became more conspicuous because of his deficiencies, and the community in which he lived assumed greater responsibility for the care and maintenance of the person we now call mentally retarded."[1]

As early as the fourteenth century, some individuals began to recognize the difference between mental illness and mental retardation. This was reflected in an action taken by King Edward II of England, who provided a guide to protect the rights and properties of those individuals who were permanently handicapped. Thus the practice of protection and training for the mentally retarded individual was initiated, which is different from the practice of protection and treatment for the individual who is temporarily handicapped because of mental illness.

II. Increasing Awareness in 1980

"Educational philosophies regarding mentally retarded children have shifted throughout the twentieth century. In the early part of the century, the mentally retarded child was removed from the regular classroom to relieve the teacher and other students of the stress caused by his presence. Subsequently, educators adopted the notion that mentally retarded students would be safer and happier in a classroom that minimized competition. Attempts were frequently made to teach them a simplified version of traditional academic subjects. Today, these attempts have been replaced by the philosophy that encourages individual educational planning to help the person with mental retardation to achieve realistic goals."[2]

Mainstreaming, normalization, and deinstitutionalization became guides for the community as meaningful plans were designed and implemented with and on behalf of mentally retarded citizens.

Mainstreaming assumes that all children will be accepted into the school system because they are people.

Normalization assumes that each mentally retarded individual, regardless of age, will have access to a life style and pattern of living as close as possible to the life style other citizens enjoy in his community.

[1]Dickerson, Martha U., Social Work Practice for the Mentally Retarded. New York: The Free Press, 1981.

[2]Ibid.

Deinstitutionalization is a process that has served to return thousands of individuals to the community from the institutions to be rehabilitated, supported and maintained in more "normalized" situations.

III. Definition

Mental Retardation refers to sub-average intellectual functioning, which originated during the developmental period and is associated with impairment in adaptive behavior.

IV. Causes

In three out of four persons with retardation the causes are not clearly known. Retardation may be introduced during the pre-natal, peri-natal or post-natal stages.

A. Organic - Brain damage due to many causes, such as:

1. *Genetic disorders*
   a. *Down's Syndrome*
2. *Infectious childhood diseases*
   a. *encephalitis*
   b. *meningitis*
   c. *whooping cough*
   d. *measles*
3. *Metabolic disorders*
   a. *excessive phenylpyruvic acid in urine (PKU)*
   b. *insufficient secretion of thyroid hormone-hypothyroidism*
   c. *R.H. incompatibility- mother with R.H. negative blood factor carries R.H. positive fetus. The mother's body produces anti R.H. antibodies, causing destruction of red blood cells in baby.*
4. *Physical and traumatic damage*
   a. *unsuccessful attempt to abort fetus*
   b. *deprivation of oxygen*

c. *prolonged birth process*

d. *overuse of X-ray*

5. *Toxic agents affecting mother and child*

a. *alcohol*

b. *certain prescribed medications (thalidomide)*

6. *Infection of mother during pregnancy*

a. *syphilis*

b. *German measles*

B. Non-Organic - Social or psychological damage can be caused by social-cultural factors:

1. *Insecurity of family income*

a. *underemployment*

b. *unemployment*

2. *Minimal attention to health*

a. *nutrition*

b. *cleanliness*

c. *preventive care*

3. *Minimal education*

a. *poor communication patterns*

4. *Presence of dangerous influences*

a. *alcohol*

b. *drugs*

c. *prostitution*

5. *Inadequacy of parenting*

a. *absenteeism*

b. *rejection*

c. *neglect*

d. *abuse*

e. *inappropriate role and behavior modeling*

f. *low level of motivation*

6. *Negative perceptions*

a. *of ghetto resident/minority member by society as a whole*

NOTE: A negative relationship is evident in the high incidence of mental retardation in children born into racial/minority and/or low income groups.

V. Incidence and Prevalence

A. Mental retardation is the (most/least) widespread of childhood disorders.

B. It is estimated that *6 1/2 million* individuals in the United States have been diagnosed as mentally retarded and are part of our population today. They and their families present more than *20 million* persons.

C. A child with retardation is born every *5 minutes*.

D. The number of mentally retarded is (increasing/decreasing).

VI. Identification

A. The mentally retarded are identified by:

1. *medical diagnosis*

2. *school tests & underachievement*

3. *recognition of social inadequacy*

B. The person with mental retardation may have additional handicaps.

1. *physical deformities*

2. *impaired hearing*

3. *impaired vision*

4. *difficulty in comprehending*

5. *smaller body than average*

6. *poor muscular coordination*

VII. Classification

A. *Mild* (usually called *educable*)

1. *I.Q. 70-51*
2. *slow development*
3. *with training can lead independent lives*
4. *89% of retarded population*

B. *Moderate* (usually called *trainable*)

1. *I.Q. 50-36*
2. *backwards in development*
3. *will need to live and work in sheltered situation*
4. *6% of the retarded population*

C. *Severe*

1. *I.Q. 35-20*
2. *motor development, speech, language retarded*
3. *needs protected environment - probably could achieve minimal self care skills*
4. *3.5% of retarded population*

D. *Profound*

1. *I.Q. less than 20*
2. *gross impairment in coordination and sensory development*
3. *needs constant care for survival*
4. *1.5% of retarded population*

VIII. Implications

The trend in the twentieth century to sustain mentally retarded individuals in the community has implications for every social- educational-recreational service system. Even as the child who has mental retardation will participate in regular school programs, the young adult with retardation will become a contributor to the work force. It follows then, that the elderly person who has retardation will receive service along with his age peers from the many agencies designed to meet the needs of senior citizens.

SITUATION 1

The client should be able to accept or reject Joy. Just like anyone else, AADD people have personal preferences. Relationships don't ever occur spontaneously. They must be allowed to grow and develop. In time, possibly a relationship with Ruth will happen. Joy is feeling insecure about her own ability to relate to others. She must learn to accept herself too. Then she will be better able to accept rejection and be open to relationships. It is not important to be totally accepted, and it never occurs anyway. Joy was patronizing Ruth, because she assumed every one of the clients should like her. Relationships are earned, not acquired. If Joy feels uncomfortable with developmental disabilities, her body language might betray her true feelings of ambivalence toward the client. Ruth would be able to sense this. Is a relationship made or broken on a few interactions? People might have consistently entered and left Ruth's life. Maybe her defense is to avoid involvement. (Don't we do this in our own relationships?) Credit must be given to Joy, because she is taking the first step in seeing the client as capable of feelings. She also has let herself exhibit real feelings of acceptance and rejection. She has let herself be vulnerable to Ruth, and that is the first step to creating an authentic relationship. By allowing the client the "right" to reject we are also implying the right to choose - a very normal thing. This helps us accept AADD clients as more alike than different.

SITUATION 2

Laverne could be deeply troubled and this is her way of expressing it. Does she like her home situation? Are the other clients friendly toward her and is there a good relationship with them? Are the other clients younger, possibly producing a "generation gap" in terms of interest etc.? Maybe Laverne was just tired. Stopping for a coffee break could help. However, if this is the case, Laverne should be helped to express her needs more directly. Maybe Laverne is sick of going around in a group. She might possibly crave more individual trips into the community. Laverne might be trying to get attention, and use this as a way to manipulate situations. This is, in fact, what the client was doing. The caregiver, Brenda, told her to "go ahead and leave" and the others started to walk away. The client appeared surprised and quickly followed the group. She even offered to treat another client, Ada, to coffee if the group wished to stop. Laverne met her match and was challenged by it.

SITUATION 3

Because Louise could not walk away as Thomas could, decisions are made for her. Cindy had to have everything her way because it was her group. What about the clients' choice? Participants (clients) should determine the group's purpose. We must base the needs of individuals as primary to the formation of a group. Cindy appears to think she knows what is best for all the clients without regard to their choice of participation. Cindy's over-anxiousness is getting in the way of her sensitivity to individual needs. Is there a tendency to make decisions for AADD clients who cannot walk or talk?

SITUATION 4

Possibly Doris and Sara feel involved when they serve coffee. They know the process and this is enjoyable for them. Possibly they are special because they feel they might not be able to understand other activities. With some support of other senior center participants they might be encouraged to move on to other activities. The other seniors are placing their values on Sara and Doris by defining the activity and exploitation. As the saying goes "One Man's Ceiling is Another Man's Floor." Sara and Doris may feel they gain group acceptance by doing for the other seniors. Once again, they could be encouraged to seek other ways to participate in relationships. Is it wrong to have your needs met through serving coffee if it makes you feel good? (There is no right answer.) Maybe other seniors would enjoy serving coffee. Possibly, Doris and Sara have dropped "hints" to the other seniors that they would like to move on to other activities.

SESSION IV

CLASSIFICATION OF "DIFFERENCE"

1. "LABELS, LABELS, LABELS"

   - Discussion focused on feelings about labeled people

2. CLASSIFICATION - USE or ABUSE

   - Lecturette/Discussion on the Impact of Labeling and Classification

3. SITUATION MANAGEMENT

   - Small Group: Problem solving
   - Large Group: Share-out

SESSION IV

PURPOSES

1. Identify "labels" commonly used
2. Use classifications appropriately when working on behalf of a person
3. Recognize the negative effect of "labeling"

PROCEDURES

The different exercises in this session end with cartoons that speak to some of the issues, problems, and effects labeling has on daily behavior (SPP 31, 33, 38). These illustrations can be used to summarize the presented material, or to elicit further group discussion.

SP 29 may be distributed to orient trainees to this session.

1. "LABELS, LABELS, LABELS"

(45 minutes)

Step 1

In order to help the trainee recall descriptors often used, the following options may be followed:

A. Each trainee is provided a copy of "Labeling--Good or Bad?" (SP 30) and is asked to complete the page as a solo exercise, or

B. Large sheets of newsprint are displayed on the walls. One sheet is devoted to "Labeling--Good or Bad?" (positive or negative terms) as applied to old people. The second sheet is focused upon "Labeling--Good or Bad?" (positive or negative terms) as applied to developmentally disabled people. SP 30 may be used for trainee notetaking.

Whichever option is used, the participants are asked to add their ideas to the lists. Remind them not to restate a label that already appears. Challenge them to compile a comprehensive list.

Step 2

The trainee summarizes the lists. The following observations may prove useful for engaging participants in a short discussion:

1. "Somehow the individuals (aged and/or developmentally disabled) appear to be discounted."
2. "Which one of the descriptors would you like to have used to describe yourself?"
3. "They seem to be segregated"
4. "There seem to be more positive labels when we describe old people. Could that be because we know that we shall be old too, some day?"

A previously compiled list may be useful to the trainer. It is found on MP 47.

Step 3

Distribute the page "Feelings, Perceptions and Reactions." (SP 32) Ask the participant to complete this exercise either alone, or as a member of a small group.

Assemble participants in a large group for share-out of information under A, B, and C in turn. Provide support to participants to share out the range of feelings, perceptions and responses. A list of usual responses is available on MP 48 for the trainer's use.

2. "CLASSIFICATION - USE AND ABUSE"

(60 minutes)

The instructor's personal background for this session may be enhanced by consulting the following references:

Goffman, E., 1963. Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs, NJ: Spectrum Books.

Wolfensberger, W., 1972. The Principle of Normalization in the Human Services. Toronto: National Institute on Mental Retardation. (See chapter 2, "The Concept of Deviances in Human Management", 13-25).

The trainer presents a lecturette/discussion covering the points made on MPP 49-52. The trainees have been provided their own note pages to fill in (SPP 34-37). Following is the rationale for including the sub-sections of the session, as well as the methodology, of the lecturette/discussion.

I. Definitions

This is included to help the trainees recognize how casual, careless use of language may reflect the attitudes entertained by themselves and others.

II. Classification

This part of the session is designed to encourage recognition of the correct use of classification. Four examples are presented for the instructor's use. The trainees should be encouraged to use the "Range of Purpose" chart (MP 50) as they consider conditions, syndromes or deviances with which they are familiar. This process will help the learner recognize that certain classifications are time-limited, or service-need-specific, i.e. learning disability is a relevant classification only during the period of time the individual needs service from the educational system.

Once the trainees are familiar with the range of purpose of classifications, it is time to consider the several factors affecting duration of need for classification in Section II D, (MP 50).

Using the conditions, syndromes or deviancies suggested in the manual or from the trainees contributions, they should check for the following factors. As a way of further clarification, the answers are completed using the examples provided from the Range of Purpose Chart (MP 50). The numerals represent the following: Mental Illness = 1; Down's Syndrome = 2; Senility = 3; Learning Disability = 4.

1.	Temporary 1	/	Permanent 2, 3, 4
2.	Curable 1	/	Incurable 2, 3, 4
3.	Adventitious 2, 4	/	Acquired 1, 3
4.	Obvious 2	/	Concealed 1, 3, 4
5.	Responsible for Condition 1	/	Not Responsible for Condition 2, 3, 4

This part of the session will help the trainees deal with some of the myths commonly entertained about certain classifications, i.e. "mental illness is always apparent because of bizarre behavior." In another example, trainees may appropriately challenge the assumption that senility is always incurable. The trainee should come to understand the need for differential attention to each individual when considering the factors of the classification used to describe the individual's syndrome, condition or deviancy.

The trainees are now ready to move on to Section II E (MP 50), to consider the goals for service. Once again, the instructor is prepared to discuss this section in terms of the examples provided. As in Section II D, the student should consider this section in terms of their own examples.

Completion of Section II E will prepare the students to discuss some of

the social and ethical issues that affect goal determination as found in Section II F (MP 51).

III. Misuse of Classifications (Labeling)

This section is included to help the trainee recognize the causes and effects of labeling, as well as the behaviors that co-exist with verbal labeling. Under Section III A (MP 51), the instructor presents three causes for labeling and invites the trainees to identify any other causes.

Section III B (MP 51) can be presented as a mini-lecture by the instructor, and thus remove the threat of confrontation of the trainees about negative labeling behaviors in their experience. However, the instructor should consider acknowledging her personal negative experiences regarding labeling as a way of giving encouragement to the trainees to address their own practice as well as the practice of their colleagues.

IV. Implications for Practice

The instructor should lead a discussion on this issue. The following points should be covered:

1. Every individual should monitor his/her use of classifications.
2. Every individual should extinguish the use of labels and epithets from his own or other's practice.

3. SITUATION MANAGEMENT

(45 minutes)

Once again divide the participants into small groups. Assign a problem to each group (SP 39). Participants should be reminded to read the other problems on the page to be familiar with them. About 25 minutes of small group discussion should be adequate.

Reassemble the large group and discuss the issues again. Members of each small group should present their findings and then invite reactions from the entire group. Please refer to MP-53 for additional ideas around each situation.

"LABELING - GOOD or BAD?"

List Positive and Negative Terms
used to describe the following groups

OLD PEOPLE	
ancient	hypochondriac
biddy	experienced
feeble	old lady
rusty	spinster
pops	old boy
elderly	old maid
gray	knowledge
senile	grampa
cranky	gramma
sickly	susceptible
wise	forgetful
wrinkled	crabby
mature	lovable
rigid	good listener
frail	baby sitter
wise	old geezer
hostile	ego builder
bitter	charming
spinster	dependent
cautious	good talker
slow	unappreciated
nasty	self-centered
fussy	hard of hearing
confused	old fogies
gentle	feeble minded
concerned	old fashioned
fussy	cantankerous
retirees	on the go
limited	with-it
crabs	old hag
cronies	mixed up
crocks	old fart
"sexy senior citizen"	
antique	fossil face
second childhood	
living in the past	
mean and nasty	

DEVELOPMENTALLY DISABLED PEOPLE	
dummy	handicapped
vegie	dumbell
strange	slow learner
kids	dependent
lovable	retarded
forgetful	uninhibited
shy	withdrawn
weird	ugly
stupid	lunatic
imbecile	client
patient	residents
"folks"	women
"different"	children
backward	'tards
D.D.'s	M.R.'s
ladies	mental retard
backwards	those people
girls	disorganized
boys	"attached"
confused	loving
mongoloid	basket cases
vulnerable	impressionable
smelly	unattractive
messy	crazy
low grade	incompetent
isolated	separated
moron	basket weavers
dumb	adult male
special	appreciative
exceptional	limited
men	people
feeble minded	
not playing with a full deck	
buck-fifty short	
developmentally delayed	
"those kinds of people"	
bats in the belfry	
mentally impaired	

FEELINGS, PERCEPTIONS AND REACTIONS

List some of the feelings commonly triggered by the presence of an aging/aged developmentally disabled person.

rejection	*embarrassment*	*over-protectiveness*
guilt	*consideration*	*nervousness*
compassion	*sympathy*	*curiosity*
anger	*shock*	*patronization*
sadness	*astonishment*	*impatience*
fear	*amazement*	*pity*
concern	*agitation*	*empathy*
disgust	*apathy*	*hopelessness*

List the typical perceptions and reactions of other people when they learn that you work with aging/aged developmentally disabled people.

"What made you start...?"
"That's nice..."
"Stars in your crown."
"I couldn't do that."
"Are they dangerous?"
"You must be nuts."
"Patience of a saint."
"Is there a retard in your family?"
"Ain't it depressing."
"Keep up the good work!"
"It must be rewarding..."
"I don't want to offend you, but..."

Sometimes there is a long pause--- a person just does not know what to say.

List typical responses that you may make to the individuals who make comments about your work and your clients.

Arguing and getting defensive are common, but there are responses that are constructive. Here are some statements that are honest and educative at the same time.

"No, I'm not special. I need a paycheck just like you."
"Do you enjoy your work? Well, I enjoy mine."
"They are not special, so why am I?"
"I enjoy being needed."
"Why don't you come and visit?"
"I'm not special, just concerned."
"I enjoy what I do."
"I don't take care of them. I indicate some directions and supply possible options."
"I am proud of my work and enjoy it. Don't you enjoy your work?"
"They have the same rights, needs and feelings as we do."
"Mentally retarded people are less dangerous than the rest of society."
"Once I got involved and saw them as persons, they became beautiful just like all of us."

Classification - Use and Abuse

"I have become a stranger to my brethen
An alien to my mother's son"

Psalms 69:8

I. Definitions*

A. Classification. — Systematic arrangement in groups or categories according to established criteria.

B. Label — Anything functioning as a means of identification of a descriptive term, an epithet.

C. Epithet — A term used to characterize the nature of a person or thing. An adjective or descriptive for a person's name or title. An abusive or contemptuous word or phrase used to describe a person.

II. Classification

A. Purpose — *The classification of a condition, syndrome, deviancy, as the initial step toward providing differential service to an individual based upon need.*

B. Examples

1. *Mental Illness*
2. *Down's Syndrome*
3. *Senility*
4. *Learning Disability*

C. Range of Purpose

1) Education — *Classification is based upon assessing the individual's ability to experience educational opportunities that will lead to personal/social independence.*

2) Social Security — *Classification has to do with the individual's capacity to earn a living.*

3) Health Agencies — *Classification is based upon whether the individual is able to function in his normal environment.*

* Definitions from The American Heritage Dictionary of the English Language. New York: American Heritage Publishing Company, 1969.

RANGE OF PURPOSE CHART

CLASSIFICATION	Education	Social Security	Health Agency
Mental Illness			X
Down's Syndrome	X	X	X
Senility			X
Learning Disability	X		

D. Factors Affecting Duration of Need for "Classification"

1. *temporary/permanent*
2. *curable/incurable*
3. *adventitious/acquired*
4. *obvious/concealed*
5. *responsible/not responsible*

E. Goals for Service

1. *treatment/maintenance*
2. *education/habilitation/rehabilitation/correction*
3. *segregation/integration*
4. *employment/subsidization*
5. *dependency/independency*

F. Social/Ethical Issues Affecting Goals Determination

1. *prevention/treatment*

2. *research/service*

3. *comprehensive service/specialized service*

4. *medical-biological concerns/educational-rehabilitative concerns*

5. *segregation/integration*

6. *work/non-work*

III. Misuse of Classification (Labeling)

A. Causes

1. *lack of knowledge of unique differences between deviancies or labels; i.e. learning disabled, mentally retarded, developmentally disabled*

2. *lack of awareness that a specific behavior, attribute or characteristic does not in and of itself legitimate classification or labeling*

3. *lack of understanding of purpose of classification and by whom classification should be administered.*

B. Results of Labeling (Epithets)

1. *tendency to define individual in terms of handicap; i.e., "the retarded woman."*

2. *perception of an individual as tainted, or unacceptable person*

3. *tendency to consider all negative behaviors exhibited by an individual who has been labeled, as a result of the condition; i.e., irresponsible toileting or self-care because "he's retarded."*

4. *tendency to consider positive behaviors of the "labeled" person as unusual, noteworthy, etc.*

5. *tendency to infantilize the labeled person; i.e., provide service not needed, deny the right to risk, negate the right to be accountable, use first names or nick-names*

6. *tendency to patronize the labeled person; i.e., overly considerate, talk down to, "there but for the grace of God, go I" attitude*

7. *tendency to have minimal expectations of an individual's potential to achieve, thus depriving them of opportunities*

8. *tendency to perceive the "labeled" person as a-sexual*

9. *tendency to reinforce the "labeled" person's perception of himself as alien from his community*

10. *tendency to segregate the individual -- the more extreme the stigma, the more extreme the segregation*

11. *tendency to perceive individual as an object of pity, ridicule, dread, or menace*

12. *tendency to perceive individual as the eternal innocent*

IV. Implications for Practice

It is important for every individual to carefully consider and monitor his/her use of "labels". It is important to use a classification, or a label, in a clinical discussion that has as its purpose the determination of goals, with and on behalf of the individual. It is difficult to identify any other time when such a term is appropriately used. Derogatory descriptors are inappropriate and alienating in all circumstances.

SITUATION 1

The administration is generalizing about what "all" older people like or "should" like. By assuming everyone likes music the manager expresses her opinion as fact. She has acquired some knowledge about older people. It is true that many older people do like music. Clients should be given a decision about listening to music. Often different personal moods put all of us in need of silence or to want to listen to various types of music. We don't have to listen to music all day, nor would we necessarily care to. Have you ever been switched on hold while using the phone and been forced to listen to music while you waited? We could have been insulted. But why don't clients have the same rights? Have you ever worked in a group home and found that the TV station that is on, just "happens" to be the one the staff prefers? That's the same pressure. We must learn to respond to individual needs of the clients.

SITUATION 2

We have the choice of making friends, and there is always the chance they will leave us through death, moving, or because they have made other friends who are more important to them. But it appears as though the staff might be trying to protect the client from the inevitable. Any relationship is a risky proposition. Aren't we infantilizing the client when we choose not to allow him/her to risk? This over concern can increase the client's dependence. Loss is all around us. To get "tough" we must increase relationships not decrease them! The client is the best person to decide if s/he wants to risk in any relationship.

SITUATION 3

Obviously, credit should be given to both client and caregiver to care enough to want to share with each other in more intimate, individual ways. However, it is clear that the caregiver saw the disability (label) first, and the person second. If we define in relation to a person's disability we don't let an authentic relationship arise between us. It is natural, however, to be curious about a particular disability. Caregivers should be supplied with as much detailed information on developmental disabilities and/or aging as they wish. It is better, however, to discover the person first, than to read the files of the client and begin to understand his/her disability. Knowing "too much" can sometimes get in the way of our relating to the AADD as a person.

SITUATION 4

What are the implications if staff persons talk about a client in his presence? The indications are that the AADD person is really insignificant and powerless. Often a staff person speaks for a client, even while he is listening. Of course, there are many different aspects of this problem. First of all, what is the real complaint? Could Jack be a person who others tend to ignore and he then must search for attention? Is Jack's remark accurate? Maybe he should be included in helping prepare and serve food. If the doctor has ordered certain foods or diets because of medical problems as obesity, a dilemma could result. How do you do what the doctors order and then support the client's "rights" also? The caregiver is responsible for explaining to the AADD person his/her rights and the legal repercussions for ignoring them. The staff person must then document the result. It is not the staff person's responsibility or right to force the compliance of the person. It is ultimately the client's choice and that decision must be honored. But documenting the decision is important to ensure caregivers' minimal liability.

SESSION V

SUPPORT SYSTEMS ARE AGELESS

1. BROKEN SQUARES EXERCISE
   - Small Group: Problem solving and discussion

2. MY SYSTEM OF SUPPORT
   - Large Group: How do you use your relationship to meet your support needs?
   - Solo: What are your personal support system relationships?

3. MY CLIENT'S SUPPORT SYSTEM
   - Small Group: Problem solving around individual support systems
   - Large Group: Share-out

4. IMPLICATIONS FOR INDIVIDUAL PRACTITIONERS

SESSION V

PURPOSES

1. Develop and discuss the central role of problem solving
2. Identify systems of support and the roles/relationships within them.
3. Recognize the implications such systems/supports have for individual practitioners.

PROCEDURES

1. BROKEN SQUARES EXERCISE

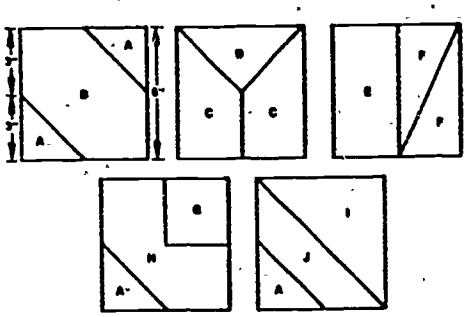
(45 minutes)

Game Preparation

As participants arrive they should be seated around tables in groups of six. Tables should be spaced far enough apart so that no one can see the progress other tables may make. Five of the six persons at each table will actively take part in the "Broken Squares" exercise. The other individual will be an observer/judge for his table group. If there are too few participants to form a complete group, they should observe the action between the tables and be ready to share their observations/insights after the exercise. If any participants has done this exercise before, they should definitely be observer/judges. These non-players may be the latecomers to this training session. Once again, this procedure does not penalize those who arrive promptly.

The six participants at each table (five players plus one observer/judge) will need a set of broken squares. For 24 participants you will need to make four sets of broken squares. What follows are directions to make one of these sets.

From poster board cut out five cardboard squares that are 6" x 6". Mark each square as directed below, lightly penciling in the letters. The squares will be more accurate if cut out with a razor and straight edge. Make sure all pieces of the same name can be interchanged among all squares. Sometimes pieces will fit one square and not another. It is important that pieces fit no matter which square they might become a part of. Therefore, the lines should be drawn and pieces cut out, so that all pieces marked A are exactly the same size, all pieces marked B the same size, etc. Several combinations are possible that will form one or two squares, but only one combination will form all five squares, each 6" x 6".



Number five envelopes 1, 2, 3, 4, 5. Distribute the cardboard pieces into the five envelopes as follows: envelope 1 has pieces I, H, E; envelope 2 has A, A, A, C; envelope 3 has A, J; envelope 4 has D, F; and envelope 5 has G, B, F, C. Erase the penciled letter from each piece and write instead, the number of the envelope it is in. Then participants can easily return the correct pieces to the appropriate envelopes when the game is over. If multiple sets of broken squares are used, make each set a different color, so it is easier to prepare the game for the next group of trainees.

The following information should be typed on each envelope:

INSTRUCTIONS: Each of you has an envelope containing pieces that will form squares. When you are told to begin, your group is to form five squares of equal size. The task will not be completed until each person has a completed square before him.

RULES:

1. nobody can talk
2. nobody can ask anyone else for a piece, but others may give you pieces.

1 The basic idea for this exercise was taken from J. William Pfeiffer and John E. Jones, A Handbook of Structured Experiences for Human Relations Training, Vol. I, La Jolla, CA; University Associates, 1974.

Before the game starts, the trainer should elicit from the group the necessary elements of succeessful group cooperation in problem solving.

These suggestions can be listed on a chalkboard or on newsprint. Some suggestions might include the following:

1. Each individual should understand the total problem.
2. Each individual should understand how he can contribute to solving the problem.
3. Each individual should be aware of the potential contributions of other individuals.
4. There is a need to recognize the problems of other individuals in order to aid them in making their maximum contribution.
5. Groups that pay attention to their own problem solving processes are likely to be more effective than groups that do not.

Game Plan:

Five of the members of each table group are given unopened envelopes which contain puzzle pieces. In the front of the envelopes are typed the group instructions. The observer/judge at all the tables is given further directions (MP 66) that have been duplicated so that they can be referred to. Any non-player should receive these directions too. The trainer asks participants to look at the group instructions on the front of the envelopes as he reads these directions out loud. Individuals should be allowed time to raise questions before the exercise begins.

The trainer then asks the participants to take the puzzle pieces out of the envelopes and begin to form the required squares by following all rules. The trainer should help monitor the tables, and encourage the observer/judge to stop all types of "cheating", and to re-explain rules if/when necessary. The observer/judge should be analyzing and looking for the behavior listed on the bottom of her directions page (MP 66).

It could take groups up to 20 minutes to get their puzzle pieces together. Participants may appear not to be doing anything for quite a while. But the trainer should not jump in to "help" unless the situation looks really hopeless. If it appears that some assistance will be needed to help a group accomplish its goal, limited advice could be given by the observer/judge, the trainer, or other participants who have just completed the exercise at the other tables. Members might also be given permission to talk or write messages to each other to facilitate the process.

Game Discussion:

After all groups have accomplished the goal of forming squares, the observer/judge at each table should discuss his perceptions of the group's problem solving tactics within this experience. SP 41 should be distributed so that participants can take notes during the discussion if they choose to. Individuals in

each group should be given a chance to respond to the observer/judge's perceptions and comments. The non-players who become "roving" observer/judges should then be called on to make comments on similarities and differences they noticed in the different groups' problem solving methods.

Questions from the observer/judge instruction sheet (MP 66) could be used by the trainer to elicit group comments. Also, the list of group problem solving skills developed earlier could be introduced to discuss the various groups' skills in the group problem solving areas that had been identified as crucial (See MP 56). Additionally, group members should be encouraged to relate their experiences to "back home" situations where inadequate communication might hinder problem solving.

2. MY SYSTEM OF SUPPORT

(45 minutes)

SP 40 may be distributed to orient trainees to the session.

Step 1

Participants should be seated in a large group, and a blackboard or newsprint should be placed so it is visible to all participants. The trainer should introduce the concept of support systems by asking the question: How do you use your relationships to meet your basic needs? This discussion is undertaken to get participants to understand the processes identified in personal support systems.

On the blackboard/newsprint, place the figures as found on MP 67. These figures could have been drawn before the session to facilitate the presentation. The following discussion will be developed by referring to this figure "chart". Review support system components that the figures represent (MP 67).

Whenever basic needs are considered within your support system, there are always persons (or a person) to whom you must relate. In each area trainees should think about key people who are involved with them in meeting needs in the different support areas.

After examples of important support individuals have been identified, trainers and participants should consider how they behave in their interactions with these people. For example, consider the individuals who help maintain health. Doctors may be domineering and dictatorial, and you may view them as authoritarian. Or you may be friends with your doctor and see him frequently at social gatherings. If this is the case, how you perceive your relationship with him may be different.

An easy method can be introduced to note the different ways relationships with different individuals may make us feel:

\+ if you feel in a "one-up" position with the other person.

\- If you feel in a "down" position with the other person. In other words, they are "holding the cards."

= If you feel your relationship with the other person is equal.

The symbols can be placed next to the key individuals, on the support system chart.

A role is either assigned, assumed or negotiated. If you are in school, your assigned role is that of a student. If you go to a doctor your assumed role is one of patient. Friendships are negotiated relationships. Roles can overlap too. We must make these roles "work" for us if we are to make our support system work, or to survive in our support system. All of these roles contain privileges and responsibilities, and our behavior and reactions are functionally different in the varying relationships/roles.

If you are in a + role, your language is more frequently verbal less threatened, and freer. Also there might be communication "short cuts", such as little gestures and "in jokes" that exist between you and the other person. An = role causes one to think about what one says, but not out of fear. A - role usually results in persons choosing words carefully and being dependent on the other person to see where the conversation "goes". These roles are not in and of themselves bad or good. They are just the components of a common base of communication.

As we get older, = roles often become - roles, especially when health concerns are dealt with. Equal communication is often greatly hindered if we need something. Needing something often puts us into a subservient and compliant role. This is not always the case though. In a crisis situation, when it really hurts physically or emotionally, we are almost always more ready to develop an = relationship. Often when the hurt comes from way inside, we feel close to others around us.

The symbols +, -, = represent varied roles with individuals. The roles could include:

sanctioning	demanding	helping
controlling	criticizing	loving
withdrawing	supporting	hating
shaping	advising	respecting
denying	listening	collaborating
eliciting	dictating	approving
refusing	supplementing	cooperating
rejecting		

Different roles you could find yourself in are:

decision-maker	spouse	student
colleague	lover	employee
doorman	friend	trainer
doormat	worker	employer
partner	consumer	supervisor
child	helper	trainee
parent	teacher	

Your reactions to these roles give you different feelings, and affect the atmosphere of the relationship. For example:

crapped on	put down
honest	dumped on
protective	guarded

People can hurt your feelings, love you, hate you, affect you on a "gut" level.

(The above terms may be placed on the blackboard or newsprint for easy reference).

Individuals in different categories could overlap because of their different roles within the social system. The same names start appearing in different categories, and trainers should be made aware of this.

We depend on different people for different things. If religion is a important aspect of the recreation/leisure time * support system, then the minister, father, or rabbi could be important in moments of crisis also.

Often there are only one or two vital people all over the support system. Their relationship in each role may vary. For example, in some involved relationships (husband and wife) there's an ebb and flow, but often the relationship with a dentist is a static one.

* Religion is placed under the correct system. The original meaning is re-creation, a most appropriate term for our religious pursuits.

Through the examples the instructor provides, participants should begin to think of individuals within their own unique support systems. The instructor should spend time discussing individuals who impact on all the support systems (symbols) as placed on the newsprint/blackboard. By illuminating this heavily with personal experience, the participants will begin to feel involved in the process.

Step 2

Individuals should now understand the different role components of a support system and the different relationships (+, -, =) that result. Distribute

a blank sheet of paper and ask participants to put support persons and relationship symbols for their support system on this sheet, just as you, the trainer, illustrated for them on the newsprint/blackboard. Re-emphasize that our roles affect our communication style. Participants should be encouraged to think about a relationship of theirs and begin to get in touch with its +, -, or = aspects. They should be able to identify how they behave differently with different people. (The word list, previously described, should help here.) Participants should be given about 10 minutes to reflect on their support systems. A few trainees might choose to share their personal support system/relationships with the rest of the group. These reactions can be used to review and summarize the points made in Step 1, the initial support system discussion. Also, ask if participants are happy with the balances of =, -, = in their lives. Do they feel they are letting others control them, or are they happy with the "ratio"?

3. MY CLIENT'S SUPPORT SYSTEM

(45 minutes)

Step 1

After this personal glimpse into our own support systems, the trainees are now able to consider the client's support system. Make the statement that AADD clients are more apt to be in - positions than + ones. Let participants share their reactions toward this statement. Is it true in their personal experiences?

Distribute SP 42. Participants should, once again, break into four groups. Each group is assigned one of the case studies to consider.

A support system analysis is the focus of each group's discussion. Considering the instructor's initial discussion and illustration, and the trainees' own support systems as examples, each group is to analyze the AADD client's own support system as illustrated by each case study.

A complete "history" of the client is not included in the case study; there is not a lot of data available on each client. Participants are invited to supply information themselves when it is appropriate. During the large group discussion they can support their decisions, based on past experience, "common sense", applicable legislation or research that would affect decisions etc. Note: Trainees have often complained that enough information is not supplied in the case study. Assure them that there are no right or wrong answers, only good or poor explanations for choices. Each small group's creative efforts must be harnessed to adequately consider the clients' support systems.

The back of SP 42 is to be used as the worksheet to develop the support system. Use the support system symbols and add the key individuals and the types of relationships (+, -, =) on this worksheet. The small groups should discuss their rationale for the evolving support system with their group members. A group concensus must be reached before individuals can add to the client's support system. During the last five minutes, all group members should stop to read the other case studies before the large group assembles, so everyone is familiar with all clients and their support contexts. The small group discussion will take from 20 to 30 minutes.

Step 2

The large group should assemble and discuss each client's support system as illustrated in the four case studies. Discussion should center around the rationale for group members' decisions on choosing key individuals and identifying their roles. Finally, questions should focus on the positive and negative aspects of the client support system and a discussion about the similarities and differences between the clients' and their own support systems.

As we just came to realize, we have many roles which make us interdependent on others. We assume our friends and relatives have this same support system framework. But there is still a tendency to deny our clients

access to all the varied roles. This happens partly because of the "labeled" status of the AADD individual. His life is often limited to a few people (often caregivers) who supply all his needs. More often, persons are in "one down" (-) rather than "equal" (=) relationships. Because of this, it is not just their disabilities which handicap them, but the roles we perceive them to be in. Behavior, then, is dependent not just on one's capacity, but on the critical interactions within our relationships.

An "unequal" (-) relationship is often one filled with anxiety, stress, loss of control and a nagging resentment that one is in a dependent position. The dependent person becomes, by definition, one who is passive; he must wait for others "criticisms." It is important in both personal and professional relationships to work for = relationships as much as possible. If you are an adult you want to be a partner, or helping person; not a doormat, child, or little girl. You don't want to be patronized. It is time to face the fact that an AADD person does not either. His dignity must always be upheld. We must release control to the client, and work to be equals (=) in our relationships with AADD persons.

4. IMPLICATIONS FOR INDIVIDUAL PRACTITIONERS

(15 minutes)

The final few minutes should be a summary about what was learned in the last couple of hours concerning support systems and their positive and negative aspects. Although this summation focuses on the AADD client, the rationale for the statements comes from our own personal experiences and philosophies, which have developed from our previous considerations of personal support systems.

The AADD individual has lifelong needs to be met, with as much control and decision making as possible resting in this person himself. When working with the AADD person, a new role must emerge with AADD persons as peers.

Too often we want people to have behavior which is socially acceptable to us, not to themselves. Often this results in a client who attempts to gain power through manipulation. But this client's manipulation is a sign of the person seeking more ownership of herself. It is a positive step.

It is important to consider this point: How much do I need to be in control because it makes me uncomfortable not to be? AADD clients do not have to be completely competent intellectually to know what is best for themselves in many situations. It is time to put as much attention on developing positive interdependent relationships as we do on activities of daily living. For example, if programming is developed around toothbrushing, as much consideration must be given to reasons why the AADD client chooses not to brush, if she has made the choice.

There are two critical points to consider.

1. It is important to always work to help AADD individuals move off of dependency to interdependency in all life situations. This means the client should be able to make decisions on her own and choose when to rely on others' opinions. To do that, the caregiver must risk and let the client go. It is not the caregiver's responsibility to always be protective. It is OK for the client to experience failure and get a "cold mackerel" in the face once in a while. The caregiver needs to be honest, and the client needs to see this modeled for her.
2. The caregiver cannot assume all responsibility because the client has developmental disabilities. It is not the caregiver's fault! The caregiver does not have to work from guilt. If she does, what the caregiver is really saying is "I'm happy I don't have developmental disabilities." We must move from sympathy to empathy. We can accept the fact of limited abilities but appreciate the lifelong capacity for growth and development for ourselves and our aging and aged developmentally disabled peers.

It is important for trainers to use "I" statements as much as possible. Care must be taken to say, "This is how I feel." It is important for ourselves and our AADD clients to be responsible for our own feelings and not to intellectualize about what ought to be. Each of us should own up to what is/isn't being done, and how each of us has responsibility for our own actions.

BROKEN SQUARES EXERCISE: Observer/Judge Instructions

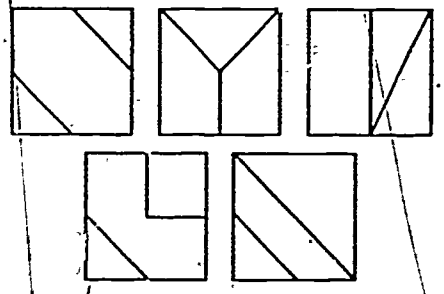
As a judge make sure:

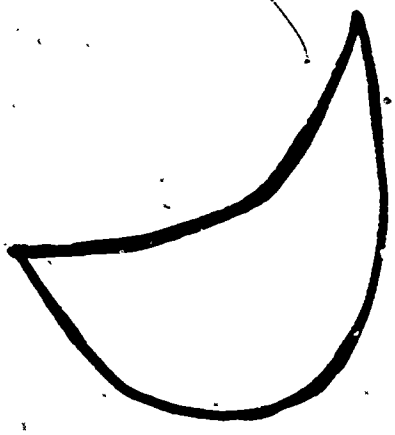
1. There is no talking, pointing, or gesturing in any way.
2. Participants can give pieces to others, but cannot take pieces from others.
3. Participants cannot place pieces in the center for others to take.
4. A participant can give away all pieces even if he has formed a square.

As an observer looks for:

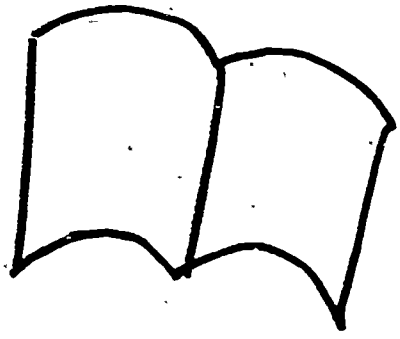
1. Who is willing to give away puzzle pieces?
2. Does anyone finish "his" puzzle and then let others take over?
3. Is there anyone who continually struggles with his pieces, yet is unwilling to give any or all of them away?
4. How many people are actively engaged in putting the pieces together?
5. Which persons appear to be leaders/followers?
6. What appears to produce differences of participation levels among players?
7. What behaviors block/facilitate getting the correct squares together?
8. What are the non-verbal reactions of players as they see their plans carried through or distorted?
9. What is the level of frustration or anxiety?
10. Is there a turning point where the group begins to cooperate?
11. Do individuals break the rules in order to help others get their square together? How?

Here is the solution to forming the five squares.

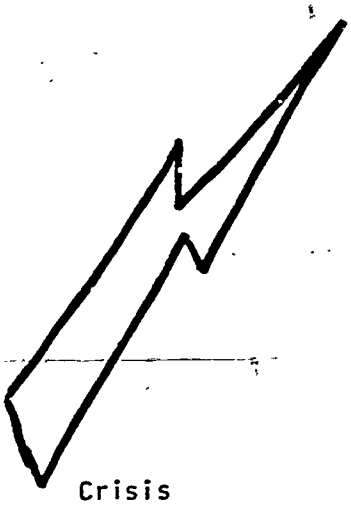




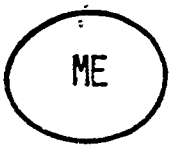
Recreation/Leisure

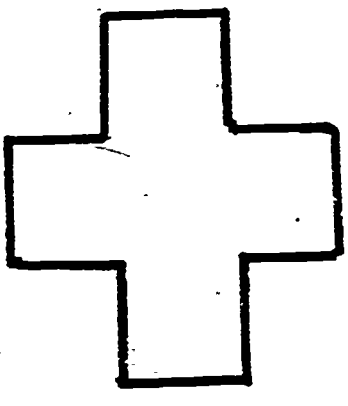


Vocational/Educational

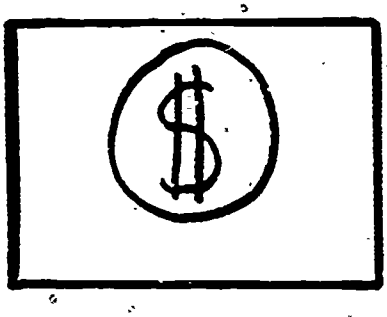


Crisis

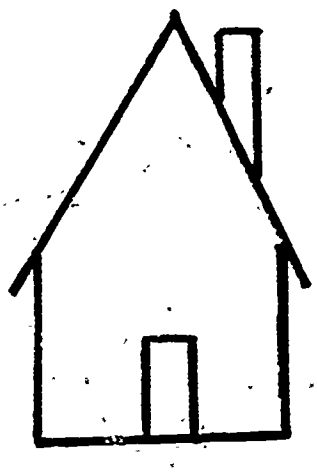




Health



Financial



Housing

SESSION VI

COMMUNICATION AND COMMUNITY

1. "WARM UP"

   - Small Group: Sharing strengths and weaknesses
   - Large Group: How attitude affects communication

2. COMMUNICATION WITH THE AADD PERSON

   - Small Group: Why communication?
     What is communication?
     Developing good communication
   - Large Group: Summary
   - Individual: Personal reflection

3. COMMUNICATION ON BEHALF OF THE CLIENT

   - Small Group: Why communication?
     What is communication?
     Developing good communication

4. PRACTICE IN COMMUNICATION

   - Triads: Role playing situations to solve problems

5. TRAINER/TRAINEE DISCUSSION

   - On site problems
   - Training concerns

SESSION VI

PURPOSES

1. Improve communication style
2. Develop skills in identifying and describing caregiver-client problems
3. Take responsibility for redirecting training to meet individual needs

PROCEDURES

SP 43 can be distributed to orient trainees to this session.

I. WARM UP EXERCISE

(20 minutes)

This session will rely upon verbal interaction between participants. Therefore, this exercise will set the mood for the rest of the period.

Small Group:

Trainees will choose another participant with whom to discuss the caregiving role. The following questions provide a guide for the short discussion. Each member of the dyad should respond to the questions:

A. What is your best skill on the job?
Would you feel adequate to teach them to others?

B. What is the most difficult aspect of your work?
What would you like to learn from others?

C. How do you experience your clients' feelings as you perform your "best" and your "most difficult" task?

NOTE: Participants may wish to discuss strengths and weaknesses not related to the job, because they affect the role of the caregiver. This should be encouraged.

Large Group:

After re-assembling, the trainer will ask the dyad members how they perceived their partner's behavior and expressions during the sharing period. The following questions provide a basis for this discussion. The remarks that follow each question can enhance the trainer's contribution.

1. DID YOUR DYAD MEMBER EXPRESS HERSELF DIFFERENTLY WHEN SHE MOVED FROM DESCRIBING HER "BEST" WORK TO THE "MOST DIFFICULT"? (She might have begun to talk more softly or hesitantly and change her facial expressions by frowning etc.)

2. HOW DID YOU AND THE DYAD MEMBER MUTUALLY SHARE EXPERIENCES? (Possibly she was able to pull you into the feeling. For example, she might have described her fear so well that you became fearful and could really "feel" the situation as she retold it. You might have been happy together as she described her handling of an incident she was especially proud of. Maybe you became jealous and wished you could perform as well as she did in that area.)

3. IN WHAT WAYS DID YOU SHARE SOLUTIONS AS PROBLEMS AROSE? DID YOU FIND YOU HAD MUTUAL STRENGTHS AND WEAKNESSES? HOW DID YOU FEEL ABOUT RECEIVING ADVICE? (It is important to state that any form of communication results in feelings we either internalize or share. If we have similar experiences, we usually feel better because the other person understands what we went through. Often words flow freely and are clearer if we have communicated positives. Sharing negatives results in stammering an being "tongue-tied," almost like talking with the mouthful of marbles. Sometimes communication is blocked because we resent getting feeback on our performance.

4. HOW DID YOUR ROLE CHANGE WHEN IT BECAME YOUR PARTNER'S TURN TO SHARE? DID YOU BEGIN TO FEEL MORE SURE OF YOURSELF, OR POSSIBLY FEEL INADEQUATE IN HELPING HIM DESCRIBE HIS EXPERIENCES? (It is difficult to move into a situation where you must share. You become vulnerable and aware of the other person's perceptions of you, for they are often in the role of a resource person and you are in a requesting role. When we feel inadequate to the task we are often in a "one-down" (-) position; often in such situations we must request assistance. If difficult or [illegible]ing problems are shared, a relationship of trust and respect must have developed. It is important for caregivers to become sensitive to how their communication style (voice, language, tone, body language) changes, and under what circumstances. Often caregiving staff is in the role of organizing and planning, which is different from the clients who are continually in the helpee or follower role. Insights can be gained on creating equal (=) relationships between client and caregiver.

2. COMMUNICATION WITH THE CLIENT

(40 minutes)

Step 1:

Two dyads join to become a four-person group. Listed below are three questions given each group for discussion.

A. WHY DO YOU HAVE COMMUNICATION WITH THE AADD CLIENT? IS IT DIFFERENT THAN OTHER INTERACTIONS YOU HAVE? HOW?

B. WHAT ARE THE TASKS OF THE CAREGIVER WHEN COMMUNICATING WITH THE AADD CLIENT? WHAT ARE THE RESPONSIBILITIES?

C. WHAT ASPECTS OF COMMUNICATION SHOULD CAREGIVERS DEVELOP?

The trainer should request a brief discussion of each question, in turn, and using the following comments, expand on the participant's contributions.

A. WHY DO YOU COMMUNICATE WITH THE AADD CLIENT? IS IT DIFFERENT THAN OTHER INTERACTIONS YOU HAVE? HOW?

1. Do the job
2. Benefit from each other's experience
3. Understand the AADD person better
4. Be sociable
5. Find out about problems
6. Reward good behavior
7. Recognize people
8. Build confidence
9. Discover feelings
10. Identify/express needs
11. Assist in problem-solving
12. Learn other people's values
13. Settle differences
14. Learn and teach
15. Have fun

The main purposes of communication are: 1) clarify, 2) educate, 3) enjoy each other, 4) socialize, 5) request, 6) express feelings. All trainee responses can be grouped under these major headings. In whatever communication patterns with the client, the worker should model values and attitudes important for the AADD person to learn. Although the client may have limited communication, he enjoys the benefits of good client-caregiver interaction.

B. WHAT ARE THE MAJOR TASKS OF THE CAREGIVER WHILE COMMUNICATING WITH THE CLIENT? WHAT ARE THE RESPONSIBILITIES?

The caregiver's responsibility is to be a supportive listener. It is important to mutually determine the needs of the client, arrive at decisions, and accomplish goals. Even a more severely impaired person can tell us about himself--his preferences for example--and these should be honored. Action should be guided by what the AADD person perceives to be a solution to his need. It is important to allaw both caregiver and client equal access to the following tasks/responsibilities:

Tasks	Responsibilities
teaching	sounding board
guiding	surrogate parent
enabling	surrogate friend
limit-setting	initiator
modeling	supporter
informing	resource
serving	
reinforcing	

C. WHAT ASPECTS OF COMMUNICATION SHOULD CAREGIVERS DEVELOP?

1. PATIENCE - often people caught up in their competencies to help don't allow AADD persons to help themselves. For example, it takes patience to allow pauses in conversations to permit time for the client to express his own needs. This "quiet time" often leads to more meaningful exchange because the AADD individual is given a chance to express his own desires.

2. HONESTY - honesty in communication often involves courage. For example, it takes courage to acknowledge the client's disability rather than ignore it. The caregiver must strive for a position of comfort in his relationship with the client so that honesty can be achieved, and appropriate praise, carrection, and feedback, provided.

3. UNDERSTANDING AND EMPATHY - the caregiver cannot be honest with a client unless she has feelings for where that clients is coming from and understands the person's point of view.

4. INVOLVEMENT - the caregiver must ally himself with the AADD person and permit his own behvior to reflect the wide range of his honest emotions and give the client sanction to share his range of feeling. In the process, infantilization is avoided and respect is developed.

5. CONSISTENCY - although consistency in communication is valued, it is unrealistic to assume that all relationships can be stable all the time. We should not expect to always feel the same way about relationships with spouse, children, or friends; therefore, we should not feel guilty when you have "off" days with the AADD person. We might explain our feelings to him, because it is patronizing to try and deceive him. In most cases he will know our true feelings anyway.

Other important communication characteristics include the ability to innovate, and be repetitious and simplistic when the need arises.

Step 2

These four-per on groups should now be able to describe the best ways to communicate with AADD clients and what behaviors should be avoided in the interaction. This exercise will supplement and summarize the previous discussion. Each group should appoint a recorder and he should be provided with a sheet of paper to record responses. The assignment to the group is to identify and discuss specific positive and negative communication behaviors that commonly occur between caregiver and client.

The trainer asks each recorder in turn to record for his group the responses to the above assignment. As in earlier sessions, the trainer may supplement the contributions from the group by referring to the following list of suggestions:

A. APPROPRIATE COMMUNICATION BEHAVIORS

1. Willingness to share
2. Ability and motivation to listen
3. Awareness of personal feelings in order to understand others
4. Willingness to model good communication
5. Introduction of activities
6. Limit setting
7. Listening
8. Feedback
9. Openness to new experiences
10. Equal (=) relationship

11. Age appropriate treatment
12. Normal speech tones
13. Clarity and explicitness
14. Body communication (gestures, postures, facial expressions)

B. INAPPROPRIATE COMMUNICATION BEHAVIOR:

1. Pretense
2. Interruption
3. Intrusiveness
4. Superficial feelings of happiness
5. Pontificating
6. Remarking about clients in their presence
7. Sarcasm
8. Bossing
9. Infantilization
10. Patronization

As a result of the above exercise the practitioner should have become aware of the responsibility to listen over and over again so that she can reinforce, redirect, or clarify communication. It is important to interact and communicate with the AADD individual so that through the experience his ability to develop relationships is expanded. This interaction may be tiring, boring, laborious, repetitious, and simplistic, but it is essential.

Step 3 (Optional)

Trainees will now be able to project themselves into specific situations where communication with the client is necessary. They can begin to assess

their behaviors by reflecting how they see themselves reacting during client-caregiver interactions. Distribute SP 44, 45 to all participants. Each trainee will complete SP 45 by studying the three situations on SP 44. After completing the form, a brief discussion permits trainees to share their reflections with the large group, and the trainer may reinforce concepts introduced earlier.

Time restraints may not allow adequate consideration of Step 3. Often participants find themselves intensely involved in steps 1 and 2. If this occurs, Step 3 could be "lifted out" of the session and used independently, when time permits. It is an excellent review for summarizing communication with the client.

3. COMMUNICATION ON BEHALF OF THE AADD CLIENT

(30 minutes)

Step 1

By this time participants should have gained an appreciation for the importance of the AADD person's involvement in decision making, and appropriate communication with the AADD person. Consideration should now be given to communicating on behalf of a person; it is not the same as doing for them. Participants should divide into four small groups and discuss the following concerns:

A. WHO COMMUNICATES ON BEHALF OF THE CLIENT?

(The AADD person's entire support system i.e. administrators, social services, mental health department, family, church, community educators, waitresses, other caregivers, etc. are often signficantly involved in decisions impacting on the AADD person.)

B. WHAT IS THE PURPOSE OF COMMUNICATION ON BEHALF OF THE CLIENT?

(Income maintenance, custodial care, health, nutrition, clothing selection and maintenance, transportation, crisis management, finances, budget, limit setting, and safety comprise much of client-caregiver communication. All supportive and defining aspects of the AADD person's

life are often carried out on his behalf. These areas often reflect the seven basic needs mentioned previously (Session II). If caregivers seek to help the AADD individual develop interpersonal communication styles characterized by trust, then the AADD person must be brought into discussions on his own behalf. Through this more mutual relationship, the client moves toward self-advocacy. This implies that the caregiver advocates with him, on his behalf. The caregiver should become, to the fullest extent possible, a model for his colleagues as they view the AADD person's right to be a full participant in all areas of his life (A) and in all negotiations (B).

C. WHAT ARE THE PREFERRED CAREGIVER COMMUNICATION PATTERNS, AND WHAT BEHAVIORS SHOULD BE AVOIDED?

(Although the role is the same and responsibilities emerge as they did when communicating with the client--guiding, informing, resource, limit-setting, initiator, supporter etc., the most important role the caregiver must assume while involved in this type of interaction is to be a client advocate, and to model for the client and other professionals the client's responsibility to advocate for himself. In any interaction with the support system there will be a need to share information, change attitudes, and problem solve around needs. These tasks must be done assertively, always with the AADD client present and the needs of the AADD client perceived as primary. Sometimes this will make unfavorable impressions on others because it inconveniences them. However, the client is the primary resource person from whom to elicit information and advice around problem solving. Her attendance is mandatory at meetings that involve decisions about her. Phone calls often limit client participaton, and should be delayed until the AADD person can be involved. The key concern, is how to support the client as the system serves her. Through this process we begin to assertively advocate for the AADD person. Through our modeling in this relationship the client can learn to advocate for herself.)

Step 2

Participants are now prepared to consider particular situations involving communication on behalf of the AADD person. Distribute SP 46 . Each person should read the problem situation independently and respond in writing to the questions that relate to personal actions and decisions Trainees can briefly discuss their reflections with the entire training group, and the trainer can use this exercise to reinforce previously presented concepts.

4. PRACTICE IN COMMUNICATION

(40 minutes)

Preparation:

This exercise provides trainees with the opportunity, through role play, to practice their newly developed skills of communication. Distribute SPP 47, 48. Direct individuals to form triad groups. Assign a particular situation (SP 47) to each group. Each triad must decide on roles for each of its three members:

a. COUNSELOR - the caregiver, giving advice

b. PERSON WITH THE PROBLEM - another caregiver, relative or client

c. OBSERVER

Allow a few minutes for each triad to prepare for their role-play situation. The issues presented after each situation on SP 47 should provide direction for the "counseling caregiver" as he interacts in his role. Once again, detailed informtion is not provided but must be generated as the situation develops.

Task:

Role-play involves the two participants in "acting out", through verbal interaction and body language, as though they were in a play or soap-opera. The observer in each group has the special task of being aware of the ongoing interpersonal communication styles of the two role-playing participants. The observer must critique the role-play and be able to make comments and suggestions about the process. During the role-play, the observer should direct his attention to whether the issues, as presented, have been addressed. (SP 47)

Small Group Discussion:

The observer will report to the other two members whether she believes

the issues were addressed (SP 47). After brief discussion, all triad members should allow themselves a few minutes to make notes about the interaction on SP 48. Once again, the observer will lead a short discussion with the other two members./ Trainees should be able to support their comments as they compare and contrast.

Trainer Summary:

As a way of closing this exercise, the trainer can allow all trainees an opportunity to share with the large group any significant experiences and perceptions around this exercise. The trainer can discuss communication barriers that could have occurred in any of these situations. The following questions will focus this discussion.

1. What difficulties did the participants experience in each of the roles -- counselor, person with the "problem"?
2. What barriers to effective listening emerged during the exercise?
3. What did participants notice about the effectiveness of their and others' self-expressions?

Communication blocks could be:

1. On the part of the "counselor":

   a. lacks sensitivity by using jargon
   b. tendency to irritate
   c. acts as if she "knows it all"
   d. tendency to ramble
   e. tends to talk more than listen
   f. does not seem to want to accept the "client's" point of view.

2. On the part of the client, relative, or other caregiver:

   a. does not seem to be paying attention
   b. talks about things that don't relate
   c. does not seem to want to discuss
   d. Seems to have the counselor "all figured out".
   e. seems to have a hard time bringing up personal issues

5. ASSIGNMENT FOR SESSION IX (optional)

(10 minutes)

At this point, participants should recognize their work as an ongoing process of problem solving, and that the ability to formulate solutions often centers around the ability to communicate. Traineees are asked to develop one or two problems that emerge from their daily practice with AADD clients. These situations should be based on real life problems. These problems will become the basis for discussion in Session IX. An example of a problem:

> Earl's friend, Walter, died in his sleep. Although Walter was 76 and quite ill at the time of his death, Earl (age 58) has nightmares and refuses to talk about death. How do you discuss death with a 58-year-old man who has, chronologically, an 8 - 10 year old I.Q.? I don't want to talk down or over this person's head.

6. MID-TRAINING EVALUATION - (optional)

(10 minutes)

As a way of ensuring that training meets learning needs of the participants, discussion around the following questions will encourage individualized direction and emphasis of the training:

a. Is the training meeting your needs?

b. What would you like the group to consider before the sessions end?

The trainer is challenged to individualize his training efforts to take these individual responses into consideration.

SESSION VII

PROBLEMS AND POTENTIALS OF COMMUNITY LIVING

1. "WINDOWS ON THE WORLD"

2. "REDISCOVERING THE COMMUNITY" - Videotape

3. MOVING TO COMMUNITY
   - Part I: Where do I stand?
   - Part II: Risks and Barriers
   - Part III: Challenges and Opportunities

4. COMMUNITY RESOURCES
   - Sharing our expertise

SESSION VII

PURPOSES

1. Recognize the uniqueness of individual perceptions
2. Identify ways to creatively involve the community
3. Clarify risks, barriers, and potentials of community living
4. Develop expertise on community resources

PROCEDURES

Participants can be given SP 49 in order to orient themselves to this session.

1. "WINDOWS ON THE WORLD"

(20 minutes)

Upon arriving, participants should be given newsprint and magic markers. The trainer should instruct each person to draw a window. After completing their windows, each trainee should place the newsprint on the floor in front of him. Participants should be given the opportunity to discuss their "window" with the group. Such characteristics as window style, scenery, and type of curtain, etc. might be commented upon because of significance to the trainee's experience. It will become apparent that all windows are unique. Yet all will agree everyone has drawn a window.

The trainer should comment that windows are similar to opinions; they represent individual points of reference. The windows can also represent ways others view us. If we are "open to the world", we can let others see our individual strengths and weaknesses. Finally, the trainer can briefly comment on the importance of "owning" everything we say. All personal statements reflect our unique point of view, but are not said to be challenges to others'

opinions. We want to share suggestions with others and to learn from their experiences. A review of SP 3 would be appropriate at this time.

2. VIDEO TAPE

(15 minutes)

Show videotape, "Rediscovering the Community" (See Appendix MP 203 for this and other resources.) Distribute the discussion guide (SPP 50, 51) for the videotape as a summary. If time permits it may be used to enhance the group sharing.

3. MOVING TO THE COMMUNITY

(1 hr. 30 min.)

Part A:

Participants should divide into four-person groups. SP 52 should be distributed to all trainees. Through small group discussion participants will become sensitive to positive and negative aspects of institutional and community living. An appointed group recorder should note the group members' responses. The completed workbook page will form the basis for a large group share out.

It becomes apparent after completing this exercise, that one type of living arrangement is not always good or bad. Each has its value at particular times and places (i.e. the institutional environment of the hospital is necessary, relevant, and ideal for a patient recovering from brain surgery). Responsible decision making involves knowing the purposes and goals of various living alternatives. The trainer should not feel it important to summarize the discussion during the share-out. It is important that trainees begin to feel

comfortable with their feelings around community living, and expand their perceptions by learning from the other trainees. MP 91 can be used to enrich the trainer's contributions.

Part B:

Each step of this exercise (1, 2, 3) is designed to help students focus on the positive and negative aspects of taking risks. Before the session begins, the trainer should place newsprint, entitled Barriers/Risks, on the wall/bulletin board. Throughout Steps 1 and 2, trainee-identified barriers and risks to a greater degree of community involvement should be continously noted. Examples of barriers that might be suggested are included under Step 3. These barriers will become the focus of the large group share out in Step 3.

Step 1

Trainees should react to a problem concerning a community resource - health care. A newsprint sheet should be prepared to read:

Problem:

An AADD individual that you know needs a doctor's appointment and transportation to the office.

Responsibility:

1. Who makes the appointment?

Client _____ Staff

2. Who makes the transportation arrangements?

Client _____ Staff

Participants should reflect on their experience with a particular client and then place their initials on the newsprint sheet at the point that represents where they believe the emphasis for decision making is placed: on staff, on the client, or somewhere in between. The instructor should prompt the trainees to comment on why they made their decisions. Trainees are encouraged to creatively support their answers through their personal experiences.

As trainees express concern over the ability of a client to become more involved in personal decisions, the trainer should note these concerns on the Barriers/Risks newsprint sheet mention previously. It will be informative to ask the trainees the following questions:

1. WHY ARE MORE DECISIONS MADE BY CAREGIVERS? (Note: most trainees will realize that staff tends to make many decisions for the AADD person.)

2. DID YOU CHOOSE A CLIENT YOU LIKE/DISLIKED? HOW DOES THIS CHOICE AFFECT HOW YOU SUPPORT THE PERSON TO DO MORE THINGS BY HIM/HERSELF?

Step 2

SMALL GROUP

SPP 53, 54 should be distributed to trainees. Participants should be instructed to individually complete the form. In the first two columns, trainees are to indicate with an X whether they (SELF column) and/or their clients (AADD column) make a habit of involving themselves in the specified activity.

The trainer should ask participants to add up the number of activities they regularly participate in as compared to their AADD client. In most cases, it becomes quite apparent that the AADD individual lives a much more constricted lifestyle, i.e. possibly engaging in a weekly bowling outing, attending a movie once a month, and visiting his sister on major holidays. Trainee should be asked why AADD individuals, in most cases, engage in fewer activities than they do. Many "but they can't..." responses will be noted At this time, SPP 55, 56 should be distributed to the participants.

Participants should complete the form by circling the place on the continuum that represents the degree of barrier or risk (i.e. ability, danger, access, availability, preference) they think exists for AADD persons in general or for a specific AADD person, for the various activities presented.

LARGE GROUP

Trainees should be invited to share the instances that cause them concern for their clients. Particular attention should be paid to SPP 55, 56. Responses do not represent firm decisions, and participants will have the opportunity to explain their choices. The trainer's goal is to support this sharing process so that trainees will learn that everyone has individual ideas and perceptions about the AADD person's involvement in various activities.

In our experience: One participant raised a question about whether she should permit her clients to go canoeing. She stated that none of the clients could swim. Another participant replied that her clients did not swim either, so they didn't go canoeing. Instead, they discovered a metro park that regularly ferried people around a large, picturesque lake and participated in that experience.

As the large group interacts, the trainer should continue to interpret the participants' concerns and the issues raised, and record them on the Barriers/Risk sheet (see MP 83). This exercise should solicit responses that speak to safety concerns and individual preferences.

The following step will help the trainee identify more subtle factors. Trainees will begin to realize that perceived barriers and risks produce decisions around participation that are never clear-cut. Participation depends on what people can/can't do, as well as fears, both real and imaginary, that impose limits. The Barrier/Risks sheet (see MP 83) will be useful here.

The following are examples of barriers/risks that were identified in other training sessions:

1. Guardianship restrictions
2. Licensing, insurance
3. Expensive fees, admissionss
4. Inadequate skills
5. Physical limitations
6. Seizures
7. Power tools
8. Drowning
9. Crime rates
10. Differences in functioning level
11. Level of community awareness - "We don't want him here."

12. Family protectiveness
13. Staff protectiveness
14. Different weather conditions
15. Medication restrictions
16. Client not understanding/accepting "limits" on smoking, drinking, and eating

Participants will gain an awareness for how much further everyone must go if total involvement of the AADD person in the community is to be achieved. Further participation beyond moving AADD persons into community residences is a much more subtle and difficult task.

Step 3:

In order to help the participant recognize the interrelationship of fear and lack of knowledge, and how these factors affect personal perceptions of the degree of risk, this step is included. The instructor should post the completed Barriers/Risks newsprint sheet (MP 83). Two additional newsprint sheets should be prepared with the following information:

Sheet #1: Heading: OTHERS

1. What about my property values?
2. They are dangerous
3. What can we do to stop it?
4. Why didn't you tell us three months ago?
5. They are better off in the institution.
6. Let them go out in the country.
7. The nearest hospital is 20 miles away.

8. Let's develop the area first.
9. There are dangerous railroad tracks in this town.
10. What about the swimming pool next door?
11. But what about my rights?
12. We have deed restrictions.
13. We'll sue.
14. Let's burn it.

Sheet #2: Heading: OURSELVES

1. But all they want to do is watch T.V.
2. They enjoy coloring books.
3. He might not see the cars.
4. That's a busy street.
5. But the stove is hot!
6. There's no sidewalk.
7. We're liable.
8. We only have one van.
9. There's not enough money.
10. They can't make change.
11. They like to do things together.
12. The ice is bad this year.
13. They don't know any better because of the INSTITUTION.
14. They're too old and "set in their ways" to learn.
15. They'd drink 15 cups of coffee per day if they could!
16. If they stayed up, they'd never get up in time in the morning.
17. There's only one staff person.

These two sheets should also be posted. The instructor should ask trainees to look at the three lists and consider the question, HOW ARE ALL THESE STATEMENTS ALIKE? The trainer should ask for individuals to share-out their responses. The group leader should guide participants toward recognizing that their responses come from feelings of fear or lack of knowledge, resulting in constricted limits placed on an AADD person's involvement.

The trainer should close by emphasizing the importance of ongoing decision making which uncovers the roots of fear and constantly questions the limits imposed by others on AADD individuals. This constant questioning will serve to confront the worker with the infantilizationn that is apt to be affecting decision-making. To eliminate the infantilization is an early step toward achieving the larger goal of helping each client achieve maximum use of his community and its resources.

Part C: (Optional)

SP 57 should be distributed and read by trainees. The questions at the bottom of the page should be discussed in the large group. This exercise will summarize the tentative, ambiguous, but challenging factors involved in helping ourselves and others to achieve independence and community participation.

4. COMMUNITY RESOURCES

(25 minutes)

In order to introduce the participants to a breadth of information and available community resources, an exhibit should be prepared:

A. Information Resources

SPP 58-60 can be placed on a table so that participants can add this information to their manuals. The trainer should display a selection of books and other information. These could include arts, crafts, and game books; magazines; literature on special populations (disabled and/or elderly); audiotape materials and records; addresses of organizations serving special populations.

B. Supply Resources

Different materials for various arts and crafts activities can be placed around the room. Participants should be encouraged to contribute to this display. If time permits, trainees may share ideas, suggestions, and "how-to" tips in a large group setting. The trainer may also use this time to review and discuss the information on SPP 58-60.

Participants should be allowed free time to browse through materials and information which has been placed around the room. As participants look around, they can begin sharing information with others about resources they have found to be effective.

WHAT IT'S LIKE WHERE WE LIVE

INSTITUTION ⟷ COMMUNITY

1. Label of diagnosis attached to individuals

   Benefits:
   problems (i.e., medical) are well known and more quickly treated.

   Risks:
   persons tend to be seen as "problems" and can become pessimistic about the patient/client.

2. Maintenance of routines and schedules

   Benefits:
   efficiency is maintained

   Risks:
   atmosphere is sterile and non-involving

3. Patient/client role is maintained - emphasis is on mental or physical illness

   Benefits:
   specialized services can be efficiently and effectively monitored.

   Risks:
   person tends to be seen as disabled first, before his individuality is explored; needs tend to be seen as fragments, which results in an individual being seen/understood by parts, instead of as a unique, whole person.

4. Effort is made to eliminate stress

   Benefits:
   medical, social and psychological stresses that a person cannot control independently can be medicated or monitored by others.

   Risks:
   excuse for creating a comfortable, anxiety-free situation that doesn't challenge a person to grow.

5. Rigid helper roles

   Benefits:
   staff can become competent in areas requiring the monitoring of physical needs.

   Risks:
   staff function by job description, often failing to see persons in a wholistic perspective; relationships are rigid and unequal, tending to be impervious to the range of human feeling - this results in dehumanizing behavior.

1. Freedom of movement in the community, and needs met within the range of community services

   Benefits:
   persons are free to choose among services allowing personal decision making; individual remains "in charge" of satisfying/meeting his own needs.

   Risks:
   service gaps result because certain needs are not considered important enough to consider.

2. Personal decision making around organizing one's time

   Benefits:
   an atmosphere of "normal" society results where person is free to express individual tastes and needs.

   Risks:
   lack of skills and/or personal resources (intellectual, emotional, or social) can result in life-threatening situations.

3. Many social roles are available - emphasis is on wellness

   Benefits:
   major components of community life are interwoven throughout the day, making life an integrated whole. Social, psychological and physical needs are met.

   Risks:
   person might need help, but is unable to secure it independently, and could be ignored and misunderstood.

4. Stress controlled by individual limitations, strengths

   Benefits:
   individual can begin to see his limitations through legitimate failure and perceive his strengths by pushing his abilities to their limit.

   Risks:
   person may not be able to control his stress level because of personal or organizational pressures, resulting in physical or emotional problems.

5. Flexible helper roles

   Benefits:
   persons tend to play teacher, learner, or friend roles; equal relationships can result easily because there is a realization that everyone is interdependent. If assistance is needed, helper is more optimistic about seeing helpee begin to function in more healthy, growth-enhancing way.

   Risks:
   there are no risks to being mutually sensitive and caring about each other as we strive to create equality in all our relationships. However, staff might be threatened by loss of power in situations, as client moves to more (=) relationships.

SESSION VIII

USING THE COMMUNITY

1. "USING THE COMMUNITY"
   - Game/Simulation
   - Large Group: Share-out

2. "BECAUSE SOMEBODY CARES" - Film

SESSION VIII

PURPOSES

1. Experience the processes in utilizing community services
2. Sensitize participants to the anxiety and frustration that appear inevitable in meeting needs in the community
3. Provide the opportunity to explore new ways of community involvement.

PROCEDURES

1. "USING THE COMMUNITY"

(45 to 90 min.)

GAME DESCRIPTION

The simulation is designed to help participants get in touch with interactional and organizational processes integral to obtaining appropriate community resources. Securing services for a client is frequently a difficult and frustrating task, requiring large amounts of creative energy; but the goal must be achieved if true community participation is to be a reality for the AADD client. Communication and pro lem solving skills are used while this game is played as a way of emphasizing the need for competency in these areas in order to make maximum use of the community on behalf of the AADD client.

The objective of the simulation is for each player (participant) to obtain a needed service for one of three AADD clients, Henry, Robert and Arlene. Each client requires different services. The game is played around nine situations, three per AADD client. The goal is to secure the appropriate community resources for each of them. The length of the game depends on the number of game players.

The trainer should study MP 100 to become familiar with the overall structure of the game. The steps of the game are as follows:

First, the player (trainee) receives a packet of material that gives him information about the "client". Second, the player proceeds to the Information Office, indicated by a ★ . There he obtains a card elaborating on the AADD client's particular need. Third, the game participant must then negotiate the "maze" of rules, instructions and obstructions in order to reach the service goals. The game monitor (often the trainer) is responsible for being completely familiar with the simulation, and making certain the players have completed the game correctly. In order to assist the game process, two volunteers from among the participants are needed. They work at the 1) Information Office, indicated by ★ ; and Information Table, indicated by ● . There can be 9 to 27 players involved in the game. Specific instructions for preparing for the game follow.

MATERIALS PREPARATION

Step 1:

Packets of material should be duplicated for the 1) ★ Information Office Volunteer, 2) ● Information Table Volunteer, 3) Game Monitor, 4) Players.

A. ★ Information Office Volunteer needs:

1. Volunteer Instructions (MP 102)
2. ★ Information Office Check Lists (MPP 108- 116), stapled together)
3. Game Diagram (MP 100)

B. ● Information Table Volunteer needs

1. Volunteer Instructions (MP 102)
2. ● Information Table Check Lists (MPP 117-125, stapled together)
3. Game Diagram (MP 100)

C. Game Monitor

1. Game Process Sheets (MPP 146-154, stapled together)
2. Note: The game monitor should be totally familiar with the materials in the volunteers' and players' packets. He may duplicate these materials for himself to use during the game also.

D. Players

1. Player Instructions (MP 101)
2. "Your" Client (MPP 105-107)

One-third of the players receive "Henry" (MP 105)
One-third of the players receive "Robert" (MP 106)
One-third of the players receive "Arlene" (MP 107)

Step 2:

See MPP 137-145. These pages present a unique challenge in the preparation of materials. Each of the nine pages provides the different materials required to permit one player to resolve one situation. Therefore, if more than nine players will be participating, additional copies will be needed to accommodate them. Example:

> Please refer to #H3 (MP 139). For one player to play the game around situation #H3, 5 player cards are required. Card #1 (5x7) includes the copy as indicated. Card #2, 3, 4, 5 (3x5 cards) include the specific information indicated. Please note, sometimes there is information on only one side of the 3x5 card. Please copy the correct symbol (★, ●) where indicated. Use the same directions for each of the other pages in this series.

Step 3:

Make one copy of all the service cluster pages, MPP 126-136. During the game, they will be used at the Community Services Desk.

100

SETTING UP THE GAME

The room should be arranged with three tables: 1) ★ Information Office; 2) ● Information Table; and 3) Community Services Desk. (See Game Diagram, MP 100). Make a sign to identify each table. Be sure to make the correct symbol (★, ●) where indicated. Locate three tables some distance from each other so that there is room to move about.

a. ★ Information Office - place all 5x8 cards on this table, as well as all 3x5 cards, labeled with a ★ .

b. ● Information Table - place all 3x5 index cards, labeled with a ● on this table.

c. Community Services Desk - Place descriptions of service clusters on this desk. (MPP 126-136). Instructions for use of Community Service Desk (see MP 104) should be duplicated and taped on top of the table for easy reference and to prevent removal.

IMPORTANT

Post the Service Clusters Sheet (MP 103) somewhere in the room, remote from the Community Services Desk. (This is important in order to simulate the broad dispersal of resource information in a community).

PLAYING THE GAME:

Step 1:

All prepared packets (players and volunteers) should be distributed at random to participants. The game monitor (trainer) should read the first paragraph under the Game Description (MP 93) to the participants. Instruct

all participants with player packets to read the enclosed Player Instructions (MP 101). The two participants who were given volunteer packets should read the enclosed Volunteer Instructions (MP 102). Tell players how much time they have to "play" the simulation if there is a time limit.

Step 2:

During the simulation the game monitor should remain near the Community Services Desk. Many questions the players have will involve information on this table. The game monitor should refer to the appropriate game Process Sheet (MPP 146-154) as "trouble" occurs. This sheet will help the monitor locate the source of the problem.

There are a few problems that may be anticipated. Three instructions on the Community Services Desk instruction sheet (entries 2, 3, 4, on MP 104) refer the monitor to some of the major mistakes players make.

The monitor should be setting the "tone" of the game. The players will feel anxious about "what to do next". Players should be responsible to come to the monitor with "problems". The monitor should try to feel comfortable with allowing the players to feel frustration, and not give too much support.

It is imperative that the game monitor know all the processes of the simulation. It is recommended that the monitor become familiar with each of the nine game situations (collecting cards, checking codes, etc.) before the game is actually played. Then problems with the process will be eliminated for the monitor. A thorough reading of the game process sheets (MPP 146-154) is also recommended.

Some players may finish ahead of time. If this occurs, these players could help others having trouble, or if there is time they could "play" another client situation. Any types of problem solving strategies players develop i.e. talking together, should be encouraged.

Game is complete when all situations are solved or allotted time has expired.

Step 3:

Each new game situation will present unique problems and challenges to the players. The final activity of the game simulation is to provide a large group discussion where the players can discuss the feelings generated by the maze of rules, instructions and obstructions to the procurement of client services. This allows the trainer to lead the discussion to the acknowledgement of existing obstructions in the day-to-day work experience of the trainees. The following questions are suggested for use in this discussion.

1. What did you do to first gain information on how to proceed?
2. What were some of your experiences in this process?
3. Were there any frustrations in the process?
4. Were there gaps in the service system?
5. How did you make the process easier for yourself as you went along?
6. What information could have been more helpful to you in the community?
7. How did this game relate to any "real life" experiences you have had?

2. **FILM**

(45 minutes)

To complete the student manual, distribute SP 61 at this time.

Show film, "Because Somebody Cares" (See appendix MP 203 for this and other resources.) A discussion should provide additional information for focusing on particular issues, and for leading a group discussion. "Because

Somebody Cares" sensitizes viewers to the special needs of some older persons whether they are struggling to remain in their homes despite handicaps, or are residing in institutions. It gives insights into the ways volunteers can meet the needs of many of these older persons. The film acknowledges that those who voluntarily give service to the elderly receive as much as they give. It illustrates that caring people of all ages can enrich the lives of older people.

Consider the following questions:

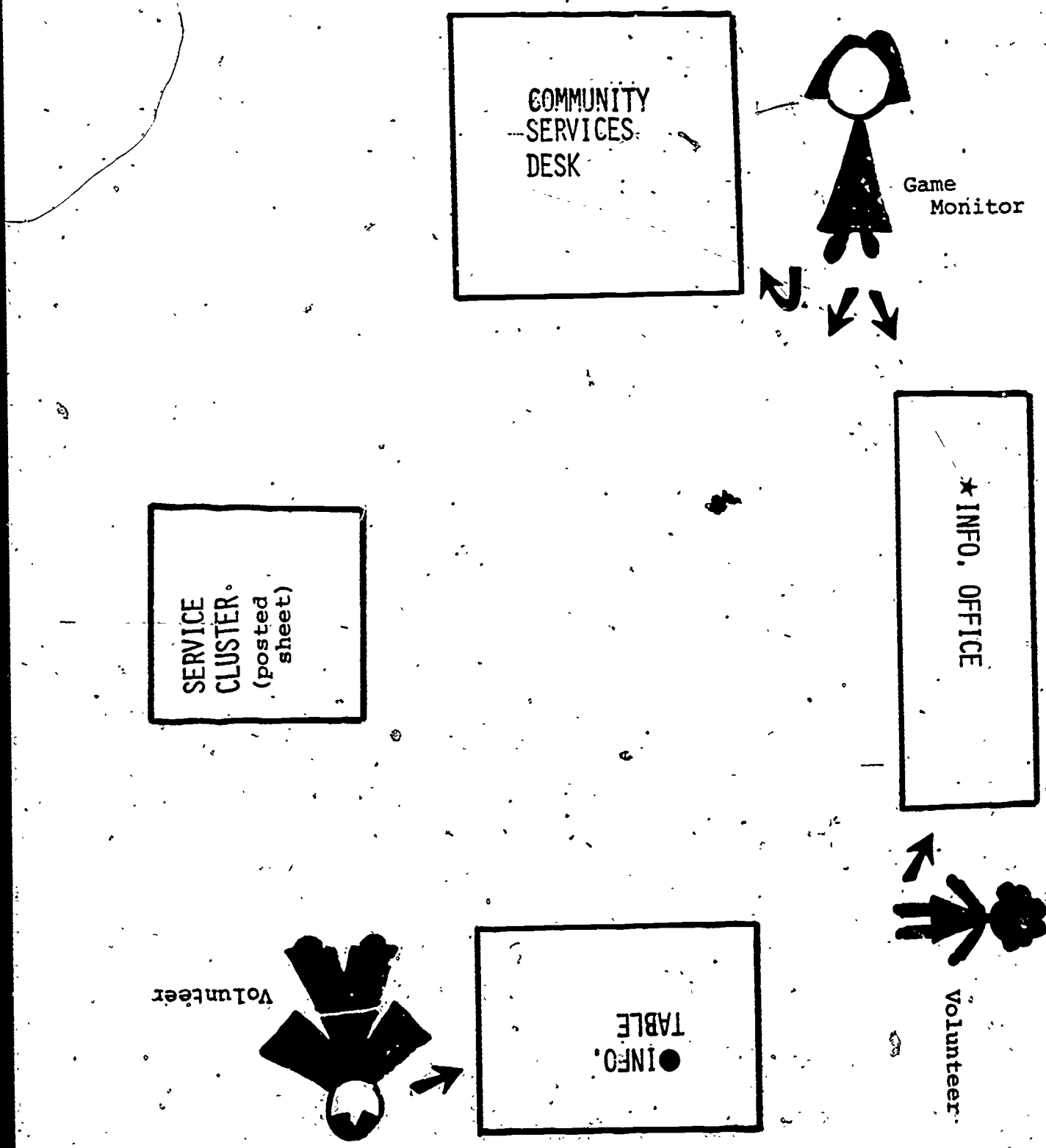
1. What are some of the obstacles older people face in trying to maintain their independence and remain in their own homes?

2. Why are some people reluctant to volunteer service to the elderly? How was this reluctance addressed by the family depicted in the film?

3. What supports would need to be provided for disabled persons to become volunteers? What supports (if any) would be unique to the AADD individual?

4. Discuss the pros and cons of volunteering through an agency versus a more spontaneous volunteering role initiated on an individual basis?

GAME DIAGRAM



PLAYER INSTRUCTIONS

1. Read all directions before you proceed.
2. Always wait in line; unless you're instructed differently.
3. Know your client's ID number. This is very important.
4. Your goal is getting into the community to find agencies/services which meet your client's identified need. You only have the amount of time specified by the Game Monitor.
5. You will be securing index cards which "prove" you have obtained the needed service for an AADD client. The number of cards you might need to get varies. Many of these cards have directions on the backside to give you clues as to how to continue.
6. You secure cards and other valuable information at the ★INFORMATION OFFICE, and at the ● INFORMATION TABLE.
7. The Community Services Desk offers the agencies that provide needed services.
8. The Game Monitor answers any questions the two game volunteers can't. You must check in with this person at the end of the game and show him/her the cards needed to "prove" you secured the service for your "client."
9. Read the client's "case history" on the page enclosed in your materials, so you can get to "know" your client. Some of the information on that page will be necessary for you to refer to throughout the game.

NOW YOU ARE READY TO BEGIN THE GAME/SIMULATION

10. Proceed to the ★INFORMATION OFFICE and pick up the card corresponding to your client ID#.
11. Read the card and determine the service needed.
12. Refer to the SERVICE CLUSTERS Sheet, placed somewhere in the room. Determine the general category for this service and note the acronym (initials) indicated in parentheses for this category.
13. Proceed to the Community Services Desk. READ THE SPECIAL DIRECTIONS AT THIS DESK FIRST. After determining which service cluster you need, this desk links you with the appropriate service. When you find the correct agency/service, follow the directions given on that service cluster page.

VOLUNTEER INSTRUCTIONS

The enclosed GAME DIAGRAM will give you an idea of the game process. These VOLUNTEER INSTRUCTIONS provide you with additional information needed for your role in the game:

ROLE.

You will be given various index cards to distribute to players at appropriate times. Organize these cards on your workspace according to the client's ID #, which is on each card. The number of cards needed for a client varies.

Included in this packet are various CHECK LISTS to monitor your own work. Each CHECK LIST is also identified with the client's ID#. The CHECK LISTS give you specific directions for each client situation. They tell you who gets what, when.

a. All players must tell you their client ID# so that you can turn to the proper CHECK LIST in front of you. The client ID# is in the upper left hand corner of each page. When a player approaches you, ask him what he is looking for. Before you give him a card(s) be sure he presents the other cards he has secured to this point. (See Column A). This will help to identify player progress so you can refer individuals to the game monitor for individual problems. The symbols (★, ●) on the CHECK LISTS indicate at which source (★INFORMATION OFFICE or ●INFORMATION TABLE) a card was secured.

b. The CHECK LIST will indicate what cards should be given a player at one time (See Column B). NOTE: The first card you give any player is the 5x7 card!!

c. Please indicate that the transaction has been completed by penciling the player's initials in one of the columns to the far right on each CHECK LIST. This becomes necessary because more than one person can be playing the same client situation at one time.

Players may ask you about the resources at the Community Services Desk. (See enclosed GAME DIAGRAM). Tell them that the RESOURCE CLUSTERS Sheet is posted somewhere in the room.

TAKE YOUR TIME. You are new on the job. It is the object of the game to cause frustration and bewilderment among the players. Don't be overly friendly with the players. Do your job!! Be strict. Don't allow individuals to cut into line or talk you into extra favors.

CAUTION:

The game's complexity will raise many questions. Players should be referred to the Game Monitor if questions are raised that you are unprepared to answer.

SERVICE CLUSTERS:

HEALTH (H)

H(a)
Therapy
Psychol. Aid
Visiting Nurses
Alcohol/Drug Trmt.
Mental Health

H(b)
Emergency Service
Clinics
Medical

H(c)
Dental
Nutrition

RECREATION (R)

Camping
Recreation

ADVOCACY (A)

Legal Assistance
Protective Services

COMMUNICATION (C)

Braille
Hearing Impaired
Speech Pathology

DIAGNOSTIC (D)

EDUCATION (E)

COUNSELING (Co)

SURVIVAL (S)

Financial Aid
Home Services
Life Skills Training
Meals
Prosthetic Devices
Transportation

VOCATIONAL (V)

Employment
Training

ALT. LIVING (ALt)

Foster Care
Group Home
Nursing Home

REFERRAL (Ref)

Social Services
Testing

VOLUNTEERS (Vo)

Home Services
Grocery Shopping
Visiting the Elderly
Telephone Reassurance
Leisure Skills Dvlpmnt.

RELIGIOUS (Re)

Church/Synagogue

COMMUNITY SERVICE DESK: Instructions

1. All materials here are available to you, but you must follow PROCEDURES. An acronym (initials) is found on the top of each service cluster grouping. (You need to look at the Resource Cluster Sheet, posted in the room, to determine the appropriate acronym for the service cluster your need.)

2. As you proceed to look at the available agencies/services, make sure that your client qualifies by age, county, and type of service.

3. As you look at the various agencies under a particular service cluster, look at the agencies in order. The first agency listed that supplies you with the relevant service is the appropriate one.

4. If you are directed to look at a different service cluster to determine the applicability of a particular agency in that grouping, be sure to return to the service cluster you were originally searching through.

5. Often more than one person needs to look at the agencies/services under the same service cluster. Share the sheet and/or hurry, so the next person can look at it.

6. Don't take anything off this Community Services Desk!!

7. When you finally find the correct agency to meet your service need, follow the directions on the sheet and then proceed.

"Your" Client: HENRY

Henry has lived the last 60 years at Maplewood Regional Center, a state institution. It is no longer relevant to discuss the decisions and procedures that brought Henry to the institution so many years ago. This is his home now. He appears to enjoy the security of the familiar buildings and grounds, and has resisted any efforts to find a more intimate residential setting for him. Henry seems to enjoy the companionship of life-long friends in the institution. Henry attends to his personal needs and assists with simple chores around the institution. Sometimes he attends a craft program. Mostly, he is quietly occupied with his own thoughts and dreams. Although Henry has some trouble hearing, his eyesight is extraordinarily good for a man his age.

Lately, Henry has been complaining about his teeth. Apparently he has been spending some sleepless nights with an aching pain.

AGE: 74

COUNTY OF RESIDENCE: Reagan County

"Your" Client: ROBERT

Robert lived in a state institution for many years, until he returned to the community a few years ago. He lives in a bustling resort community where he works for a natural resources department. With minimal supervision, Bob sands and paints snowmobile trailers, checks the batteries and maintains accurate records of the registration numbers for the vehicles. Robert would like to help out with other work activities if he could. His work hours, 8:30 to 3:30, Monday, Wednesday, and Friday, leave him time to enjoy fishing at a nearby lake.

Bob takes care of his own apartment, shops and prepares his own meals. Bob maintains a close bond with some friends in the Detroit area and spends holidays and vacations with them. He is a contented man, proud of his accomplishments and a respected member of his community.

AGE: 65

COUNTY OF RESIDENCE: Anderson County

"Your" Client: ARLENE

Arlene, 51, lives in the Acosta Group Home. She recalls going to live in an institution, at age 10, where she stayed for 30 years. In the last few years she has been enjoying more and more independence, even though she frequently must use a walker. A few days before we interviewed Arlene, she had injured her foot while on an outing with other residents from the group home. Although temporarily in a wheelchair, Arlene continues her daily activities within the home and at the sheltered workshop. Arlene enjoys music and collects records. Frequently she plays cards and visits with her friends. Arlene attends a local church and has developed a friendship with another member of the congregation. She enjoys writing, reading poetry, and various craft activities. Arlene has a life that includes many activities and interests of her choice. Since Arlene is legally blind in one eye, she can utilize the services of agencies which provide assistance to the visually handicapped.

Her group home has non-profit institutional status

AGE: 51

COUNTY OF RESIDENCE: Carter County

CLIENT: H1 check list ★INFO. OFFICE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1		#H1			
2	#H1 ●CLIENT: H1	★APPLICATION			
3					
4					

CLIENT: H2 check list ★INFO. OFFICE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED:		
			a	b	c
1		#H2			
2	#H2	★CONSULTATION			
3					
4					

CLIENT: H3 check list ★ INFO. OFFICE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1		#H3			
2	#H3	★MEMBERSHIP			
3	#H3 ★MEMBERSHIP	★RESERVATION ★APPLICATION			
4					

CLIENT: R1 check list ★ INFO. OFFICE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1		#R1			
2	#R1	★APPLICATION			
3	#R1 ★APPLICATION ●CLIENT: R1	★RESERVATION			
4					

CLIENT: R2 check list ★INFO. OFFICE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1		#R2			
2*	#R2 ●EMERGENCY !	★EMERGENCY CODE			
3					
4					

*PERSON DOES NOT HAVE TO WAIT IN LINE FOR THIS REQUEST!!!

CLIENT: R3 check list ★ INFO. OFFICE

VISIT NUMBER	COLUMN A. PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1		#R3			
2					
3					
4					

CLIENT: A1 check list ★INFO. OFFICE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1		#A1			
2	#A1	★TESTING			
3	#A1 ★TESTING ●cards: GUARDIANSHIP PAST RESIDENCE SOCIAL SECURITY LONG-TERM CARE BIRTH CERTIFICATE INFO. RELEASE FURTHER DIRECTIONS	★CONSULTATION			
4					

CLIENT: A2 check list ★INFO. OFFICE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1		#A2			
2	#A2	★NON-PROFIT ★MEMO OF UNDERSTANDING ★COMMUNITY			
3	#A2 ★NON PROFIT ★MEMO OF UNDERSTANDING ★COMMUNITY ●CLIENT: A2	★*SIGNATURE*(ON SHEET) ★INTERVIEW			
4					

CLIENT: A3 check list ★INFO. OFFICE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1		#A3			
2	#A3	★PHYSICIAN'S REFERRAL			
3	#A3 ★PHYSICIAN'S REFERRAL ●CLIENT: A3	★NEEDS ASSESSMENT			
4	#A3 ★PHYSICIAN's REFERRAL ●CLIENT: A3 ★NEEDS ASSESSMENT ●TRANSPORTATION	★PHYSICIAN'S ORDERS			
5	#A3 ★PHYSICIAN'S REFERRAL ●CLIENT: A3 ★NEEDS ASSESSMENT ●TRANSPORTATION ★PHYSICIAN'S ORDERS	●VISITING NURSE			

CLIENT: H1 check list ●INFO. ABLE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1	#H1	●CLIENT: H1			
2	#H1 ●CLIENT: H1 ★APPLICATION	●DENTAL			
3					
4					

CLIENT: H2

check list

● INFO. TABLE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1	#H2 ★CONSULTATION	●SERVICE GAP			
2					
3					
4					

CLIENT: H3 check list ● INFO. TABLE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1	#H3 ★MEMBERSHIP ★RESERVATION ★APPLICATION	●RECREATION			
2					
3					
4					

CLIENT: R1 check list ●INFO. TABLE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1	#R1 ★APPLICATION	●CLIENT: R1			
2	#R1 ★APPLICATION ●CLIENT: R1 ★RESERVATION	●SHELTERED EMPLOYMENT			
3					
4					

CLIENT: R2 check list ● INFO. TABLE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1	#R2	●EMERGENCY!			1
2	#R2 ●EMERGENCY! ★EMERGENCY CODE	●EMERGENCY CARE			
3					
4					

CLIENT: R3 check list ● INFO. TABLE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1	#R3	● TELEPHONE REASSURANCE			
2					
3					
4					

CLIENT: A1 check list ● INFO. TABLE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a b c
1	#A1 ★TESTING	●cards: GUARDIANSHIP PAST RESIDENCE SOCIAL SECURITY LONG-TERM CARE BIRTH CERTIFICATE INFO. RELEASE FURTHER DIRECTIONS	
2	#A1 ★TESTING ●cards: GUARDIANSHIP PAST RESIDENCE SOCIAL SECURITY LONG-TERM CARE BIRTH CERTIFICATE INFO. RELEASE FURTHER DIRECTIONS ★CONSULTATION	●GROUP HOME	
3			
4			

CLIENT: A2 check list ● INFO. TABLE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1	#A2 ★NON-PROFIT ★MEMO OF UNDERSTANDING ★COMMUNITY	●CLIENT: A2			
2	#A2 ★NON-PROFIT ★MEMO OF UNDERSTANDING ★COMMUNITY ●CLIENT: A2 ★*SIGNATURE* (ON SHEET) ★INTERVIEW	●VOLUNTEER			
3					
4					

CLIENT: A3 check list ● INFO. TABLE

VISIT NUMBER	COLUMN A PLAYER CHECKS IN WITH YOU:	COLUMN B CARDS PLAYER OBTAINS FROM YOU:	TRANSACTION COMPLETED: a	b	c
1	#A3 ★PHYSICIAN'S REFERRAL	●CLIENT: A3			
2	#A3 ★PHYSICIAN'S REFERRAL ●CLIENT: A3 ★NEEDS ASSESSMENT	●TRANSPORTATION			
3	#A3 ★PHYSICIAN'S REFERRAL ●CLIENT: A3 ★NEEDS ASSESSMENT ●TRANSPORTATION ★PHYSICIAN'S ORDERS	●VISITING NURSE			
4					

CLUSTER: H(a)

Service 1: SEE #3 SERVICE UNDER REFERRAL

CLUSTER: H(b)

Service 1: ANDERSON COUNTY FAMILY AND COMMUNITY MENTAL HEALTH CENTER
85 S. 185 East
Snowton, MI 48621
Phone: 867-2211, Ext. 290

AGE GROUPS SERVED: All Ages COUNTIES SERVED: Anderson

SERVICES OFFERED:

Emergency services (Suicide)
Consultation/Education
Children's services
Alcohol and Drug treatment
Elderly services
Screening & Evalution

STEPS NECESSARY TO OBTAIN SERVICES:

1. Appointment or contact with center.

Service 2: SEE #1 SERVICE UNDER REFERRAL*

* If you are dealing with client ID#R2, go directly to Service # 3 under Hb

Service 3: MAIN GENERAL HOSPITAL
141 West Monroe
Snowton, MI 48621
Phone: 526-4061

AGE GROUPS SERVED: All Ages COUNTIES SERVED: Reagan, Carter, Anderson

SERVICES OFFERED:

General hospital inpatient
Outpatient
Surgical
Orthopedics
Emergency care

STEPS NECESSARY TO OBTAIN SERVICES:

1. Physician's order
2. IN EMERGENCIES, GO DIRECTLY TO THE •INFO. TABLE AND GET THE EMERGENCY CARE CARD.

CLUSTER: H(c)

Service 1: BEFORE PROCEEDING, PICK UP A CLIENT: H1 CARD AT ● INFO. TABLE.

CLUSTER: D

Service 1: TRI-COUNTY FAMILY LIFE SERVICES

CARTER COUNTY	ANDERSON COUNTY	REAGAN COUNTY
1329 Holcomb Road	52641 Apple Lane	54338 Alexandra
Baxter City, MI 48414	Snowton, MI 48621	Minolta, MI 48444
Phone: 266-1291	Phone: 876-1122	Phone: 182-668

COUNTIES/AGE GROUPS SERVED:

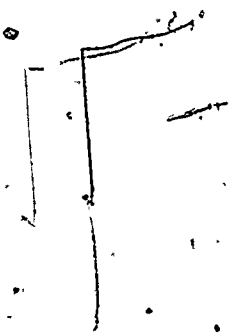
Carter County	50 years and older
Anderson County	all ages
Reagan County	65 and older

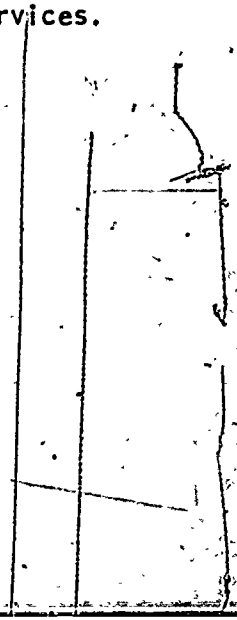
SERVICES OFFERED:

Diagnostic
Counseling
Recreation (for youth 16-24 only)
Transportation (within Anderson County only)
Sheltered Employment
Meals on Wheels

STEPS NECESSARY TO OBTAIN SERVICES:

1. Application must be obtained at the ★Info. Office.(not for transport.)
2. For transportation, reservations must be made three days in advance (go to ★Info. Office for Reservation).
3. Clients must be present for counseling and diagnostic services.





CLUSTER: S

Service 1: SEE #1 SERVICE UNDER DIAGNOSTIC

Service 2: SEE #4 SERVICE UNDER REFERRAL (Important - If working with Client #H3, go directly to Service #3 on this page.)

Service 3: SOUTHEASTERN MICHIGAN COMMUNITY ACTION PROGRAM

18261 Angel Street
Mayfair, MI 48226
Phone: 867-9932

1900 Trip Street
Baxter City, MI 48414
Phone: 266-9989

AGE GROUPS SERVED: All Ages

COUNTIES SERVED: Reagan, Carter

SERVICES OFFERED:
Transportation (available only in Carter County)*
Emergency Financial Aid
Referral to other services

STEPS NECESSARY TO OBTAIN SERVICES:
1. Fill out application form (pick it up at ★Info. Office)
2. If client is being transported to the Skyview Senior Center for recreation, then a Reservation must be obtained at the ★Info. Office.

*If recreation is being provided by Skyview Senior Center, then transportation will be provided in Reagan County. If dental or medical services are needed in Carter or Reagan County, then transportation is supplied.

CLUSTER: V

Service 1: SEE #1 SERVICE UNDER DIAGNOSTIC

CLUSTER: Vo

Service 1: SEE #1 SERVICE UNDER RELIGIOUS (Important- if working with Client #A2, go directly to Service #2 on this page.)

Service 2: RETIRED SENIOR VOLUNTEER PROGRAM
455 N. University
Townline, MI 48601
CARTER COUNTY
Phone: 373-5151

AGE GROUPS SERVED: All Ages COUNTIES SERVED: Carter

SERVICES OFFERED:
Institution or Group Home
(help with requested specific services in the group home or institution)
Telephone Reassurance
No Transportation Services

STEPS NECESSARY TO OBTAIN SERVICES:
1. Must be a non-profit institution or setting.
(get a card stating Non-Profit Institution from the ★Info. Office).
2. Memorandum of Understanding must be signed
(go to ★Info. Office and pick it up).
3. Assignment should meet community needs
(go to ★Info. Office and get Community card).

Service 3: INFORMAL VOLUNTEER ARRANGEMENT (Just one neighbor helping another)

Gladys Smith told a friend of Robert's (the client) that she wished she could have someone do her grocery shopping for her. Her leg had gotten so bad from arthritis, it was a real chore. She really hated to give up this weekly grocery trip because it gave her a chance to visit other people in the community. All she could do now is have visitors in or call others on the phone.

Robert's friend suggested that Gladys call Robert to see if he'd like to do the shopping, since Robert was looking for different jobs to do.

While Robert and Gladys were talking, Robert told her of his wish for a telephone call. Gladys said she would be so happy to call Robert daily! (Go to the ●Info. Table and pick up a Telephone Reassurance card.)

CLUSTER: R

Service 1: SEE #4 SERVICE UNDER REFERRAL

Service 2: SEE #1 SERVICE UNDER DIAGNOSTIC

Service 3: SKYVIEW SENIOR CITIZEN CENTER
5400 Alenxandra
Minolta, MI 48444
REAGAN COUNTY
Phone: Director: 123-4567
Center: 891-0112

AGE GROUPS SERVED: 55 and older COUNTIES SERVED: Reagan

SERVICES OFFERED:

Recreation	Meals on Wheels
Referral	Medical
Day Care	

STEPS NECESSARY TO OBTAIN SERVICE:
1. Membership card required (pick it up from the ★Info. Office)

CLUSTER: Re

Service 1: TEMPLE ISRAEL, Rabbi Allen D. Arby
91116 Block Road
Townline, MI 48601
CARTER COUNTY
Phone: Synagogue Office: 952-0651
Rabbi's Study: 966-2111

AGE GROUPS SERVED: All Ages

COUNTIES SERVED: Everyone invited

SERVICES OFFERED:
Religious Services
Youth Programs
Visit to Nursing Homes

STEPS NECESSARY TO OBTAIN SERVICES:
1. If any of the Temple's activities are appropriate for you, please set up a conference with the Rabbi (get Consultation card from the ★Info. Office.)

CLUSTER: AL

Service 1: ANDERSON COUNTY ASSOCIATION FOR RETARDED CITIZENS
225 S. 700 East
Snowton, MI 48621
Phone: 673-6118

AGE GROUPS SERVED: All Ages COUNTIES SERVED: Anderson, Reagan

SERVICES OFFERED:

Group Home	Educational
Diagnostic	Legal Assistance
Recreation	Transportation

STEPS NECESSARY TO OBTAIN SERVICES:
1. Eligibility forms for all are needed.
2. For group home placement, complete basic application.

Service 2: SEE #2 SERVICE UNDER REFERRAL

Service 3: MAXWELL VALLEY CARE CENTER
394 W. 400 North
Mayfair, MI 48226
Phone: 225-9292

AGE GROUPS SERVED: All Ages GEOGRAPHICAL AREA SERVED: Anderson
Carter
Reagan

SERVICES OFFERED:

Nursing Home	Occupational Therapy
Medical	Group Home
Physical Therapy	Dental
Referral	

STEPS NECESSARY TO OBTAIN SERVICES:

1. Testing must be completed before any services are secured. (See ★Info. Office for the Testing card)

Service 1: MENTAL HEALTH DEPARTMENT
350 Healy
Snowton, MI 48621
Phone: 339-8391

AGE GROUPS SERVED: All Ages

COUNTIES SERVED: Anderson County

SERVICES OFFERED:

Information and Referral
Buses to special Events (for the handicapped)
Centralized Referral for Persons needing Emergency Food

STEPS NECESSARY TO OBTAIN SERVICES:

1. Telephone call

Service 2: DEPARTMENT OF SOCIAL SERVICES
District 7B
27 S. First
Minolta, MI 48444
Phone: 678-2247

AGE GROUPS SERVED: All Ages

COUNTIES SERVED: Reagan County

SERVICES OFFERED:

Information and Referral
Employment
Financial Aid
Protective Services
Nutrition Services --Senior Citizens
Foster Care
Day Care
Group Home
Education Counseling

STEPS NECESSARY TO OBTAIN SERVICES:

1. Fill out application form if not on public assistance.
2. If applying to group home, form must be filled out.

Service 3: HOME HEALTH AGENCIES (HHA)

IRON COUNTY HOME HEALTH AGENCY
595 S. 75 Easy Street
Townline, MI 8060
CARTER COUNTY

HOME HEALTH SERVICE
City County Health Dept.
106 E. 100 South
Minolta, MI 48444
REAGAN COUNTY

BEAR RIVER (HHA)
160 N. Main Str.
Snowton, MI 48621
ANDERSON COUNTY

AGE GROUPS SERVED: All Ages

COUNTIES SERVED: Surrounding area of each agency

SERVICES OFFERED:

Referral
Visiting Nurse
Medical

STEPS NECESSARY TO OBTAIN SERVICE:

1. Physician Referral (go to ★Info. Office and pick up Physician Referral card)

Service 4: SERVICES FOR THE VISUALLY HANDICAPPED (A Unified-Way Agency)
82110 Marriot Street
Mayfair, MI 40226

AGE GROUPS SERVED: 16 and older

COUNTIES SERVED: Reagan, Carter, Anderson

SERVICES OFFERED:

Referral
Counseling
Sound Recording Books
Recreation
Transportation

STEPS NECESSARY TO OBTAIN SERVICES:

1. All assessment of visual limitations must be made by a physician.
(go to ★Info. Office for Needs Assessment card)

CARD 1:

#H1

HENRY'S TEETH ARE BOTHERING HIM MORE NOW. COULD YOU SECURE A DENTAL APPOINTMENT FOR HIM?

Copy(above) on a 5x7 index card

Copy (below) on 3x5 index cards

	SIDE 1	SIDE 2
CARD 2:	H1 ●CLIENT: H1	Henry can't get a dentist appointment because the institution can't release a car to take him there on that day. An alternative form of community transportation must be found.
CARD 3:	H1 ★APPLICATION	You have now gotten transportation for your client. Congratulations! Go and pick up a Dental card from ● Info. Table.
CARD 4:	H1 ●DENTAL	Henry feels so much better after he had a root canal. Thanks for your help. Check in with the Game Monitor.

CARD 1:

#H2

HENRY FEELS HE COULD STEP OUT INTO THE COMMUNITY ONCE A WEEK AND VISIT SOME SHUT-INS IN A NURSING HOME. COULD YOU ARRANGE THIS FOR HIM?

Copy(above) on a 5x7 index card ⬆

Copy (below) on 3x5 index cards ⬇

	SIDE 1	SIDE 2
CARD 2:	H2 ★CONSULTATION	RABBI TELLS YOU: We, at the synagogue, would graciously invite your client to help us with our mission to the old folks home. In fact, we need many more people to visit there. But we can't supply transportation to the home. If you could arrange this, Henry's volunteering contribution would be greatly appreciated.
CARD 3:	H2 ●SERVICE GAP	SORRY.- There are many people in the community who desperately need transportation to get around. Often a transportation problem prohibits someone from helping others with their problems and concerns, as Henry wished to do by visiting a nursing home. Please check in with the Game Monitor.

CARD 1:

#H3

HENRY IS NOT INTERESTED IN GETTING OUT OF THE INSTITUTION BECAUSE IT HAS BEEN HIS HOME MOST OF HIS LIFE. BUT HE WOULD LIKE TO ATTEND VARIOUS RECREATIONAL ACTIVITIES IN WHICH OLDER PEOPLE IN HIS COMMUNITY PARTICIPATE. CAN YOU ASSIST HIM?

Copy (above) on a 5x7 index card

Copy (below) on 3x5 index cards

	SIDE 1	SIDE 2
CARD 2:	H3 ★MEMBERSHIP	Henry can attend these recreational activities, but he doesn't have transportation to get there. Try and arrange this. He can attend Skyview Senior Center for these activities.
CARD 3:	H3 ★RESERVATION	Henry can now attend the recreational activities with other seniors his age. He has gotten transportation. To to the ●Info. Table and get a Recreation card.
CARD 4:	H3 ★APPLICATION	
CARD 5:	H3 ●RECREATION	Henry is enjoying these recreational activities Thanks for your help. Check in with the Game Monitor.

CARD 1:

#R1

ROBERT WOULD LIKE TO SPEND A FEW HOURS A WEEK ON ANOTHER JOB. THERE ARE SOME WORKSHOPS AROUND THAT HE BELIEVES WOULD BE APPROPRIATE FOR HIM. PLEASE MAKE ARRANGEMENTS.

Copy (above) on a 5x7 index card

Copy (below) on 3x5 index cards

	SIDE 1	SIDE 2
CARD 2:	R1 ★APPLICATION	The application is almost completed. But the client must be present to sign it. Go to the •Info. Table and get the CLIENT: R1 card.
CARD 3:	R1 ●CLIENT: R1	Robert has signed the workshop application. But transportation was not considered for him. See what you can do.
CARD 4:	R1 ★RESERVATION	Robert has gotten transportation so he can go to the sheltered workshop. Pick up the Sheltered Employment card at the •Info. Table.
CARD 5:	R1 ●SHELTERED EMPLOYMENT	Robert loves his job. Because of your perseverance he can fill some of his time during the day. Sometimes a job can be important to an older person, even though s/he is past retirement age. Check in with the Game Monitor.

CARD 1:

#R2

WHILE WASHING DISHES, ROBERT SLIPPED AND FELL. IT APPEARS AS THOUGH HE HAS BROKEN SOMETHING. THIS IS DEFINITELY AN EMERGENCY SITUATION. GO DIRECTLY TO THE ● INFO. TABLE AND PICK UP THE EMERGENCY CARD. YOU DO NOT HAVE TO WAIT IN LINE.

Copy (above) on a 5x7 index card

Copy (below) on 3x5 index cards

	SIDE 1	SIDE 2
CARD 2:	R2 ●EMERGENCY!	Proceed directly to the ★Info. Office and get the Emergency Code card. You do not have to wait in line! This card entities you to talk to the receptionist directly.
CARD 3:	R2 ★EMERGENCY CODE	Go directly to the appropriate service cluster for emergency services, located at the Community Services Desk, under cluster Hb.
CARD 4:	R2 ●EMERGENCY CARE	Robert did sprain his wrist, but it is now healing. Check in with the Game Monitor.

CARD 1:

#R3

ROBERT WOULD VERY MUCH LIKE TO TALK TO SOMEONE ON THE PHONE. ALTHOUGH HE HAS MANY FRIENDS IN THE COMMUNITY, HE WOULD LIKE THE REASSURANCE FROM SOMEONE WHO CHECKS ON HIM EVERYDAY, JUST TO SAY "HI". CAN YOU GET SOMEONE TO DO THIS?

Copy (above) on a 5 x 7 index card

Copy (below) on 3 x 5 index cards

SIDE 1	SIDE 2
CARD 2: R3 TELEPHONE REASSURANCE	Robert and Gladys are very happy with their mutual helping situation. Check in with the Game Monitor.

CARD 1:

#A1

ARLENE AND ANOTHER CLIENT, ADA, HAVE DECIDED THEY WOULD LIKE TO LIVE TOGETHER IN ANOTHER GROUP HOME. COULD YOU HELP THEM LOOK INTO THE POSSIBILITIES?

Copy (above) on a 5x7 index card ⬆

Copy (below) on 3x5 index cards ⬇

	SIDE 1	SIDE 2
CARD 2:	A1 ★TESTING	Please go to the ●Info. Table and secure the following cards. Testing cannot be completed until you do. a. Birth Certificate d. Past Residence g. Further Directions b. Guardianship e. Long-Term Care c. Information Release f. Social Security
CARD 3:	A1 ●BIRTH CERTIFICATE	
CARD 4:	A1 ●GUARDIANSHIP	
CARD 5:	A1 ●INFO: RELEASE	
CARD 6:	A1 ●PAST RESIDENCE	
CARD 7:	A1 ●SOCIAL SECURITY	
CARD 8:	A1 ●LONG-TERM CARE	
CARD 9:	A1 ●FURTHER DIRECTIONS	After all these documents are collected, return to the ★Info. Office and get a Consultation card.
CARD 10:	A1 ★CONSULTATION	The group home director, Arlene, and yourself, had a meeting to determine if this was the correct placement. It was! Arlene and her friend can now live together in another group home. Pick up Group Home card from ●Info. Table.
CARD 11:	A1 ●GROUP HOME	Arlene is happy with her new roommate and her new living situation. Check in with Game Monitor.

CARD 1 :

#A2

ARLENE HAS-A SEWING MACHING. BUT THERE IS NO ONE AVAILABLE TO HELP HER LEARN HOW TO USE IT. COULD YOU GET A VOLUNTEER TO HELP HER?

Copy(above) on a 5x7 index card

Copy (below) on 3x5 index cards

	SIDE 1	SIDE 2
CARD 2:	A2 ★NON PROFIT	
CARD 3:	A2 ★MEMO OF UNDERSTANDING	Before signing the separate sheet, you must pick up card card CLIENT: A2 at the ●Info. Table.
CARD 4:	A2 ★COMMUNITY	
CARD 5:	A2 ●CLIENT: A2	You have gotten transportation for Arlene to visit the Volunteer. Now you can sign the separate Signature sheet at the ★Info. Office and pick up the Interview card at the ★Info. Office.
CARD 6:	A2 ★*SIGNATURE* NOTE: this title(above) could be placed on a blank sheet of paper instead of an index card. Then the players will sign the paper.	
CARD 7:	A2 ★INTERVIEW	Now that Arlene's interview is over, you may go to the ●Info. Table and get a Volunteer card.
CARD 8:	A2 ●VOLUNTEER	Congratulations! You have gotten a volunteer for Arlene. Now check in with the Game Monitor.

CARD 1:

#A3

SINCE ARLENE'S ANKLE HAS BEEN FRACTURED, SHE HAS BEEN CONCERNED ABOUT IT HEALING CORRECTLY. SHE KNOWS THAT A VISITING NURSE COULD BE MADE AVAILABLE TO HER, BUT SHE DOESN'T KNOW HOW TO GET ONE. PLEASE SEE WHAT YOU CAN DO.

Copy (above) on a 5x7 index card

Copy (below) on 3x5 index cards

	SIDE 1	SIDE 2
CARD 2:	A3 ★PHYSICIAN'S REFERRAL	The doctor's secretary states that Arlene must come for a complete physical before a recommendation for a visiting nurse can be made. Go to the •Info. Table and get Arlene's CLIENT: A3 card.
CARD 3:	A3 ●CLIENT: A3	Arlene can't make it to the physical without transportation. This problem must be solved first.
CARD 4:	A3 ★NEEDS ASSESSMENT	Arlene's visual disability has now been "documented" because this assessment was completed by you. She is now eligible to receive transportation services. Please pick up a Transportation card at the •Info. Table.
CARD 5:	A3 ●TRANSPORTATION	Arlene has gone to the doctor and is waiting for the doctor's recommendation so that a visiting nurse can be gotten for her. Please pick up the Physician's Orders card at the ★Info. Office.
CARD 6:	A3 ★PHYSICIAN'S ORDERS	Arlene has been authorized to receive a visiting nurse. Proceed to the •Info. Table and pick up the Visiting Nurse card.
CARD 7:	A3 ●VISITING NURSE	Congratulations! The community has been linked with the needs of your client. You have completed your task. Check in with the Game Monitor.

PROCESS

CLIENT: H1

1. The player obtains #H1 card at the ★Info. Office.	2. Client needs dental services; player finds, on the posted SERVICE CLUSTER sheet, that dental is grouped under the service cluster, Health, labeled Hc.	3. Player returns to the Community Services Desk and looks at the first service under Hc. Player is instructed to proceed to the ● Info. Table and pick up the CLIENT: H1 card.	4. At the ● Info. Table the CLIENT: H1 card, informs the player that transportation must be obtained first.
5. Player must get the acronym for service cluster transportation is grouped under at posted SERVICE CLUSTER sheet. It is the Survival cluster, S.	6. At the Community Services Desk, player finds that the first S refers him to the first service under the Diagnostic service cluster.	7. Returning to the posted SERVICE CLUSTER sheet, player finds the acronym for Diagnostic is D.	8. Back at the Community Services Desk, player finds first service under D does not provide the service because transportation is provided in Anderson County only; client #H1 lives in Reagan County.
9. PLAYER RETURNS TO THE ORIGINAL SERVICE CLUSTER, S, and looks at the second service there. Once again, player is referred to another service cluster. It is the fourth service under Referral.	10. Player returns to the posted SERVICE CLUSTER sheet and finds the Referral service cluster is labeled ReF.	11. Returning to the Community Services Desk, the fourth service under ReF is not appropriate because client #H1 does not have a visual limitation.	12. PLAYER RETURNS TO THE DRIGINAL SERVICE CLUSTER sheet, S, and looks at the third service there. Player finds transportation can be provided because client #H1 is going to a dental appointment.
To get transportation, an Application form must be picked up at the ★Info. Office.	The Application form indicates that dental services can now be gotten. Pick up Dental card from the ● Info. Table.		

THE FOLLOWING CARDS MUST BE OBTAINED BY THE END OF THE GAME:

1. #H1
2. CLIENT: H1
3. APPLICATION
4. DENTAL

PROCESS

CLIENT: H2

1. The player obtains a #H2 card from the ★Info. Office.	2. Client wants to be a volunteer; player finds, on posted SERVICE CLUSTER sheet that volunteers fall under the service cluster, Volunteers. Acronym needed is Vo.	3. Player returns to Community Services Desk and looks at the first service under Vo. It refers player to the first service under Religious service cluster.	4. Returning to the posted SERVICE CLUSTER sheet, player finds the acronym for Religious service cluster is Re.
5. Back at the Community Services Desk, player looks at first service under Re. This service is appropriate because a service to shutins is provided.	6. Player is instructed to get a Consultation card for the ★Info. Office.	7. At the ★Info. Office, the Consultation card indicates the need to secure transportation.	8. Player goes to the posted SERVICE CLUSTER sheet and finds transportation falls under the Survival service Cluster. It's acronym is S.
9. At the Community Services Desk, the first service under S refers player to first service under Diagnostic.	10. Player returns to the posted SERVICE CLUSTER sheet and finds the Diagnostic service cluster is labeled D.	11. Returning to the Community Services Desk, the first service under D is not appropriate because transportation is provided in Anderson County, and client #H2 lives in Reagan County.	12. PLAYER RETURNS TO THE SERVICE CLUSTER, S, and looks at the second service under S. Once again, player must go to another service cluster, Referral, and look at the fourth service listed there.
13. Player returns to the posted SERVICE CLUSTER sheet and finds the Referral service cluster is labeled, ReF.	14. Returning to the Community Services Desk, the fourth service under ReF is not appropriate because client does not have a visual limitation.	15. PLAYER RETURNS TO THE ORIGINAL SERVICE CLUSTER, S, and is to look under the third service there. This service is not appropriate because the client, #H2, lives in Reagan County. Transportation is provided in Carter County only.	16. Player now doesn't know where to go! All S services are used up. Player will eventually go to the game monitor for further directions.
17. The game monitor should refer the player to the ●Info. Table for further instructions.	18. At the ●Info. Table the player is given a Service Gap card because no services are provided for this need.		

THE FOLLOWING CARDS MUST BE SECURED BY THE END OF THE GAME:

1. #H2 2. CONSULTATION 3. SERVICE GAP

CLIENT: H3

PROCESS

1. The player obtains a #H3 card at the ★Info. Office.	2. Client needs recreational activities; player finds, on the posted SERVICE CLUSTER sheet, that recreational needs fall under the service cluster, Recreation, labeled R.	3. Player returns to the Community Services Desk and looks at the first service under R. Player is referred to the fourth service under Referral.	4. Returning to the posted SERVICE CLUSTER sheet, player finds the service cluster Referral, is labeled ReF.
5. Back to the Community Services Desk, player finds that the fourth service listed there is inappropriate because client #H3 does not have a visual limitation.	6. PLAYER RETURNS TO THE ORIGINAL SERVICE CLUSTER, R, and looks at the second service listed there. Player is again referred to another service cluster. It is to the first service under the Diagnostic service cluster.	7. Returning to the posted SERVICE CLUSTER Sheet, player finds that Diagnostic is labeled D.	8. Back at the Community Services Desk, player looks at the first service under D. It is not appropriate because recreational activities are supplied for youth only.
9. PLAYER AGAIN RETURNS TO THE ORIGINAL SERVICE CLUSTER, R. Under the third service, player finds service is appropriate!	10. Player is referred to the ★Info. Office to get a Membership card.	11. On the Membership card, player is informed that transportation has to be supplied before the client can take part in recreation.	12. Returning to the posted SERVICE CLUSTER sheet, player must get the acronym for the service cluster transportation is grouped under. It is the Survival cluster, labeled S.
13. At the Community Services Desk, player looks at the first service under S. It refers the player to the first service under Diagnostic.	14. Back at the posted SERVICE CLUSTER sheet, player finds the acronym for Diagnostic is D. (Player should have this info. already because Diagnostic services have been referred to before.)	15. At the Community Services Desk, the first service under D does not work because transportation is supplied in Anderson County only. Client #H3 lives in Reagan County.	16. PLAYER RETURNS AGAIN TO THE ORIGINAL SERVICE CLUSTER, S, and looks at the second service. Player is immediately referred to the third service under S.
17. The third service under S is appropriate since client #H3 is being transported to the Skyview Senior Citizen Center. Player is instructed to get an Application card and a Reservation form from the ★Info. Office.	18. Player is instructed to pick up a Recreation card at the ●Info. Table.		

THE FOLLOWING CARDS MUST BE SECURED BY THE END OF THE GAME:

1. #H3
2. MEMBERSHIP
3. RESERVATION
4. APPLICATION
5. RECREATION

CLIENT: R1

PROCESS

1. Player obtains #RI card at the ★Info. Office.	2. Client needs a sheltered workshop; player finds on the posted SERVICE CLUSTER sheet, that sheltered workshops fall under the Vocational service cluster, V.	3. At the Community Services Desk, player looks at the first service under V. Player is referred to the first service under the Diagnostic service cluster.	4. Returning to the posted SERVICE CLUSTER sheet, player finds that Diagnostic is labeled D.
5. Returning to the Community Services Desk, player looks at the first service under D. The client is eligible for this service. An Application form must be secured at the ★Info. Office.	6. The Application card directs the player to the ●Info. Table to pick up an CLIENT: RI card.	7. The CLIENT: RI card states that the player must get transportation for the client first.	8. At the posted SERVICE CLUSTER sheet, the player finds that transportation falls under the Survival service cluster, S.
9. Returning to the Community Services Desk, player looks at the first service under S. Player is referred to the first service under Diagnostic service cluster.	10. Back at the posted SERVICE CLUSTER sheet, player finds Diagnostic labeled D. (Player should have this info. already because Diagnostic services have been referred to before.)	11. Returning to the Community Services Desk, player looks at the first service under D. Client is eligible for transportation. A Reservation form from the ★Info. Office is needed.	12. The Reservation card informs the player to secure a Sheltered Employment card from the ●Info. Table.

THE FOLLOWING CARDS MUST BE SECURED BY THE END OF THE GAME:

1. #RI
2. APPLICATION
3. CLIENT: RI
4. RESERVATION
5. SHELTERED EMPLOYMENT

PROCESS

CLIENT: R2

1. The player obtains a client card, #R2, at the ★Info. Office.	2. The player is directed to go to the ●Info. Table to get an Emergency card. The card gives the player the right to go directly to the front of the line at the ★Info. Office to obtain the Emergency Code card.	3. Player can proceed directly to the Community Services Desk, because the Emergency Code card supplied the acronym needed to the correct service cluster, Hb. (Health)	4. Looking at the first service under Hb, service is inappropriate because suicide is the only problem considered under emergency care.
5. Player then looks at the second service under Hb. Client #R2 is referred directly to the third service under Hb. This service is appropriate.	6. Player is referred to the ●Info. Table for an Emergency Care card.		

THE FOLLOWING CARDS MUST BE SECURED BY THE END OF THE GAME:

1. #R2
2. EMERGENCY!
3. EMERGENCY CODE
4. EMERGENCY CARE

CLIENT: R3

PROCESS

1. Player obtains #R3 card at the ★Info. Office.	2. Client needs telephone reassurance; player finds, on posted SERVICE CLUSTER sheet, that telephone reassurance falls under the service cluster Volunteers, labeled Vo.	3. At the Community Services Desk, player finds that the first service under Vo refers the player to the first service under the Religious service cluster.	4. Returning to the posted SERVICE CLUSTER sheet, player finds that the Religious service cluster is labeled Re.
5. Back at the Community Services Desk, the first service under Re is inapplicable since telephone reassurance is not provided.	6. PLAYER RETURNS TO THE ORIGINAL CLUSTER, Vo, and looks at the second service provided. Client is ineligible because services are provided in Carter County only; client #R3 lives in Anderson County.	7. Player looks at the third service under Vo. It is appropriate because the informal volunteer arrangement has worked out. Player is directed to pick up a Telephone Reassurance card at the ●Info. Table.	

THE FOLLOWING CARDS MUST BE SECURED BY THE END OF THE GAME:

1. #R3
2. TELEPHONE REASSURANCE

PROCESS

CLIENT: A1

1. Player obtains #A1 card at the ★Info. Office.	2. Client needs alternative living arrangement; player finds, on the posted SERVICE CLUSTER sheet, that alternative living is grouped under the service cluster, AL.	3. Going to the Community Services Desk, player looks at the first service under AL. It is inappropriate because client #A1 lives in Carter County. Services are provided in Anderson and Reagan counties only.	4. Player looks at second service under AL. Player is referred to the second service under Referral service cluster.
5. Returning to the posted SERVICE CLUSTER sheet, player finds the Referral service cluster is labeled ReF.	6. Back at the Community Services Desk, player looks at the second service under ReF. Again, client #A1 is inappropriate because she lives in an ineligible county.	7. PLAYER RETURNS TO THE ORIGINAL SERVICE CLUSTER, AL, and looks at the third service there. It is appropriate. A Testing card must be secured at the ★Info. Office.	8. The Testing card directs the player to get many more cards at the ●Info. Table. They are: Birth Certificate; Long Term Care; Info. Release; Soc. Sec; Past Residence; Guardianship; Further Directions.
9. The Further Directions card directs the player to return to the ★Info. Office for a Consultation card.	10. The Consultation card refers the players to the ●Info. Table for a Group Home card.		

THE FOLLOWING CARDS MUST BE SECURED BY THE END OF THE GAME:

1. #A1
2. TESTING
3. GUARDIANSHIP
4. PAST RESIDENCE
5. SOCIAL SECURITY
6. INFORMATION RELEASE
7. LONG TERM CARE
8. BIRTH CERTIFICATE
9. FURTHER DIRECTIONS
10. CONSULTATION
11. GROUP HOME

CLIENT: A2.

PROCESS

1. Player obtains a #A2 card from the ★Info. Office.	2. Client needs volunteer; player finds, on the posted SERVICE CLUSTER sheet, that volunteers for leisure skill development are grouped under Volunteers, labeled Vo.	3. At the Community Services Desk, the first service under Vo. refers Client #A2 to the second service on the page	4. Player looks at the second service under Vo. Client is eligible for this service. Player is requested to pick up Non-Profit card, Memo of Understanding and Community card from the ★Info. Office.
5. The Memo of Understanding informs the player that a CLIENT: A2 card must be picked up at the ●Info. Table before the Memo of Understanding can be signed.	6. The CLIENT: A2 card indicates that transportation has been obtained. The player is directed to return to the ★ Info. Office and sign a separate sheet to attach to the Memo of Understanding card. Also the player is to secure an Interview card at the ★Info. Office.	7. Player is instructed on the Interview card to go to the ●Info. Table and get the Volunteer card.	

THE FOLLOWING CARDS MUST BE SECURED BY THE END OF THE GAME:

1. #A2
2. NON-PROFIT
3. MEMO OF UNDERSTANDING
4. COMMUNITY
5. CLIENT: A2
6. SIGNATURE
7. INTERVIEW
8. VOLUNTEER

CLIENT: A3

PROCESS

1. Player obtains a #A3 card at the ★Info. Office.	2. Client needs a visiting nurse; player finds, on the posted SERVICE CLUSTER sheet, that visiting nurses fall under the service cluster, Health, labeled Ha.	3. At the Community Services Desk, the player looks at the first service under Ha. Player is referred to the third service under the service cluster, Referral.	4. At the posted SERVICE CLUSTER sheet, player finds that Referral is labeled ReF.
5. Returning to the Community Services Desk, the third service under ReF is appropriate for client #A3. Player is directed to obtain a Physician's Referral card at the ★Info. Office.	6. Physician's Referral card requests player to obtain a CLIENT: A3 card at the ●Info Table. Player is informed that transportation must be gotten before the physical is completed.	7. Returning to the posted SERVICE CLUSTER sheet, player finds that transportation falls under service cluster Survival, labeled S.	8. Back at the Community Services Desk, player looks at the first service under S. Player is referred to the first service under the service cluster, Diagnostic.
9. Returning to the posted SERVICE CLUSTER sheet, player finds the Diagnostic service cluster is labeled D.	10. At the Community Services Desk, the first service under D does not apply because transportation is supplied within Anderson County only. Client #A3 lives in Carter County.	11. PLAYER RETURNS TO THE ORIGINAL SERVICE CLUSTER, S. Player is referred to the fourth service under Referral.	12. Returning to the posted SERVICE CLUSTER sheet, player finds that the Referral service cluster is labeled ReF. (Player should have this info. already because Referral services have been referred to before.)
13. At the Community Services Desk, player looks at the fourth service under ReF. Client is eligible for this service because services are for the visually handicapped. Client #A3 has poor vision.	14. Player is directed to go to the ★Info. Office to get a Needs Assessment card. This card directs the player to go to the ●Info. Table to pick up a Transportation card.	15. The Transportation card informs the player that a Physician's Orders card must be obtained at the ★Info. Office.	16. The Physician's Orders card refers the player to the ●Info. Table to get the Visiting Nurse card.

THE FOLLOWING CARDS MUST BE SECURED BY THE END OF THE GAME:

1. #A3
2. PHYSICIAN'S REFERRAL
3. CLIENT: A3
4. NEEDS ASSESSMENT
5. TRANSPORTATION
6. PHYSICIAN'S ORDER
7. VISITING NURSE

SESSION IX

INDIVIDUAL PROBLEM SOLVING

1. PARTICIPANT PREPARATION
   - Small Group: "Preparing" the experts

2. "PANEL OF EXPERTS"
   - Role Play: 1. Discuss immediate problems and concerns
     2. Allow participants to evaluate the experts' "performance"

3. TRAINEE PROBLEM SOLVING
   - Triad: Individual problem solving
   - Large Group: Comments on problem solving approaches

SESSION IX

PURPOSES

1. Focus on problems involving the caregiver and AADD client.
2. Develop problem solving strategies around identified situations.
3. Develop awareness of problem solving approaches as integral to ongoing AADD client-caregiver interaction.

PROCEDURES

During Session VI (MP 79), participants were asked to submit brief descriptions of actual problems confronting them in their work with the AADD. These descriptions provide materials for this session. Problems should be replicated for each trainee. Following are examples of problems that were submitted to the authors when they conducted this session.

Problem I: One of our clients, Mitch, age 81, suffers from congestive heart failure. In the past eight months, he has suffered two major strokes and minor cerebral spasms. His doctor has recommended a low-cal, no salt, low carbohydrate diet. Mitch has been quite cooperative, but occasionally, when under stress, resorts to stealing food. He says sometimes he would rather just eat normally and risk another, (perhaps fatal) heart attack. Does he have the right to kill himself?

Problem II: I have a client who has to lose weight for health reasons. She is pretty consistent with doing exercises every night but has problems staying on a diet. The menus are set up so that everyone can have the same thing. We try to keep her busy with leisure activities -- keeping her mind off food! She continues to sneak food.

I. PARTICIPATION PREPARATION

(20 minutes)

Distribute SP 62.

Two trainees are chosen as "experts." Each "expert" is asked to discuss with the trainer, in front of the entire group, one of two pre-selected problems. As a way of preparing the "experts", each "expert" is asked to chair one of two groups made up of the remaining trainees. The groups' members are asked to provide the "expert" with consultation around the problem. As a result of this input from a group of peers, the two "experts" are prepared to join the trainer in two dialogues in front of all the participants.

2. "PANEL OF EXPERTS"

(1 hour)

The two groups gather, and each problem is discussed by the trainer and "expert" in front of the large group. During and after each discussion, the participants should question, clarify, challenge, support, and otherwise provide feedback as to the problem solving strategies of the "Panel of Experts." The trainee who originally submitted the problem will receive advice and counsel from all participants, as well as the "Panel of Experts." More importantly, participants will begin to perceive the significance of obtaining different points of view, leading to individualized solutions.

The trainer should point out that no book will ever be written telling us "everything we ever wanted to know" about the AADD person. Although each AADD individual is unique, the processes of change that occur with age are universal. Physical decline will occur in a predictable way, although the rate of decline is individualized. It is the caregiver's responsibility to help the AADD client maintain his existing health, and to manage his declining abilities as well as possible. Caregivers as well as AADD clients face the inevitable and universal process of aging and dying and must do so within the context of living life to its fullest. Problem solving must reflect a spirit of constant optimism.

When discussing problems pertaining to behaviors, it may be helpful to know the difference between limits and rules. Limits are imposed on everyone, disabled or not, and should be considered before any action is taken.

1. Is the person hurting himself and/or others?
2. Is the person damaging property?
3. Is an individual being forced into acts against his/her will?

Rules, however, are negotiated, and should be determined by the individual's abilities for growth, and need for personal guidance in specific situations. Rules are cautionary, reflecting the conditional nature of individual behavior. Therefore, rules established for the good of the organization, will be of little use, unless they can be justified in relation to the individual's further development. It is better to have FEW RULES imposed on an individual because each rule must be monitored, rewarded and disciplined in order to be growth producing.

In order to check the validity of a rule, ask these questions.

1. Does this rule teach something to the AADD person?
2. Are you always "coming down" on the AADD individual? (This behavior often leads to ongoing frustration for the person, if not blatant abuse.)
3. Does the rule place the AADD person in unequal (-) roles, fostering continued dependency?

3. TRAINEE PROBLEM SOLVING

(1 hour, 10 minutes)

Triad:

Groups of three trainees should be given two problem situations (again avoid using a problem prepared by any one of the three group members). Triads may take up to twenty minutes to discuss the problems.

Large Group:

When the large group reassembles, each triad will present a summary of the problem as well as any significant problem solving strategies and solutions their group formulated. A short discussion period should follow each group's presentation, so that all trainees may provide feedback. Each trainee should be prepared to comment on the trainer's and other participants' attempts to provide solutions to the particular problem he had presented.

SESSION X

A LIFETIME OF AGING

1. "A LIFETIME OF AGING"

   PART I

   - Solo: Identify growth and change processes of various life phases
   - Dyad: Discuss ideas/experiences with another participant
   - Small Group: Share-out how the aging process is alike/different for the AADD person

   PART II

   - Dyad: Identify and discuss ideas and experiences with the characteristics of the life phases: loss, rejection, withdrawal, alienation, separation, and termination
   - Small Group: Share-out how these characteristics are alike/different for the AADD person
   - Large Group: Implications for individual practitioners

2. "ROSE BY ANY OTHER NAME" - Film

3. EVALUATION

   - Large Group: Emphasizing strengths/weaknesses of the training process

SESSION X

PURPOSES

1. Explore similarities and differences regarding aging and disabilities.
2. Recognize the strengths and limitations of each life phase.
3. Identify the range of values, choices and opportunities that mark every life phase.

PROCEDURES

1. **"A LIFETIME OF AGING"**

(1 hour, 45 minutes)

Distribute SP 63 to trainees.

The aging process is a universal phenomenon but different in the ways it affects each person. Each individual must make the most of his own aging and dying. This exercise will familiarize trainees with the process of growth and change as it affects themselves as well as the AADD clients over a lifetime. Its purpose is to develop awareness of aging as a dynamic process.

Distribute "A Lifetime of Aging", SPP 64, 65, stapled together.

PART I

SOLO EXERCISE

(10 minutes)

Trainees should complete Side I of the form SP 64, briefly noting the physical, social, emotional and psychological changes for each developmental stage of a lifetime of aging from birth to death. These notes should serve as a reminder to them as they share their thoughts in the upcoming dyad. Particular attention should be paid to the phase in which the participant presently finds himself.

DYAD EXERCISE

(15 minutes)

Each trainee should choose another participant who is presently not in the same life phase he is. Each trainee should add to his notes, learning as much as he can from the other dyad member's experience.

SMALL GROUP

(15 minutes)

Two dyads should join and briefly share information. It is their major responsibility to discuss how the aging process is alike and different when the life of a developmentally disabled individual is being considered.

P A R T I I

DYAD EXERCISE

(15 minutes)

Trainees should again choose a participant, but one whom they did not choose for the previous exercise. Participants should complete Side II of "A Lifetime of Aging" (SP 65) commenting on personal experiences that illustrate any/all of the conditions being considered.

SMALL GROUP

(20 minutes)

Two dyads join as a group to share information to be used in the upcoming large group discussion. The trainer should assign major responsibility

for a life phase to the different groups. The groups should then plan how to present their findings, and what issues to emphasize. The groups should be reminded to consider the similarities and differences imposed upon the life phases when an individual is developmentally disabled.

LARGE GROUP

(20 minutes)

Each small group presents to the total group their compiled information, emphasizing the similarities and differences that aging poses for the developmentally disabled. MPP 164, 165 can be referred to for comments that could enrich this discussion. Once again, the trainer should emphasize the importance of using "I" statements, (SP 3). This will continue to enable trainees to personalize the aging process, and thus identify more closely with their own and the AADD clients' processes of aging and dying. The trainer should conclude this share-out by posing a question that trainees can begin to consider.

REFLECTING ON THIS SESSION'S EMPHASIS ON THE AGING PROCESS, WHAT DO YOU IDENTIFY AS IMPLICATIONS FOR YOU AS A PRACTITIONER WHO WORKS WITH THE AADD?

The following points should be made:

1. The AADD individual is first of all a whole person.
2. The client's right to the dignity of interdependency as opposed to the unreality of independence or infantilization of dependence.
3. The caregiver's right to refuse responsibility for all aspects of the AADD person's life because of the identified disability (label).
4. The client's right to risk and risk again.

The trainer should recommend these points as suitable for reflection and discussion at any time in the trainee's experience with AADD individuals.

2. **FILM**

(20 minutes)

Show film, "Rose By Any Other Name" (See Appendix MP 203 for this and other resources). A discussion should provide additional information for focusing on particular issues.

> "Rose" is a 15-minute color film that helps people of all ages understand the needs and problems encountered when older adults engage in sexual intimacy. The film explores the related issues of the need for privacy and self-determination, and the problems of loneliness, communication and emotional fulfillment among the aging. Designed to help older people, their families, those who work with the elderly, and those who make policy decisions concerning the elderly, "Rose" improve the viewer's ability to develop informed judgments about the life-long need for affection, privacy, and sexual expression.
>
> Rose Gordon, a 79 year old woman in a nursing home, is discovered in the bed of a male resident. We see the relationship between Rose and Mr. Morris as warm, intimate and fulfilling, but threatened by the administration and staff of the home, Mrs. Gordon's family, and the very architecture of the institution. The film explores the reactions of other people to a loving relationship between an aging pair and the pressures that are brought to end its "unseemliness."
>
> The film stimulates group discussion about the needs for improved interpersonal communication, increased awareness of and sensitivity to individual rights, institutional constraints, and professional responsibility.

Consider The Following Questions:

1. How does the physical structure of an institution affect individual privacy?
2. What are the rights of an AADD person in terms of initiating and maintaining relationships of var. ng degrees of intimacy?
3. How can caregivers encourage and protect AADD persons' decisions? What appropriate/inappropriate actions can you identify?
4. What administrative actions are necessary to help professional staff meet the needs of AADD persons?

3. EVALUATION

(20 minutes)

The trainer can distribute SPP 66, 67 and ask trainees to respond to the questions verbally, or write down comments. In either case, trainees should be encouraged to be candid with their feelings so that the trainer can use the feedback as a basis to supplement future training experiences.

REFLECTIONS ON "A LIFETIME OF AGING"

Initial Statement

All characteristics of growth and change involve loss, and losses occur at any age. They are not assigned to a particular period of growth. Loss is built into our lives, and we learn about it from our earliest hours. If we don't accept losses, we will never grow as individuals - as persons who are inevitably bound by the human condition, yet free to pursue our own individuality. AADD persons, although experiencing the same life changes, often run into situations that make it more difficult to experience and accept many of life's realities.

PRE-ADOLESCENCE

GROWTH AND CHANGE

The child passes through the physical stages of maturation - crawling, walking. He moves from a preoccupation with himself and his needs to realizing the existence of others in his environment. He usually becomes more capable of communication needs - first by nonverbal, and then verbal expressions.

"NORMAL" GROWTH

The infant initially experiences separation from the womb. When going to school for the first time, the child may experience this as mother's rejection of him. A black child in a white school (or vice versa) may experience alienation and rejection because of not feeling "understood." The child may experience the death of a close relative such as a grandparent, and raise the question "Am I going to die sometime?" It is important to answer this question honestly, although full implications of it may not be meaningful. The death of pets are common. Flushing the goldfish down the toilet, or burying the gerbil in a cigar box in the backyard are opportunities for the child to grow compassionate and stronger. Explaining seasonal changes and how the life-death cycle of animals, insects, plants, revolves around it helps the child develop an appreciation for the beauty of all ages.

AADD EXPERIENCES

Many times, the AADD person had been placed in the institution at a young age; thus, as a young child he lost the constant attention of family and probably perceived the change as a rejection, even though the placement may have been due to relatives not being able to cope with the situation or society not offering options. Often, the institution's policy was to encourage parents to refrain from visiting their child for the first months, so she could "adjust" to the new environment. The impact of separation from loved ones was particularly severe. Any relationship among siblings which developed before placement was terminated, raising feelings of loss, rejection and separation in both the disabled and non-disabled children.

ADOLESCENCE

GROWTH AND CHANGE

Rapid physical changes occur and biological (hormonal) changes cause emotions to run wild as the young person attempts to come to grips with his impending separation from family.

"NORMAL" LOSS

Peer pressure to conform causes anxiety among those who look, dress, or act differently from the "norm". The nonconformist person often experiences rejection and alienation. At the same time, the person is losing his need for the dependency of early childhood. Parents frequently experience rejection by their children who think they are "pretty stupid for not understanding". Mistakes that are made may be perceived as lifetime problems, and are blown out of proportion. The loss of relatives may be especially painful. The development of intimate relationships and the loss of innocence are occasions for continued growth. Rejection, failure and disappointments (not getting a role in the school play; not going to the prom; ACNE) are all problems that prepare one for more problems coming "down the road." The growing individual must learn to constantly live with the losses and rejection and unfulfilled dreams. He must learn to fight and not withdraw, to continue to take risks.

AADD EXPERIENCES

The institutional reality often limited the social network open to the "normal" teenager. Although the person who was institutionalized may have attended school and had some work experiences, normal opposite sex relationships were usually discouraged or denied. Often men and boys were housed separately from the women and girls. They were *in* the world but not *of* it. Relationships were discouraged because of "what might happen."

YOUNG ADULTHOOD

GROWTH AND CHANGE

It's the time to settle down and become responsible for the future. Family is often established through marriage and children. Change of life style may occur. Because of personal decisions, family responsibilities, etc., there is a sense of self control and independence, and the realities of interdependence and dependence are not perceived.

"NORMAL" LOSS

The realisation becomes clearer that ideal dreams have not necessarily been fulfilled, and if the dream is to come true, it will have to be done now. Disillusionment can result, because if it doesn't work out, the individual has only himself to blame. When young, losses were felt more concretely, i.e., a lost pet. But now the subtleties of rejection are complex and produce more opportunities to feel the rejection. There is a gradual loss of strength and power, as well as dramatic life occurrences i.e., diseases and accidents that have to be managed and at times require adjustment to a completely different life situation. To lose a job is critical because independence and control are strongly valued. The possible death of a partner, other family member or friends causes anxiety. Privately we say "I'm glad it is not me." Young adults are often angry because parents die, leaving them feeling helpless and powerless. The denial of feelings of loss may cause problems of acceptance of other losses in future years.

AADD EXPERIENCES

The young person may have moved from the institution to other community residence as an expression of optimism and growth. Yet feelings of rejection and alienation from the community may still be strong. Neighbors often don't want them living next door. People frequently make unkind comments in public places. Churches often develop "special" Bible classes separate from the other adults. Often materials for young children are used to teach adults. Schools frequently have developed "reading" programs based on the young children's interests and needs. All these influences would emphasize to the young person that they would have to fight for their rights as adults. Parents and other relatives who were relied upon to provide special vacations, gifts, etc. may have died or moved away.

MIDDLE AGE

GROWTH AND CHANGE

Often marriages break up and new ones form. A shift in a job may require geographical relocations. Thus, new friends must be found and others left behind. A woman's reproductive capacity is lost (menopaus); often she questions her continuing womanhood. The children are moving out of the house and it's time to consider a new job or a new career. Physical aging (wrinkles, white hair) becomes more noticeable.

"NORMAL" LOSS

Often family or job crises produce dependent relationships where a person must seek physical, mental, or financial help. Some of the perceived "independence" is lost. Acceptance of the loss of a friendship through death or separation, and dealing with the change by turning it into an opportunity for growth, must be learned. Declining health produces an awareness of eating and drinking patterns, and we regret that habits were not changed long ago. The losses of family and friends continue and there is a realisation that it is "our turn next."

AADD EXPERIENCES

The struggle to maintain one's adult status continues although many people seek to "protect" the individual from "dangers in the environment." His relationships are often limited to caregivers and an occasional visit from a family member. Peer relationships are often not encouraged, and critical social skills may be underdeveloped. The importance of various relationships to enrich one's life has never been explored, thus this may not be missed or perceived as a loss. Educational/vocational programs are often terminated because persons are "getting too old."

OLDER ADULTHOOD

GROWTH AND CHANGE

As sensory changes occur, persons realize they can't do as many things. There is more attention paid to basic survival needs.

"NORMAL" LOSS

Realization that potential crises are all around. Retirement is often forced upon persons. Friends and/or partners die. Dependence in many situations must be accepted. The last thing to be dealt with is death of those "near and dear". There is no way to stop the onslaught of years realized, yet dignity within these loss experiences must be maintained.

AADD EXPERIENCES

Often the AADD persons are protected from the realities of aging and death and they never have the opportunity to discuss the issues or come to grips with the death of friends or their own ultimate deaths. Statements are made such as "They don't understand." "It will upset them." "They don't think about those things." Having spent most of their lives in protected environments, they often still believe in Santa Claus. Caregivers frequently dismiss their "childish" ways and say it's because of their disability. But it's really evidence of the loss of real world experiences; caused by the inability of significant others to let life teach and enrich the lives of the AADD individual through permitting risk taking. Death then is not the greatest loss, but the lost opportunity to live a life.

Summary Statement

It is important to stress the similarities in the life experiences of the AADD and the non-disabled. For example, if we experience rejections, an AADD client can also! FEELINGS ARE NOT RETARDED. It is important to talk with our clients about their feelings, to help them and ourselves work through difficult experiences such as living in the institution and not knowing why; being kept out of the Boy Scout troop because of a disability; or having a friend die. Loss is painful for all of us, developmentally disabled or not. The caregiver should be challenged to communicate concern, to the AADD individual, for it is as necessary for developmentally disabled persons as it is for anyone to discuss life's inevitabilities.

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"Age Page" - gives periodic, up-to-date, and concise information on issues critical to the elderly such as: flu, medicines, nutrition, accidents, etc. Some of these are located in the appendix of this manual.

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APPENDIX I

SUGGESTED VIGNETTES FOR PROBLEM SOLVING

RELATIONSHIP ISSUES

1. Elizabeth, an older more severely disabled adult, usually has dolls and a radio to play with. Today, however, after a newly formed discussion group had been together for a month, the group leader removed these objects from the table which was attached to her wheel chair. The group leader said they'd get in the way of an activity. Elizabeth started to cry.

2. Julie, an older client, hides her head most of the time. Carol, a caregiver, wants to help her hold her head up when she is around people. Carol appears to be quite timid, and that seems to be why her head is down on her hands. It was noted by Carol, however, that when one caregiver, Sally, entered the room, Agnes acknowledges her presence by looking up with a smile. How might Carol proceed with her attempts to help this client develop more meaningful relationships?

3. A group meeting centered around Raymond, an elderly client in a supervised apartment setting. Raymond talked infrequently. His two roommates were always glad when Raymond went away to go shopping or to the sheltered workshop. One week, Jerry, a concerned caregiver, felt he wanted to get to know Raymond better. Upon approaching him a few times and being told he was busy, Jerry made one last attempt. He asked Raymond to a local Jaycee baseball game. Raymond retorted, "Why do you keep bothering me? I told you, I didn't want anything to do with you!"

WHAT DOES IT MEAN TO BE "AGE APPROPRIATE"?

1. The use of coloring books and other child-like activities was being discouraged in a certain home. It was felt that such activities did not enhance the adult status of the older clients. It was Easter time and a mimeographed copy of colored Easter egg designs was given to several clients by a client's brother. The clients were upset when they were not allowed to color them. Otto commented, "I'd like to decorate the big window."

2. Ann Marie, a caregiver, brought a Dr. Seuss book called, A Book About Myself, By Me. It described a child's likes and dislikes in terms of food, activities, colors, seasons, etc. Peggy, an older client, was happy because Ann Marie bought the book for her. Ann Marie always paid attention to everyone's concerns and preferences; clients and caregivers appreciated it. All were happy to see Ann Marie and Peggy getting along well. They thought the book was "cute."

3. The administration of a group home for older adults had been planning the Christmas party for months. Tonight was the night. Everyone - clients, relatives, and staff alike - were dressed up. All the clients were excited about the food and decorations. But Calvin, an older client, mentioned to a friend that it was Santa Claus he was waiting for. Sure enough, right at 9:30 p.m. Santa arrived with his bag filled with surprises. Calvin was very happy and rushed over to tell Santa what he wanted for Christmas.

4. Four AADD patients in a nursing home were coming together for group activities that had been planned for a week. The activities were based on ideas from a new book about physical education activities for the older developmentally disabled person. Two volunteers who were leading the exercises were anxious to try them out. Over the loudspeaker came an announcement that a cartoon movie, starring Mr. Magoo, was to be shown in another room. All patients were invited. The individuals in the group looked up in expectation, apparently eager to go. The volunteers....

GETTING TO KNOW EACH OTHER

1. Casey, an AADD person in a group home, has become committed to a young 25 year-old woman in the same setting. Casey always discusses Gladys, the woman client, as liking him. He always wants her to go with him. He can't seem to concentrate on other matters in a discussion, because of his overwhelming concern for this woman. "Will Gladys like it?" or "Can't Gladys go?" are repeated statements. Gladys, however, doesn't give Casey the time of day. She doesn't talk to him and often laughs behind his back.

2. Harold has problems related to the female staff. He makes overly affectionate and inappropriate advances to women. Harold was questioned as to what love was. He said, "It is kissing and dancing with your girlfriend." He said he believes this because he does the same things with girlfriends: talking, watching TV, going to dances, etc.

3. Russell is being discussed at a staff meeting because of his attempts to sleep with a female staff person. Although the staff has initiated individual activities with all clients, Russell has determined the increased attention is basically sexual. He appears to be extremely confused about his relationship with various women in his life: women caregivers, women who attend his church, women clients, etc. He seems to see all women as potential girlfriends and sexual partners.

REACHING OUT TO THE COMMUNITY

1. A home administrator expressed concern for her older clients by stating that she was reluctant to move the clients out of her group home because that would lead first to supervised apartment living and then eventually to independent living in the community. She perceived that such a move would be detrimental to her older clients who have few family and friends. Furthermore she noted, "Everyone is aware of the fact that the needs of the normal aging person aren't met with the social supports systems provided by the society."

2. It was found that Alda, an older client in a group home, was attending a Baptist Church. The social worker noted Alda's records that she had always been a Catholic. When Kathy, the staff person, was questioned about this by the social worker, Kathy replied; "Alda likes the Baptist Church now." Alda added, "Besides, the only ride I can get to church is with Edna, who picks me up for the early service."

3. A home manager was talking to the administrator of the group home one day. Marie, the home manager, spoke angrily of her attempts to contact a church to get a volunteer to visit one of the older clients who was very lonely. Marie had contacted the secretary of the church and was told the pastor would call. Meanwhile, a month had gone by. Marie spoke bitterly: "See it's the same as when we moved in here. Nobody in the community wanted us. There were threats of broken windows then. Even now the community doesn't want to support us."

4. Irma, an older client, is particularly sloppy about her dress in relation to the "norms" of the community. The staff feel clothes and appropriate dressing is important for the clients who appear so "different" anyway. Irma has many clothes that the staff feels are too tight, because Irma has been overweight for two years.

5. The site hostess, Helen, had just gotten through explaining to her senior center staff and volunteers how important it was to teach the AADD people, Hank and Hal, who would be coming to the nutrition site soon, to do tasks over and over again till they could perform skills (e.g., coffee making, putting donations in a jar) independently, if this was at all possible. One volunteer was concerned about how this would look to other seniors. This would make it even more evident that Hank and Hal were slow, and would emphasize their disability.

6. Mary, a senior center participant for years, complained that she was thoroughly disgusted with what was "going on" at the center. After a few questions, Helen, a staff worker at the center, became aware of Mary's concern. Recently, a developmentally disabled woman, Elizabeth, had come to the site. Elizabeth especially enjoyed the travelogue movies that were shown on Tuesdays, after the noon meal. Elizabeth had a habit of asking questions and mumbling during the movie. Many of the seniors told her to be quiet. This would work, but sometimes she had to be reminded a couple of times. Mary felt that Elizabeth should not be allowed to attend the movies, because of her behavior. Besides, Mary had been at the center the longest, and the center "owed" her some cooperation. After all, she knew the site and the other seniors. Elizabeth simply did not belong here. Maybe there was another place..... Helen took Mary aside and ...

7. Two older retarded seniors have begun attending the senior center in Hollyhock, a small midwestern town. The seniors, Mabel and Mildred, are residents of a group home in Hollyhock. This group home has become "infamous" lately, because several neighbors surrounding the home have heard loud noises at night, and have also observed several of the group home clients rush outside half dressed. Some anonymous letters have been sent to the home saying that "those kind of people are not welcome here." Last week a window was broken during the day when no one was home.

   The group home manager, Dick, explained to the senior center staff that since his clients were eligible for center activities, he would be bringing them three days per week. Mabel and Mildred have attended the center three times now. Both seniors appear anxious at times. Sometimes they have difficulty staying with an activity, especially discussions and arts and crafts. Both staff and other seniors have expressed concern. A common statement is: "But we're afraid of what they could do."

8. Several Parklane Senior Center personnel, Liza and Cathy, have become concerned about two Center participants, Jack and Mildred. Both of these people arrived for the first time last Monday. The seniors couldn't explain where they lived, and when given a pen to write their addresses on the registration form, they were only able to write their first names. No one knew anything about them; they explained they lived "across town in a group home" and that Stephanie drops them off. Stephanie has never talked to anyone at the Center.

STRUGGLING TO BE UNDERSTOOD

1. Crystal is bitter because she doesn't have frequent contact with some of her geographically close relatives. Although she complains about this, Crystal forgets to ask her sister for relative's addresses and phone numbers. Her sister is presently in Florida for the winter months.

2. Audry, an older client in a group home, has been talking about someone's stealing her money. She has talked with the staff and feels she's been taken advantage of because of her age and disability. She feels that this is just another incident to support the contention that she has been deprived of proper upbringing and attention her whole life.

3. An older client, Lillian, doesn't have anything to do during the day. She can't go to the workshop because she hurt her shoulder and the doctor hasn't approved of her going back. Furthermore, Lillian doesn't want to return to work. She goes out with friends from church in the evening. She seems to spend the daytime sitting and brooding over personal injustices over her life time. The house manager says he has explored all options for Lillian, and nothing appeears realistic at this time.

4. Dee, a resident of a group home, observes staff doing things for the residents. When Mabel, another resident, cannot wash her coffee cup as fast as she can, Dee "takes over" and washes out Mabel's cup for her. This makes Mabel angry and triggers disputes.

5. Hazel feels she does not get proper consideration of her needs and wants. She has no relatives to take her on outings. She wants to go out more, like the other residents in the house. She lectures the caregivers about her problems, and appears to resent the fact that she is much older than the caregivers (56 versus 20's).

WHAT IS "SUCCESS"?

1. David, a caregiver, was very depressed. The week before he had been so happy because a group of severely disabled AADD clients he had worked with responded to him very well. He had played his guitar, and Florence, a client, sang a song he had taught the group the week before. However, the next week the group didn't respond at all. At that time, had brought some paint, paper, and magic markers to do some drawing. Some of the older clients would not use the materials. Others nodded off to sleep.

2. Carol, a caregiver working with a group of older severely disabled AADD clients, had gotten Willa, a client, to shake her hand when each person was introduced at a group meeting. Willa hides her face a great deal of the time. Carol has mentioned to the home manager her frustration on such small accomplishment for each group.

3. Craig, a caregiver for a group of four older, severely disabled AADD clients, was expressing disappointment as to the little progress the group had made. He mentioned that one client, Rachel, did please him by shaking his hand last week. He felt that was progress. "But it is so slow and nonrewarding," he commented. Craig was worried because he felt he'd soon burn out if things didn't improve.

SEEING OTHERS AS INDIVIDUALS

1. Mr. Sonstad, an older client, can't seem to remember women's names -- staff or clients. He always wants to talk about himself and constantly needs "help." He adores his girlfriend, Mary, and talks about her constantly. But he can't remember her name either. The female staff appears to infantilize him by commenting on his baby behavior and humoring him in patronizing ways by such comments as, "WE don't want to do that, do WE, Mr. Sonstad?" Phillip's friend, John, came to visit while Phillip was working at the group home. Immediately upon his entrance, Mr. Sonstad extended his arm to shake it and wanted to know John's name. John and Mr. Sonstad had a very involved discussion about the Winter Olympics. Mr. Sonstad asked about John by name for days afterward.

2. Sarah had bought a housecoat at the discount store and was eager to show the staff. She had been saving for a month for it. When Sarah came into the office, a staff person smiled briefly and said a few courteous words, interrupting Sarah. Then she quickly returned to filling out her forms. Sarah turned to leave and was reminded to put the store receipts into an envelope.

3. One home manager, Melanie, has gone back to school because she is interested in learning about her older clients. Melanie feels AADD people are not getting all the attention they need/deserve due to their advancing age. During class she raises some of her concerns about the older clients. "They don't want to do things with other clients. They prefer sitting at home. It's also hard to get them to the workshop. Activity is important for everybody, and I feel we need help in getting them the right activity for their age." Later she mentioned another concern. "They don't seem to act their age. They don't make their beds and keep their rooms clean. They sometimes want to finish watching TV before coming to dinner. They don't show responsibility—isn't there someway for them to learn responsible adult roles?"

4. Kathleen, an older client, has invited a family friend Debbie, to dinner. Debbie offered to bring jello. Kathleen remembered, "Oh, but be sure to bring diet jello. We can only have that because Raymond is on a strict diet for his heart problems."

5. Sam and Kate, senior center staff persons, were concerned because they couldn't help Joe and Martha, two AADD individuals, learn the procedure for entering the center and getting involved in the activity. Although Sam and Kate had explained the routine a number of times, Joe and Martha would either get lost, wander into a wrong activity, not hang up their coats, or cry because they couldn't find the bathroom. Some of these behaviors were disturbing to the other senior center participants. Sam and Kate were frustrated and began to feel that this integration process couldn't work a this center. The site hostess had other ideas. She took Sam and Kate aside and started pointing out to them that they were trying to "make too much progress, too fast" with these clients. What are some specific things she could tell Sam and Kate to do, to make procedures more understandable for Joe and Martha?

1. A new caregiver, Jenny, was in the kitchen one morning talking to an older client, Grace. Jenny asked Grace if she wanted a cup of coffee. They sat at the kitchen table with their cups. Meanwhile another client, Frances, spotted them and complained to the home manager that Grace was having special privileges. The home manager explained to Jenny that everyone had coffee together so no favoritism was shown. Four other older clients entered the kitchen for coffee.

2. Rachel is an older client who has two younger roommates who are in their 20's. Rachel is quite unhappy. The roommates talk about their boyfriends, marriage, local music and TV. Rachel has no interest in this conversation at all. The roommates get upset with Rachel. They refer to her as an "old woman" because she can't move as fast as they can. Rachel would prefer to set up a cleaning schedule too, but the roomates care little about cleanliness. They cook together, but the younger women are constantly requesting hamburgers.

3. Jack, a 54 year-old client, had a conversation with Darnell, a staff member. Jack was new in the home, and Darnell wished to get to know him better. Jack explained that his mother was very sick and was going to visit her. Darnell asked, "Who will you talk to when your mother passes away?" Jack thought for a moment and then said he'd call on Kathy, a staff member at his new home. Darnell was puzzled because Jack always talked about his two old friends at the institution. When Darnell questioned him about this, Jack still insisted his new friend, Kathy, would be the person he'd talk to.

4. Irene, a 68 year old client, had a birthday. The staff felt birthdays were important, so they bought cake and ice cream to serve all the clients and staff available on that day. Irene and everyone had been told of the party, so all came down for refreshments at 2:00 p.m. After getting their treats, everyone returned to their rooms, including the staff. Irene went upstairs to unwrap a gift she received from a favorite caregiver. All seemed happy over the treats.

GETTING YOUR WAY

1. Pauline, an older client, has tantrums and is told to go to her room when she does this. When she is called upon to help out or asked to become involved in any way, she flies off the handle. Immediately she is told to go to her room. Then Pauline is spoken of in tiny whispers: "Poor Pauline, she just can't seem to control herself", or "We feel Pauline needs to be alone again to think about what she's done."

2. Norton is an older client. When you talk with him he talks about his clothes, his room, his job--he never wants to hear about what others do. One day when Randy, a caregiver, talked with him about more general things, he gazed at the ceiling and appeared to neither hear nor understand him. Randy felt "uncomfortable". He immediately asked him how Lillian, his girlfriend, was doing. Norton then became interested and actively involved in the interaction.

WHOSE NEEDS ARE WE MEETING?

1. Three older clients in a group home have been of some concern to the staff because they don't seem to want to get involved socially with others. Additionally, they don't seem to use their leisure time in any constructive way, except watching TV. Because of this the home manager has decided to have these clients come to a group once a week. Activities are discussed, and clients are expected to take part in agreed upon activities during the following week.

2. A group home was situated near a small truck farm. The couple who owned it called the home one afternoon to inquire whether the clients would like to have some sweet corn that evening. The couple knew they couldn't use all the corn themselves and thought the clients would appreciate this fresh vegetable. A caregiver, Bill, had answered the phone. He said the menu was set for that evening. He mentioned that the clients had agreed on the menu last week; dinner was already started. He said he appreciated their generosity but refused the offer.

3. The brother of an older client, Elizabeth, took her home for the weekend. For Friday and Saturday evening Elizabeth seemed content to stay up till 11 to watch TV and play games, etc. On Sunday evening at 7:00 p.m., however, Elizabeth got very upset because she hadn't been taken home yet. She said she was very tired and must get home in time to go to bed. Questioning this, the brother set up an appointment with the home manager. They found out the client was to be in bed by 9 p.m. because of the early rising hour (6:45 a.m.) the next day. The home manager commented that she felt Elizabeth was just being responsible about her bedtime. Elizabeth's brother felt, however, that Elizabeth was too worried about this matter, and he also questioned the early hour to be in bed.

4. John appears to enjoy his food. Because of that, it takes him quite a long time to finish. This is frustrating to both clients and staff because of the need to go to different activities at a certain time, or to finish washing dishes, etc. The staff got together and decided to get a timer and give John so much time to complete different parts of the meal, including dessert. This didn't seem to work. John would continue eating slowly as the timer went off in his ear. Staff started taking away "stars" so John couldn't earn the priviledge to go to extra activities. But this didn't work either.

5. A visitor was being escorted through a group home that had been specifically established for AADD people. She explained that the clients really didn't need to have much direction and were quite independent. Rather proudly she discussed the charts in the hallway. Large chore schedules made out of colorful construction paper were in evidence on the refrigerator. A large menu with this week's foods was on one wall, and many of the foods were illustrated with pictures from magazines. A neatly made calender that took up most of the hallway, listed events. A "star" chart let clients know if they earned a special privilege during a particular week.

6. An artistically inclined caregiver, Janet, wished to involve two older clients in art-type activities. She felt such stimulation would encourage the clients to open up to new experiences and help them become aware of their world.

   The first week she showed the clients some pictures and let them touch a couple of brass sculptures she had brought from home. Everyone seemed to enjoy this activity. There was even some disussion concerning how the artists could make products. The next week she brought some paper and paints. The clients were not interested in them and politely asked if they could go to their rooms to hook rugs.

7. Andy was observing Susan, the group home supervisor, because it was Andy's first day on the staff. Upon entering the kitchen, Jack, a client, came up to Susan and excitedly told her about a movie he had heard about at workshop and wanted to see. Susan said that all requests had to be written down, so they could be considered and then put on the calender. Susan turned to Andy and said, "We feel this helps the clients to practice their writing skills and be responsible for what they want to do." Jack said he would see if he could get May, another older client, to write the letter. Susan escorted Andy out into the hall and showed her the mailboxes that had been made too receive all the clients mail and written instructional notes frm caregivers and other clients.

8. A few group home caregivers commented on the good opportunity it would be for the older men, scattered in their group homes, to get together once in a while. It took a while to find a common time, but a time was finally agreed upon. One staff person volunteered to pick up everyone. They went to a restaurant for coffee, but had to break up much sooner than the men wished to. This was due to programming commitments in some of the homes, as well as the good deal of time it took to pick up and return the men. Later they discussed the problem in another group meeting. What transportation alternatives were there in this situation? What programming changes could have been made to ease the pressure to "get back to their respective residences?

9. Andy, a 52-year-old resident, is very excited when he gets home from the workshop. He has a note for the home manager that details his conduct and behavior for that day in the workshop. This routine is a daily occurrence. The staff is always supportive and indicates that they are proud of his accomplishments at the workshop.

APPENDIX II

EXPANDED INFORMATION ON AGING ISSUES

National Institute on Aging

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Accidents and the Elderly

Accidents seldom "just happen," and many can be prevented. Accidental injuries become more frequent and serious in later life. Thus, attention to safety is especially important for older persons.

Several factors make people in this age group prone to accidents. Poor eyesight and hearing can decrease awareness of hazards. Arthritis, neurological diseases, and impaired coordination and balance can make older people unsteady.

Various diseases, medications, alcohol, and preoccupation with personal problems can result in drowsiness or distraction. Often mishaps are expressions of mental depression or of poor physical conditioning.

When accidents occur, older persons are especially vulnerable to severe injury, and tend to heal slowly. Particularly in women, the bones often become thin and brittle with age, causing seemingly minor falls to result in broken hips.

Many accidents can be prevented by maintaining mental and physical health and conditioning, and by cultivating good safety habits. For example,

Falls are the most common cause of fatal injury in the aged. Proper lighting can help prevent them. Here's what you can do:

- ☐ Illuminate all stairways and provide light switches at both the bottom and the top.
- ☐ Provide night lights or bedside remote-control light switches.
- ☐ Be sure *both* sides of stairways have sturdy handrails.
- ☐ Tack down carpeting on stairs and use nonskid treads.
- ☐ Remove throw rugs that tend to slide.
- ☐ Arrange furniture and other objects so they are not obstacles.
- ☐ Use grab bars on bathroom walls and nonskid mats or strips in the bathtub.
- ☐ Keep outdoor steps and walkways in good repair.

Personal health practices are also important in preventing falls. Because older persons tend to become faint or dizzy when standing too quickly, experts recommend arising slowly from sitting or lying positions. Both illness and the side effects of drugs increase the risk of falls.

Burns are especially disabling in the aged, who recover from such injuries more slowly.

- ☐ Never smoke in bed or when drowsy.
- ☐ When cooking, don't wear loosely fitting flammable clothing. Bathrobes, nightgowns, and pajamas catch fire.
- ☐ Set water heater thermostats or fau-

cets so that water does not scald the skin.

- ☐ Plan which emergency exits to use in case of fire.

Many older people trap themselves behind multiple door locks which are hard to open during an emergency. Install one good lock that can be opened from the inside quickly, rather than many inexpensive locks.

Motor vehicle accidents are the most common cause of accidental death among the 65-to-74 age group, and the second most common cause among older persons in general. Your ability to drive may be impaired by such age-related changes as increased sensitivity to glare, poorer adaptation to dark, diminished coordination, and slower reaction time. You can compensate for these changes by driving fewer miles; driving less often and more slowly; and driving less at night, during rush hours, and in the winter.

If you ride on public transportation:

- ☐ Remain alert and brace yourself when a bus is slowing down or turning.
- ☐ Watch for slippery pavement and other hazards when entering or leaving a vehicle.
- ☐ Have fare ready to prevent losing your balance while fumbling for change.
- ☐ Do not carry too many packages, and leave one hand free to grasp railings.
- ☐ Allow extra time to cross streets, especially in bad weather.
- ☐ At night wear light-colored or fluorescent clothing and carry a flashlight.

Old people constitute about 11 percent of the population, and suffer 23 percent of all accidental deaths. The National Safety Council reports that each year about 24,000 persons over age 65 die from accidental injuries and at least 800,000 others sustain injuries severe enough to disable them for at least 1 day. Thus attention to safety, especially in later life, can prevent much untimely death and disability.

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Senility: Myth or Madness?

"Senility"--something which most of us fear in old age--is not a normal sign of growing old; in fact, it is not even a disease.

Rather, "senility" is the word commonly used to describe a large number of conditions with an equally large number of causes, many of which respond to prompt treatment.

The symptoms of what is popularly called "senility" include serious forgetfulness, confusion, and certain other changes in personality and behavior. While doctors and patients alike used to routinely dismiss these symptoms as incurable effects of old age, they are not necessarily. Nor are small memory lapses in old age a sign of "senility." Slight confusion or occasional forgetfulness throughout life may only signify an overload of facts in the brain's storehouse of information.

Mental decline in old age might be called "dementia," "organic brain disorder," "chronic brain syndrome," "arteriosclerosis," "cerebral atrophy," or "pseudodementia." The important thing to remember is that some of the problems which are generally referred to under the medical description of senile dementia can be treated and cured, while others, at this time, can only be treated without hope of restoring lost brain function. Thus a complete, careful investigation of the source of the symptoms is necessary.

Diagnosis

The two most common incurable forms of mental impairment in old age are multi-infarct dementia and Alzheimer's disease (pronounced altz'hi-merz). Multi-infarct dementia is caused by a series of minor strokes which result in widespread death of brain tissue. This condition accounts for about 20 percent of the irreversible cases of mental impairment. In Alzheimer's disease changes in the nerve cells of the outer layer of the brain result in the death of a large number of cells. Some 50 to 60 percent of all elderly persons with mental impairment have Alzheimer's disease.

Some 100 reversible conditions may mimic these disorders. A minor head injury, a high fever, poor nutrition, or adverse drug reactions, for example, can temporarily upset the normal activity of extremely sensitive brain cells. If left untreated, such medical emergencies can result in permanent damage to the brain, and possibly even death.

In much the same way, emotional problems can be mistakenly confused with irreversible brain disease. Depression, loss of self-esteem, loneliness, anxiety, and boredom can become more common as elderly persons face retirement, the deaths of relatives and friends, and other such crises--often at the same time.

Persons suspected of having Alzheimer's disease or multi-infarct dementia should have thorough physical, neurological, and psychiatric evaluations. This includes a complete medical exam, as well as tests of the patient's mental state, and highly specific tests such as the brain scan. The brain scan is useful in that it can rule out a curable disorder. The brain scan may also show signs of normal age-related changes in the brain, such as

shrinkage, which are not necessarily a sign of disease.

The patient plays an important role in the diagnosis by giving information on past medical history, the use of drugs--both prescription and over-the-counter--diet, and general health. Because part of the medical exam depends upon how much a patient is able to remember about past events, the doctor may also ask a close relative for information.

Treatment

The best treatment comes only after a complete medical examination by one who does not dismiss complaints as "just old age." If there is a diagnosis of a curable disease, the doctor will know how to treat it or will have ready access to the best resources or specialists.

If the diagnosis is one of the irreversible disorders, there is still much that can be done to treat the patient and to help the family cope. Careful use of drugs can lessen agitation, anxiety, and depression, and improve sleeping patterns if this is needed. Proper nutrition is particularly important, although special diets or supplements are usually not necessary. The person should be encouraged to maintain daily routines, physical activities, and social contacts, and should not be discouraged from trying new things. Often, stimulating the individual--by supplying information on the time of day, place of residence, and what is going on in the immediate environment and in world events--encourages the use of skills and information which remain. This in turn may keep brain activity from failing at a more rapid pace. In the same way, providing memory aids helps people help themselves in day-to-day living. Such aids can include a very visible calendar; list of daily activities; written notes about simple safety measures; and directions to, and labeling of, commonly used items.

In any event, a patient with an irreversible disorder should be under the care of a physician. This may be a neurologist, psychiatrist, or family physician or internist--who is willing to devote the time and interest required to closely watch treatment; to treat the physical and emotional problems that may complicate the course of the disease; and, of course, to answer the many questions that the patient and family may ask.

There are many differences in the type, seriousness, and order of changes in cases of irreversible dementia. Even so, there is enough similarity in the experiences of patients and their families--the loneliness, the frustrations, the lack of information and resources for good medical care--to have led to the development of family groups around the country. Recently, seven such groups formed the Alzheimer's Disease and Related Disorders Association (32 Broadway, New York, NY 10004) to encourage research, education, and family services.

Prevention

Diet, drugs, and lifestyle may someday be used to prevent or reverse the damage done to the brain in Alzheimer's disease and other related diseases. At the present time, however, our understanding of these problems and their causes is just beginning to unfold.

Developing interests or hobbies and becoming involved in activities which keep the mind and body active are among the best ways that the elderly can avoid the problems which can mimic irreversible brain disorders. Careful attention to physical fitness, including a balanced diet, may also go a long way towards keeping healthy. There appear to be certain physical and mental changes which occur with age even in healthy persons, but in the long run, much pain and suffering can be avoided if the elderly, their families, and their physicians realize that "senility" is not part of aging.

National Institute on Aging

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Safe Use of Medicines by Older People

Most people, and especially the elderly, use medicines at some point during their lifetime. When used correctly, medicines can be of great value. They can help heal wounds, stop the spread of infections, bring on sleep, and ease pain, both physical and mental. But when used incorrectly, drugs have the ability to injure the patient or change the effects of other medicines being taken at the same time.

Drugs can be divided into two major groups: over-the-counter drugs (also called patent medicines), which can be bought without a doctor's prescription; and prescription drugs, which can be ordered only by a doctor and sold only by a pharmacist (druggist). Prescription drugs are usually more powerful and have more side effects than over-the-counter medicines.

People over 65 make up 11 percent of the American population, yet they take 25 percent of all prescription drugs sold in this country. One reason for this more frequent use of drugs by older people is that, as a group, they tend to have more long-term illnesses than they did when they were younger. Also, advancing age sometimes brings with it changes in physical abilities, eating habits, and social contacts. The result of these changes—whether it is aching muscles, constipation from lack of certain foods, or depression after the loss of a relative or friend—may often lead an older person to seek medical help. Drug treatment may be suggested to help overcome many of these physical and emotional problems.

Safe drug use requires both a well-informed doctor and a well-informed patient. New information about drugs and about how they affect the older user is coming to light daily. For this reason, those taking drugs should occasionally review with a doctor their need for each medicine.

In general, drugs given to older people act differently than they do when given to young or middle-aged people. This is probably the result of the normal changes in body makeup that occur with age. For example, as the body grows older, the percent of water and lean tissue (mainly muscle) decreases, while the percent of fat tissue increases. These changes can affect the length of time a drug stays in the body, how a drug will act in the body, and the amount of drug absorbed by body tissues.

The kidneys and the liver are two important organs responsible for breaking down and removing most drugs from the body. With age, the kidneys and the liver often begin to function less efficiently, and thus drugs leave the body more slowly. This may account for the fact that older people tend to have more undesirable reactions to drugs than do younger people.

Because older people can often have a number of physical problems at the same time, it is very common for them to be taking

many different drugs. Two or more medicines taken at the same time can sometimes react with each other and produce harmful effects. For this reason, it is important to tell each doctor you go to about other drugs you are taking. This will allow the doctor to prescribe the safest medicines for your situation.

By taking an active part in learning about the drugs you take and their possible side effects, you can help bring about safer and faster treatment results. Some basic rules for safe drug use are as follows:

1. Take exactly the amount of drug prescribed by your doctor and follow the dosage schedule as closely as possible.
2. Medicines do not produce the same effects in all people. For this reason, you should never take drugs prescribed for a friend or relative, even though your symptoms may be the same.
3. Always tell your doctor about past problems you had with drugs, and be sure to mention other drugs (including over-the-counter medicines) you are taking.
4. It may help to keep a daily record of the drugs you are taking, especially if your treatment schedule is complicated or you are taking more than one drug at a time.
5. If child-proof containers are hard for you to handle, ask your pharmacist for easy-to-open containers. Always be sure, however, that such containers are out of the reach of children.
6. Make sure that you understand the directions printed on the drug container and that the name of the medicine is clearly printed. This will help you to avoid taking the wrong medicine or following the wrong schedule. Ask your pharmacist to use large type on the label if you find the regular labels hard to read.
7. Throw out old medicines, since many drugs lose their effectiveness over time.
8. Ask your doctor about side effects that may occur, about special rules for storage, and about which foods or beverages, if any, to avoid.
9. Always call your doctor promptly if you notice unusual reactions.

A useful booklet, *Using Your Medicines Wisely: A Guide for the Elderly,* has been published by the National Institute on Drug Abuse. Free single copies are available by writing to Elder-Ed, P.O. Box 416, Kensington, Md. 20795. Multiple copies (in lots of 100) may be purchased for $17.00 by writing to the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

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Food: Staying Healthy After 65

Diet is important to people of all ages, but older people in particular may have questions about what they should eat to maintain their health. Because many health problems of the elderly are the result of poor nutrition, the following guidelines may help older people plan a healthy diet.

Most people gain weight more easily as they grow older, but they need the same amounts of most nutrients (vitamins, minerals, and protein) as younger people. This means that the elderly in particular should eat nutritious food and cut down on sweets, salty snack foods, high-calorie drinks, and alcohol.

Exercise is also important in keeping off extra pounds. A person who is exercising regularly can eat more without gaining weight than a person who sits most of the day.

Eating too little can be harmful as well. People who do not eat enough may have less energy; they may become lonely and depressed. In addition, a diet containing too few calories is also likely to be lacking in vitamins and minerals.

Older people should talk with their doctors about their eating habits, especially if they have any illnesses that might require changes in what or how much they eat. This is important because some drugs can interact with certain foods and change the effects of the medications, and other drugs can alter nutritional needs.

Nearly everyone has heard that it is important to eat a "well-balanced" diet that provides adequate vitamins, minerals, protein, and carbohydrates. Such a diet is rich in fresh vegetables (especially leafy greens), fresh fruits, low-fat dairy products, beans and/or meat, and whole grains. Eating these kinds of foods will help reduce the amount of fat and salt in the diet. Too much fat and salt may contribute to heart disease, high blood pressure, and stroke.

Vitamins and Minerals

A healthy body needs vitamins and minerals, which are found in fruits, vegetables, meats, dairy products, and cereals. Many older persons do not get enough calcium, a mineral that is used by the body in many ways. Calcium is especially important for building and maintaining strong bones and teeth. Foods rich in calcium include not only milk and cheese but also dark leafy greens (kale, collard, turnip, and mustard greens). Some seeds, legumes, and nuts (sesame seeds, beans, and almonds) also supply good amounts of calcium.

Protein

The body requires protein to build and maintain muscle tissue. All adults need about the same amount of protein-rich foods: two servings a day. One serving would include 2-3 ounces of red meat, chicken, or fish; two eggs; 1 cup of cooked dry beans; 4 tablespoons of peanut butter; or 1/2 cup of nuts. Dairy products also contain protein and can be used to increase the value of other protein sources such as cereals, beans, and nuts.

Fat and Carbohydrate

Energy is obtained from fats and carbohydrates, but it is important to eat fat- and carbohydrate-rich foods that also contain vitamins, minerals, or protein. This means eating plenty of fruits, vegetables, whole grain or enriched flour products, beans, rice, and rolled oats. Candy, pie, cake, and other dessert foods should be limited. The best snack foods are plain vegetables and fruits, which are high in vitamins and low in calories, fats, sugar, and salt.

Whole unrefined grains are recommended because the refining process markedly decreases the amount of B vitamins (only three of which are added to enriched flour), vitamin E, and trace minerals. Whole grain foods include whole wheat breads and cereals, oatmeal, whole wheat or rye crackers, barley, brown rice, and cornmeal.

Fiber

The refining process also removes the bran, an important source of fiber in the diet. Although the role of fiber is not fully known, it can help in avoiding constipation. Too much bran, however, can prevent the body from absorbing some minerals. Therefore, eating whole grain breads and cereals and plenty of fresh vegetables and fruits is a better way to add fiber to the diet than adding bran to cereal or other foods.

Towards the Future

Scientists supported by the National Institute on Aging are studying nutrient intake and requirements in the elderly, changes in taste and smell with aging, behavioral aspects of dietary habits, and the influence of nutrition on health in old age. Through such research we hope to gain a better understanding of how diet and the aging process affect one another.

For further information about nutrition and aging, please call Judy Fernandes at (301) 496-1752 or write to the Information Office, National Institute on Aging, Bethesda, Md. 20205.

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What to do About Flu

Each winter, millions of people suffer from the unpleasant effects of the "flu." For most of these people, a few days in bed, a few more days of rest, aspirin, and plenty to drink will be the best treatment.

Flu—the short name for influenza—is usually a mild disease in healthy children, young adults, and middle-aged people. But, in older people or in those of any age who have chronic illnesses, flu can be life-threatening. By lowering a person's resistance, flu may allow more serious infections to occur, especially pneumonia.

It is easy to confuse a common cold with influenza. An important difference is that flu causes fever, usually absent during a cold. Also, nasal congestion occurs more often with a cold than with the flu. Cold symptoms generally are milder and don't last as long as symptoms of the flu.

Flu is a viral infection of the nose, throat, and lungs. It spreads quickly from one person to another, particularly in crowded places such as buses, theaters, hospitals, and schools.

Because of its ability to spread rapidly, flu was once believed to be caused by the influence of the stars and planets. In the 1500's, the Italians gave the disease the name "influenza," their word for "influence."

What Causes Flu?

Not until the 1930's and 1940's did scientists discover that flu is caused by constantly changing types of viruses. These tiny parasites invade animals and human beings and begin to multiply rapidly. Disease appears when their number grows too large for the body's immune system to fight off immediately.

When someone infected with the flu coughs or sneezes, droplets containing the virus particles may reach another person, entering the body through the respiratory system. There, the viruses can multiply and cause flu.

Symptoms

The effects of a flu infection can differ from person to person. Sometimes flu will cause no obvious symptoms. Often, however, the patient will feel weak, and will develop a cough, a headache, and a sudden rise in temperature. The fever can last anywhere from one to six days. Other symptoms include aching muscles; chills; and red, watery eyes.

Complications of Flu

Flu is rarely a fatal illness. But while the immune system is busy fighting off the flu, a person is less able to resist a second infection. If this second infection is in the lungs, it could be life-threatening. Older people and people with chronic diseases (such as heart disease, emphysema, asthma, bronchitis, kidney disease, and diabetes) are at the greatest risk of developing secondary infections. The most serious of these is pneumonia, one of the five leading causes of death among people over 65.

Pneumonia—an inflammation of the lungs—may be caused by a flu virus. More often, however, it results from bacteria that multiplied in the system during the flu infection.

The symptoms of pneumonia are somewhat similar to those of the flu but are much more severe. Shaking chills are very common, and coughing becomes more frequent and may produce a colored discharge. The fever that accompanied the flu will continue during pneumonia and will stay high. Pain in the chest may occur as the lungs become more inflamed.

Bacterial pneumonia is usually treated with penicillin. This antibiotic drug, which kills the bacteria, is very effective if given early enough in the course of the disease. During the most serious phase of pneumonia, the body loses essential fluids. Patients therefore often receive extra fluids to prevent shock, a dangerous condition marked by inadequate blood flow.

Prevention

Because the elderly are prone to develop pneumonia along with the flu, many doctors recommend that their older patients get a flu shot (or vaccination) in the early fall. Side effects will sometimes occur, such as a low fever or a redness at the injection site. But in most people the dangers from getting flu and possibly pneumonia are considered greater than the dangers from the side effects of the flu shot. One exception is people who have allergies to eggs: flu vaccines are made in egg products and may cause reactions in those with such allergies.

Preventing flu is difficult because flu viruses change constantly and unpredictably. This year's virus usually is slightly different from last year's. The difference generally is just enough to get by the defenses produced by the last flu shot. Therefore, flu shots are effective for only one year.

Treatment

Vaccination remains the most commonly used method of preventing influenza. In recent years, the use of an antiviral drug, amantadine, has also been recommended for the prevention and treatment of many types of influenza, particularly in high-risk individuals. However, the usual, recommended treatment is: (1) take aspirin for the aches and pains, (2) drink plenty of fluids, and (3) stay in bed until the fever has been gone for one or two days. It is especially important to stay rested, since the fever may return if the patient becomes too active too soon. If the fever persists, a doctor should be called, since this may mean that a more serious infection is present.

Scientists continue to look for ways to prevent and treat influenza. In the meantime, the Public Health Service's Advisory Committee on Immunization Practices encourages those over 65 and others with chronic illnesses to get an annual vaccination.

The National Institute of Allergy and Infectious Diseases has prepared a brochure on flu. For free, single copies, write to NIAID, Box AP, National Institutes of Health, Bldg. 31, Rm. 7A32, Bethesda, Md. 20205. The title of the brochure is *Flu.*

February 1981

National Institute on Aging

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Heat, Cold, and Being Old

As you get older, your body becomes less able to respond to long exposure to heat or cold. In cold weather, some older people may develop accidental hypothermia (hi-po-thur-mee-uh), a drop in internal body temperature that can be fatal if not detected and treated promptly. During hot and humid weather, a buildup in body heat can cause heat stroke or heat exhaustion in the elderly. This is especially true of those with heart and circulatory disease, stroke, or diabetes.

Accidental Hypothermia

Hypothermia is a condition of below-normal body temperature—typically 95 °F (35 °C) or under. *Accidental* hypothermia may occur in anyone who is exposed to severe cold without enough protection. However, some older people can develop accidental hypothermia after exposure to relatively mild cold.

Those elderly most likely to develop accidental hypothermia are: the chronically ill, the poor who are unable to afford enough heating fuel, and those who do not take the normal steps to keep warm. The small number of aged persons whose temperature regulation is defective face the greatest danger. For unknown reasons, these people do not feel cold or shiver, and thus cannot produce body heat when they need it. It is interesting to note that many people who have "felt cold" for years may actually have a lower risk of accidental hypothermia.

The only sure way to detect hypothermia to use a special low-reading thermometer, available in most hospitals. A regular thermometer will do as long as you shake it down well. If the temperature is below 95 °F (35 °C) or does not register, get emergency medical help. Other signs to look for include: an unusual change in appearance or behavior during cold weather; slow, and sometimes irregular, heartbeat; slurred speech; shallow, very slow breathing; sluggishness; and confusion. Treatment consists of rewarming the person under a doctor's supervision, preferably in a hospital.

Heat-Related Illnesses

Heat stroke is a medical emergency requiring immediate attention and treatment by a doctor. Among the symptoms are: faintness, dizziness, headache, nausea, loss of consciousness, body temperature of 104 °F (40 °C) or higher, measured rectally, rapid pulse, and flushed skin.

Heat exhaustion takes longer to develop than other heat-related illnesses. It results from a loss of body water and salt. The symptoms include: weakness, heavy sweating, nausea, and giddiness. Heat exhaustion is treated by resting in bed away from the heat and drinking cool liquids.

Protective Measures

In Cold Weather: There is no strong scientific basis for recommending room temperatures for older people. However, setting the heat at 65 °F (18.3 °C) in living and sleeping areas

should be adequate in most cases, although sick people may need more heat.

Measures you can take to prevent accidental hypothermia include:

- ☐ Dress warmly even when indoors, eat enough food, and stay as active as possible.
- ☐ Because hypothermia may start during sleep, keep warm in bed by wearing enough clothing and using blankets.
- ☐ If you take medicine to treat anxiety, depression, nervousness, or nausea, ask your doctor whether the medication might affect the control of body temperature.
- ☐ Ask friends or neighbors to look in on you once or twice a day, particularly during a cold spell. See if your community has a telephone check-in or personal visit service for the elderly or homebound.

In Hot Weather: The best precaution is to remain indoors in an air-conditioned room. If your home is not air-conditioned, you might go to a cool public place (like a library, movie theater, or store) during the hottest hours.

Other good ways to cool off include taking baths or showers, placing icebags or wet towels on the body, and using electric fans (being careful to avoid getting an electrical shock). In addition, it is wise to:

- ☐ Stay out of direct sunlight and avoid strenuous activity.
- ☐ Wear lightweight, light-colored, loose-fitting clothing that permits sweat to evaporate.
- ☐ Drink plenty of liquids such as water, fruit and vegetable juices, and iced tea to replace the fluids lost by sweating. Try not to drink alcoholic beverages or fluids that have too much salt, since salt can complicate existing medical problems, such as high blood pressure. Use salt tablets only with your doctor's approval.
- ☐ Above all, take the heat seriously, and don't ignore danger signs like nausea, dizziness, and fatigue.

Contact for Assistance

Anyone trying to save on fuel costs can protect against hypothermia by dressing warmly and heating only one or two rooms of the home. There are government-funded programs to help low-income families pay high energy bills, weatherize (insulate) their homes, or even get emergency repairs of heating/cooling units. Your local community action agency or area agency on aging should be able to direct you to the proper source of assistance.

Caution, common sense, and prompt medical attention can help older people avoid illnesses due to heat and cold. For the brochure *A Winter Hazard for the Old: Accidental Hypothermia,* check your supermarket information rack or write to: NIA/AH, Expand Associates, 8630 Fenton Street, Suite 508, Silver Spring, Maryland 20910.

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES Public Health Service National Institutes of Health

National Institute on Aging
National Institute of Dental Research

Age Page

Taking Care of Your Teeth

Preventive health care includes many elements—exercise, nutritious meals, and prompt medical treatment when necessary. It also includes regular dental care, both in the home and in the dentist's office.

Too often, older people—especially those who wear dentures—feel they no longer need dental checkups. And because the idea of preventive dental care dates back only to the 1950's, most people over 65 were not trained at an early age to be concerned with preventive care of the teeth.

If you haven't learned the basic elements of good oral hygiene, now is the time to start.

Cleaning Your Teeth

The most important part of good dental care is knowing how to clean your teeth. Brush them on all sides with short strokes, using a soft-bristle brush and any free-style brushing stroke that is comfortable. Pay special attention to the gum line. Brushing your tongue and the roof of your mouth will help remove germs and prevent bad breath. It is best to brush after every meal, but brushing thoroughly at least once a day, preferably at bedtime, is a must. See your dentist if brushing results in repeated bleeding or pain.

Some people with arthritis or other conditions that limit motion may find it hard to hold a toothbrush. To overcome this, the brush handle can be attached to the hand with a wide elastic band or may be enlarged by attaching it to a sponge, styrofoam ball, or similar object. Those with limited shoulder movement might find brushing easier if the handle of the brush is lengthened by attaching a long piece of wood or plastic. Electric toothbrushes are of benefit to many.

Careful daily brushing can help remove plaque, a sticky, colorless film that forms on the teeth and contains harmful germs. If the plaque is not removed every day, it hardens into calculus (tartar), a substance that can be removed only by a dentist or dental hygienist. The buildup of plaque and calculus can lead to periodontal (gum) disease, in which the normally pink gums begin to redden, swell, and occasionally bleed.

If untreated, periodontal disease will get worse, and pockets of infection will form between the teeth and gums. As the infection spreads, the gums recede. Eventually, the structures that hold the teeth in place are destroyed, the bone socket enlarges, and the tooth loosens and is lost. A regular program of complete oral hygiene can prevent gum disease and tooth decay in most people.

Even though brushing is the most important means of removing film and food particles from the mouth, there are many places a toothbrush cannot reach. To remove germs and pieces of food from between the teeth and near the gum line, dentists recommend daily "flossing" with dental floss. A dentist or dental hygienist can instruct you in its proper use.

Caring for Dentures

If you have dentures, you should keep them clean and free from deposits that can cause permanent staining, bad breath, and gum irritation. Once a day, brush all surfaces of the dentures with a denture-care product. Remove your dentures from your mouth for at least 6 or 8 hours each day and place them in water (but never in hot water) or a denture-cleansing solution. It is also helpful to rinse your mouth with a warm salt-water solution in the morning, after meals, and at bedtime.

Partial dentures should be cared for in the same way as full dentures. Because germs tend to collect under the clasps of partial dentures, it is especially important that this area be cleaned thoroughly.

Adjusting to Dentures

Dentures will seem awkward at first. When learning to eat with dentures, you should select soft, nonsticky food. Cut food into small pieces, and chew slowly using both sides of the mouth. Dentures tend to make your mouth less sensitive to hot foods and liquids, and less able to detect the presence of harmful objects such as bones. If problems in eating, talking, or simply wearing dentures continue after the first few weeks, your dentist can make proper adjustments.

After a number of years, dentures might have to be relined or even replaced. Do not attempt to repair dentures at home, as this can damage the dentures and be harmful to the tissues of the mouth.

Professional Care

Even with good home oral hygiene, it is important to have yearly dental checkups. Many dentists give regular fluoride treatments to adult patients to prevent tooth decay.

Dental checkups not only help maintain a healthy mouth, but are necessary for the early discovery of oral cancer and other diseases. Mouth cancer often goes unnoticed in its early and curable stages. This is true in part because many older people do not visit their dentists often enough and because pain is not an early symptom of the disease. If you notice any red or white spots or sores in the mouth that bleed or do not go away within 2 weeks, be sure to have them checked by a dentist.

It is essential to take care of dental problems before undergoing major surgery. The results of a complicated and successful heart operation, for example, could be endangered if certain bacteria—which are always present in the mouth—get into the bloodstream and lodge on heart valves.

Although general dentists can take care of the dental needs of most older people, some dentists have a special interest in the care of geriatric patients. The American Society for Geriatric Dentistry (1121 W. Michigan Street, Indianapolis, Indiana 46202) has the names and addresses of several hundred such dentists.

For information on dental research, write to the National Institute of Dental Research, National Institutes of Health, Bethesda, Maryland 20205. Information on general dental care can be obtained from the American Dental Association, 211 E. Chicago Avenue, Chicago, Illinois 60611.

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APPENDIX III

MEDIA RESOURCES FOR TRAINING

MEDIA RESOURCES FOR TRAINING

The sources for ordering the videotapes and films follow:

1. "Things We Take for Granted" (Session I) Cat. No. 577V

2. "Hey Look At Me" (Session II) Cat. No. 578V

3. "Rediscovering the Community" (Session VII) Cat. No. 579V

   Michigan Media
   416 Fourth Street
   Ann Arbor, MI 48109

4. "Board and Care" (Session III)

   Pyramid
   Film & Video
   Box 1048
   Santa Monica, CA 90406

5. "Because Somebody Cares" (Session VIII)

   Terra Nova Films
   17832 S. 67th Avenue
   Tinley Park, IL 60477

6. "Rose by Any Other Name" (Session X)

   Adelphi University Center on Aging
   Garden City, NY 11530