Northern Lakes
COMMUNITY MENTAL HEALTH AUTHORITY

Introduction to Human Services

Your guide to providing quality care, effective documentation, and Person-Centered Planning

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WELCOME!

This training module will help to familiarize you with the Mental Health System, your role as a caregiver, and some of the conditions those we serve may be diagnosed with.

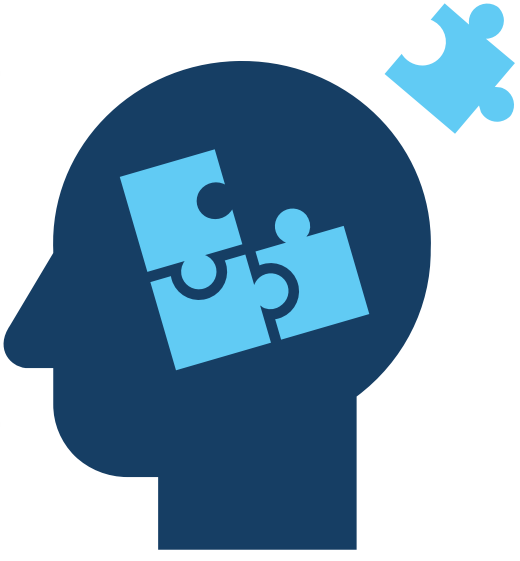
Your impact on the people you care for cannot be understated. Daily interactions with the world and individuals around us shape our perceptions, values, and beliefs.

SECTION 1: Contextual Caregiving

In this section we will explore the stigma surrounding mental health challenges, the history of mental health treatment, and how our own values, attitudes, and beliefs can impact the care we provide.

Definition of Stigma

Stigma is a word used to describe a set of negative attitudes, beliefs, or ideas that people may hold toward a specific group, in this case those living with mental illness or developmental disabilities. These misconceptions are rooted in ignorance and often lead to discrimination and shame.



Definition of Unconscious Bias

Unconscious Bias refers to any personal preference, attitude, or expectation that unconsciously affects a person's outlook or behavior. These perceptions can impact a caregiver's approach toward a person they are assisting without them realizing it.

Stigma + Unconscious Bias

Social stigma can be a source of Unconscious Bias. Society's negative stereotypes and attitudes can be absorbed over the course of years, leading to unconscious biases about the stigmatized group. It is up to us a caregivers to examine our own prejudices and correct our behavior accordingly.

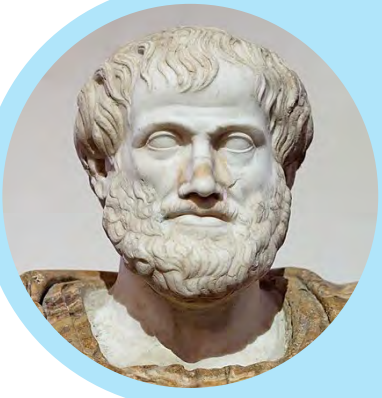
Example: A common stigma surrounding people with obesity is that they are lazy, lack discipline, and make poor health choices. As a result, healthcare professionals often make assumptions about patients based on their weight.

A Historical Perspective

Much of society's stigma surrounding mental illness and disabilities stem from the evolution of how we approach treatment for individuals affected. Below you will find a brief timeline of moments in the history of mental health treatment that provide valuable context for the services we provide today.

ANCIENT BELIEFS

Mental illness was often blamed on supernatural forces or demonic possession, fueling fear of those afflicted. Treatments included exorcisms, rituals, or folk remedies with no real benefit.



400 BCE: HIPPOCRATES

Ancient Greek physician and "Father of Medicine" Hippocrates proposed that mental illness can be caused by natural issues with a person's body, such as an imbalance of bodily fluids. While this was not entirely correct, it was an early step toward viewing mental health issues as a medical/physical issue.

500 CE – 1500 CE: MIDDLE AGES

During this time mental illness was seen as witchcraft or punishment for sinful behavior, resulting in thousands of people being executed. This period served to deepen the fear surrounding people with mental illness and began associating it with weakness of character.

1500 CE – 1815 CE: RENAISSANCE & ENLIGHTENMENT

Over time, housing and care of the mentally ill fell to poor houses and hospitals. But between rampant neglect and inhumane living conditions, these facilities had more in common with prisons. In the late 1700s figures like Philippe Pinel and William Tuke were advocates for moral treatment that included kindness, fresh air, and structured routines for patients.

1815 CE – 1900 CE: MORAL TREATMENT ERA

The work of Pinel and Tuke inspired other advocates. Reformers such as Dorothea Dix and Dr. Robert Gardiner Hill petitioned lawmakers for change. As a result, legislation was passed that required each state to provide care for the mentally ill and disabled populations.

NOT ALL HEROES WEAR CAPES

In 1887, journalist Nellie Bly went undercover as a patient to Blackwell's Island to expose its inhumane conditions. During her stay she witnessed neglect, abuse, and the wrongful institutionalization of numerous women. Her exposé, *Ten Days in a Mad-House*, shocked the public and led to a grand jury investigation, increased funding for mental health care, and reforms in patient treatment

1900 CE – 1945 CE: MENTAL HYGIENE MOVEMENT

The introduction of more biologically based treatments brought about dark days for state-run asylums. Insulin shock therapy, electroconvulsive therapy, and lobotomies were commonplace. Overpopulated facilities were criminally understaffed, resulting in these treatments often being weaponized against patients as a form of punishment.

1914 CE – 1918 CE: WWI & 1939 CE – 1945 CE: WWII

World War I marked the first large-scale recognition of psychological trauma, described as "shellshock," then later "battle fatigue." In World War II measures were taken to expand treatment options in the field. At home, conscientious objectors and veterans advocated for better mental health services.

1933 CE – 1945 CE: HOLOCAUST REMEMBRANCE

Beginning in 1933 Germany passed a law that legalized the forced sterilization of "unfit" individuals, including those with epilepsy, schizophrenia, and alcoholism. This became the T4 program which saw anyone with chronic medical or mental health issues taken from their families and executed.

It is estimated that close to 250,000 people with disabilities were murdered during the reign of Nazi Germany.

1945 CE – 1955 CE: POST-WAR REMODEL

World War II highlighted the urgent need for better mental health care, prompting the 1946 National Mental Health Act to fund improved treatment. In 1952, Thorazine became the first non-invasive medication for severe mental illness, offering hope for life outside institutions. Despite its promise, widespread use was slow, and asylum populations peaked in 1955.

A NEW DIAGNOSTIC TOOL

The first Diagnostic and Statistical Manual of Mental Disorders (DSM) was published in 1952 and introduced standardized psychiatric diagnoses. It shifted over time from theory to symptom-based classifications, especially in DSM-III (1980), improving diagnostic consistency and treatment access. While essential to modern care, the DSM also drew criticism for overmedicalization and cultural bias.

1960 CE – 1980 CE: DEINSTITUTIONALIZATION

The 1963 Community Mental Health Act shifted care from institutions to community settings, aided by new antipsychotic medications. However, underfunded programs left many without support. Negative media portrayals and public fear reinforced shame, despite growing clinical understanding. Mental illness was still widely hidden within families and misunderstood by society.

ALLIES IN HIGH PLACES

Rosalynn Carter championed mental health for over 50 years. As First Lady, she led the push for the Mental Health Systems Act of 1980. Later, she founded organizations supporting caregivers and reshaping public views, including the Carter Institute. Her advocacy improved care, policy, and awareness nationwide.

1980 CE – 2000 CE: SHIFTS IN TREATMENT

During this time mental illness was looked at medically. SSRIs like Prozac transformed depression treatment. Managed care prioritized medication over therapy, while advocacy slightly reduced stigma. However, anti-psychiatry movements began to form, leading to a harmful mindset around medication use that persists to this day.

2000 CE – PRESENT: A MODERN APPROACH

In recent years treatment for mental health issues has turned toward a pragmatic combination of Cognitive Behavior Therapy (CBT) and medications. While stigma remains, advocacy groups and programs utilizing Peer Supports continue to improve treatments and conditions for those seeking services.

As we can see, the history of mental health treatment is long, dark, and complicated. But the idea that people living with mental illnesses or developmental disabilities are at fault for their condition, or that these conditions represent a personal failure, only leads to mistreatment, isolation, and silence. Asylums generated more fear than care, and stigma prevented many people from seeking help.

Today, we know that the best defense against stigma is clear, compassionate knowledge. Education breaks down myths, builds empathy, and encourages open conversations that replace shame with strength.

SECTION 2: Developmental Disabilities

In this section we will be looking at the various types of Developmental Disabilities, their causes, signs, and symptoms.

A developmental disability is defined as, “any of various conditions… that usually become apparent during infancy or childhood and are marked by delayed development or functional limitations especially in learning, language, communication, cognition, behavior, socialization, or mobility.” – Merriam-Webster Dictionary

For someone to be diagnosed with a developmental disability they must meet the following criteria:

- The disability must occur before age 22
- Due to a mental or physical condition (or a combination of both)
- Likely to be a life-long condition
- The condition demonstrates that a person needs services that are individually planned and delivered
- The person’s ability to become economically self-sufficient is affected
- The person’s life is limited in three or more of the following areas:
    - Taking care of themselves
    - Being able to communicate and to understand communication
    - The ability to learn
    - Mobility
    - Being able to live independently

Individuals with developmental disabilities often face a range of complex challenges that impact their daily lives and overall well-being. These can include communication barriers, sensory sensitivities, and limited access to education, employment, and healthcare tailored to their needs. Stigma and misunderstanding from others can further contribute to isolation or exclusion. In this landscape, caregivers serve as an essential lifeline; their patience, advocacy, and daily support empower individuals to express themselves and pursue their goals. Recognizing and uplifting the role of caregivers is essential to building inclusive, compassionate communities where everyone can thrive.

What causes Developmental Disabilities?

For many people with developmental disabilities an exact cause for their condition cannot be determined. And while there are many causes of developmental disabilities, they can be roughly divided into two categories: physical causes and social causes.

Physical Causes of developmental disabilities include:

- Pregnancy of an older mother
- Pregnant mother contracting Rubella
- Problems with a father's sperm
- Infections that affect the brain
- Lack of oxygen during or after birth
- Physical injury to the brain
- Exposure to some chemicals that affect the health/development of the brain
- Abnormalities in the person's chromosomes
- Exposure to lead which could come from old paint, plumbing, or high levels of lead in soil or water sources

Social Causes of developmental disabilities are more complicated.

If a pregnant mother drinks alcohol the development of the baby can be affected. Drinking during the early months of pregnancy can result in physical problems and deformities, while drinking during the later months can cause emotional and social issues associated with developmental disabilities.

Another social cause involves a lack of stimulation for the growth and development of a child's brain. In order to develop infants and children need stimulation, a pleasant physical environment, physical touch, and verbal interaction by parents and/or caregivers. Throughout development the brain needs to be exposed to situations that allow the child to learn. If certain abilities are not learned during the correct phase of development, it can make learning later more difficult.

In most cases these could have been prevented.

According to the Michigan Mental Health Code conditions that qualify as a Developmental Disability are Intellectual Disabilities, Autism Spectrum Disorders, Epilepsy, and Cerebral Palsy.

Intellectual Disabilities

Intellectual Disabilities are also referred to as “cognitive disabilities.” An intellectual disability means that a person has an IQ (intelligence quotient) score below 70 or 75. The most common intellectual disabilities are a result of Autism, Downs Syndrome, Fragile X Syndrome, and Fetal Alcohol Syndrome.

DOWN SYNDROME

Down Syndrome is a result of having an extra 21st chromosome. This can sometimes occur when the person’s birth mother is older than usual. The physical appearance of someone with Down Syndrome is typically recognizable: the nose is flatter, the mouth is smaller, the tongue may be unusually large and may stick out much of the time, eyes often have a fold at the inner corner, fingers may be short and thick. In general, a person with Down Syndrome will be noticeably stocky in appearance.

People with Down Syndrome are at risk of other physical issues: the ear canal can be narrow, causing hearing problem or repeated ear infections. There is a greater risk of heart problems and for some types of Leukemia. An adult with Down Syndrome has an almost 100% chance of developing Alzheimer’s Disease at an early age.

FRAGILE X SYNDROME

Fragile X Syndrome is caused when the X chromosome does not produce enough of a specific type of protein that is essential for brain development. Because males have only one X chromosome, this syndrome is typically more severe. Physical appearance may include large ears, a long face, and large testicles. There may be many of the same characteristics present as seen in Autism, Attention Deficit Disorder (ADD), or Attention Deficit Hyperactivity Disorder (ADHD).

Elements of Fragile X are often far less serious in females. The majority do not have a serious intellectual disability, and some show no characteristics at all but can still pass it on to children.

FETAL ALCOHOL SYNDROME

Fetal Alcohol Syndrome is a result of an expectant mother drinking alcohol during pregnancy. The alcohol passes into the unborn child's bloodstream. Because the unborn child is so tiny even a small amount of alcohol has a greater effect on the baby than on the mother. Healthcare professionals cannot identify any amount/type of alcohol that is safe during pregnancy.

This one cause of developmental disabilities is completely preventable.

Effects of Fetal Alcohol Syndrome vary greatly from one child to another and can cause physical problems, intellectual disability, learning difficulty, problems with vision, and behavior problems.

Some characteristics of Fetal Alcohol Syndrome include:

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

FETAL DRUG SYNDROME

Fetal Drug Syndrome is similar to Fetal Alcohol in that it is caused by using illegal drugs or misusing legal medication during pregnancy. Many of the physical issues of Fetal Alcohol Syndrome are also seen in Fetal Drug Syndrome. Depending on the drug used a baby can be born with an addiction which can result in extreme difficulty with withdrawal.

Many over-the-counter (OTC) medications should not be used if a woman is pregnant or planning to become pregnant. It is especially important for pregnant women to avoid coming into contact with certain medications for men.

Autism Spectrum Disorder

Autism is one of the fastest growing developmental disorders, so the odds are good that you will encounter or care for someone with some variation of Autism. Characteristics typically include:

- Social Impairments
- Cognitive Impairments
- Communication Difficulties
- Repetitive Behaviors

Autism is a spectrum disorder, which means that it's impact on a person can range from mild to severe and each person's experience is unique. Approximately 40% have average to above average intellectual abilities and many persons on the spectrum take deserved pride in their distinctive abilities and "atypical" views of the world.

Due to the success of media like *Sherlock Holmes* and *Rain Man* the stereotype of the "Autistic Savant" has permeated throughout pop culture. While many of those on the Autism Spectrum have exceptional abilities in art, music, or academic skills, this stereotype is harmful and perpetuates unrealistic expectations of people who are living with this condition.

Autism occurs in all ethnic, socioeconomic, and age groups, though males are four times more likely to have Autism than females. It can sometimes be difficult to diagnose in children. Some children display no unusual signs or symptoms until age 1 or 2 and then may suddenly "regress," losing language and social skills they had previously learned.

Some typical characteristics of Autism Spectrum Disorder are:

- Difficulty playing with other children
- Not responding to their name (the person may appear deaf)
- Difficulty with pretend or imaginary play
- Avoiding eye contact
- Give unrelated answers to questions
- Have difficulty understanding, or showing understanding, of feelings
- Repeat words or phrases over and over (echolalia)
- Get upset by minor changes
- Have obsessive interests
- Flap hands, rock their body, or spin in circles
- Displaying over or under sensitivity to sensory input (the way things sound, taste, smell, look, or feel)
- Avoid or resist physical contact
- Demonstrate little safety or danger awareness

Cerebral Palsy

Cerebral Palsy (CP) is caused by an injury to the brain or lack of oxygen, usually before or during birth. There are different kinds of Cerebral Palsy, depending on which part of the brain was impacted. Because of this a person with this condition may not actually have an intellectual disability. For many intelligence is not impacted.

Symptoms of Cerebral Palsy vary from person to person. One person with severe CP may be unable to walk and require lifelong care, while a person with mild CP might walk awkwardly but not need any additional assistance. There are four main types of Cerebral Palsy.

Spastic Cerebral Palsy

The most common type of CP, people with this variation have increased muscle tone resulting in stiffness in their muscles that cause their movements to be awkward. This type of CP is often described by which parts of the body are affected.

Dyskinetic Cerebral Palsy

Dyskinetic CP causes problems controlling movement in the hands, arms, feet, and legs. Movements are uncontrollable and can be either slow or rapid and jerking. Sometimes the face and tongue are impacted, making it difficult for the person to speak or swallow. Dyskinetic CP can cause muscle tone to change from too tight to too loose, sometimes throughout a single day.

Ataxic Cerebral Palsy

People with Ataxic CP have difficulty with balance and coordination. They may be unsteady when they walk or have a hard time with movement that require a lot of control, such as writing. Quick or abrupt movement is also difficult.

Mixed Cerebral Palsy

Many people have symptoms of more than one type of CP. The most common type of mixed Cerebral Palsy is Spastic-Dyskinetic Cerebral Palsy.

Epilepsy

Epilepsy is the condition of having recurring seizures. Anyone might have a seizure at some point in life, but an Epilepsy diagnoses is based on a pattern of seizures.

Seizures can be classified in three ways: focal, generalized, or unknown onset.

Focal Onset (formerly called partial seizures)

This type of seizure starts in a specific region of the brain. Focal seizures can often be mistaken for daydreaming or being intoxicated because they can be subtle in nature. These can be broken down into two groups:

- **Focal Aware –** the person is aware of what's happening around them but cannot talk or respond. These are typically brief and may indicate that a more intense seizure is on the way.
- **Focal Impaired Awareness –** the person's awareness is impacted and they may appear confused or disoriented.

Generalized Onset

This type of seizure affects both sides of the brain and almost always affect the person's awareness in some way. They can be classified further by the type of movement observed.

- **Tonic:** involves stiffening of the body, arms, or legs which will result in the person falling if they are standing
- **Atonic:** a brief seizure that causes sudden loss of muscle tone. The person often falls to the ground of will have an abrupt head nod if sitting
- **Clonic:** uncommon, causes jerking in various parts of the body
- **Absence:** a sudden lapse in awareness that looks like a staring spell or daydreaming
- **Tonic-Clonic:** the body stiffens (tonic phase) followed by the limbs jerking rhythmically (clonic phase)
- **Myoclonic:** sudden single jerks of a muscle or group of muscles that last only a few seconds

Unknown Onset

Unknown onset means the seizure cannot be diagnosed as either focal or generalized onset. Sometimes further testing is required, or the symptoms of the seizure are unusual.

SECTION 3: Mental Illness

In this section we will look at common myths vs facts about mental illness and the signs, symptoms, and possible causes of disorders such as Schizophrenia, Bipolar Disorder, Depression, and Post Traumatic Stress Disorder.

Mental Illness is defined as, "any of a broad range of medical conditions… that are marked primarily by sufficient disorganization of personality, mind, or emotions to impair normal psychological functioning and cause marked distress or disability and that are typically associated with a disruption in normal thinking, feeling, mood, behavior, interpersonal interactions, or daily functioning." – Merriam-Webster Dictionary

Nearly 1 in 5 adults in the United States experience a diagnosable mental health disorder each year. These numbers highlight the urgency of addressing mental health needs with the same seriousness, compassion, and dignity as physical health needs.

Common disorders such as Depression, Anxiety, Schizophrenia, and Bipolar Disorder affect individuals in varied and deeply personal ways. These conditions can disrupt a person's ability to regulate emotions, navigate relationships, perform daily tasks, and maintain a sense of identity.

For example:

- Someone with depression might struggle to get out of bed, despite desperately wanting to participate in life.
- A person experiencing schizophrenia may perceive reality differently, leading to distress and isolation.
- Individuals with anxiety may endure constant, invisible battles that affect their ability to feel safe in ordinary situations.

As direct care providers, it is vital to remember that these individuals are not defined by their diagnoses. Mental illness is only one aspect of their experience. With timely, compassionate care, many people can stabilize symptoms, develop coping strategies, and pursue personal goals. Recovery is possible and support is powerful.

MENTAL ILLNESS

MYTHS	FACTS
Having a mental illness means that a person is "crazy."	Having a mental illness means that a person has an illness with challenging symptoms, just like someone with an illness like diabetes. While mental illness may alter a person's thinking, moods, or perception of reality it does not mean they are "crazy."
Psychiatric medications are bad and should be avoided.	For many people with mental illness medication is necessary, just as a medication may be necessary for someone with high blood pressure. In addition, adding regular therapy to a medication regimen can greatly improve someone's quality of life.
People with mental illness are violent and dangerous.	The media is often quick to label violent offenders as "mentally ill." But the fact is that only 5% of violent crimes in the U.S. are committed by people with a mental illness; in fact, they are more likely to be victims of violence than perpetrators. Remember: hate is not a mental illness.
A person with a mental illness can "snap out of it" if they try hard enough.	Many elements contribute to mental health conditions, including biological factors, life experiences such as trauma or abuse, and a family history of mental health conditions.
I can't do anything for a person with a mental health issue.	Friends/family can be important influences to help someone get the treatment they need by reaching out, helping them access mental health services, help them learn self-care techniques, treating them with respect, and not defining them by their diagnosis.
Therapy and self-help are a waste of time. Why bother when I can just take a pill?	Treatment for mental health conditions vary depending on the person and could include medication, therapy, or both. Many people do best when they work with a support system.

Common Mental Illnesses

Anxiety Disorders

Generalized Anxiety Disorder	Excessive, frequent, and unrealistic worry about everyday things
Panic Disorder	Unexpected panic attacks that are not due to another mental or physical condition
Social Anxiety Disorder	Intense and ongoing fear of being judged negatively and/or watched by others
Separation Anxiety Disorder	Excessive anxiety when separated from a specific person/place
Agoraphobia	Intense fear of becoming overwhelmed or unable to escape and get help

Anxiety Disorders are characterized by excessive fear and worry that result in behavioral disturbances. Symptoms are severe enough to result in significant distress or functional impairment.

To the left are five different types of anxiety disorders and their characteristics.

Depression

Depression is defined by different from mood changes and responses to everyday situations. During a depressive episode, the person experiences sadness, irritability, or a feeling of emptiness.

Other symptoms may include:

- Loss of interest in activities
- Poor concentration
- Feelings of guilt or low self-worth
- Hopelessness about the future
- Thoughts about dying or suicide
- Disrupted sleep
- Changes in appetite or weight
- Feeling especially tired or low energy

Bipolar Disorder

Formerly called “manic-depressive disorder,” a person with this condition experiences swings of mood from depression (as described above) to elation and unusually high energy (the “manic” phase).

Manic symptoms may include:

- Euphoria
- Irritability
- Increased activity/energy
- Increased talkativeness
- Racing thoughts
- Increased self-esteem
- Decreased need for sleep
- Distractibility
- Impulsive/reckless behavior

Schizophrenia

Much like Autism, Schizophrenia is a spectrum of disorders. Despite the variations many symptoms remain the same, including psychosis (losing touch with reality). The person may not be able to recognize that they are hallucinating or delusional.

Symptoms may include:

- Persistent delusions
- Hallucinations
- Disorganized thinking
- Highly disorganized behavior
- Extreme agitation
- Paranoia
- Cognitive impairment

Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) causes a pattern of unwanted thoughts and fears (obsessions).

These obsessions cause repetitive behaviors (compulsions).

Common Obsessions

- Fear of germs
- Fear of losing something
- Fear of losing control
- Aggressive thoughts toward self or others
- Desire to have symmetry/perfect order

Common Compulsions

- Excessive cleaning or handwashing
- Arranging items in a particular way
- Repeatedly checking things
- Compulsive counting
- Repeating words silently

Post-Traumatic Stress Disorder

Post-Traumatic Stress Disorder (PTSD) is caused by the person being part of or witnessing a stressful or terrifying event. The body continues to release hormones and brain chemicals associated with stress/fear response long after the traumatic event has ended.

Symptoms may include:

- Intrusive memories
- Reliving a traumatic event
- Upsetting dreams about the event
- Negative changes in mood like those of depression
- Changes in emotional reactions
- Being easily startled
- Self-destructive behavior

SECTION 4: Substance Use Disorders

In this section we will review substance use disorders, their connection to mental illness, and the difference between Dual Diagnosis and Co-Occurring disorders.

Substance use disorders are defined by a pattern of use of alcohol, drugs, and/or medications (legal or illegal) that interferes with a person's ability to function at home, work, school, or in their community. There are many common risk factors, including environmental influences and genetics.

Repeated substance use can alter how the brain functions, subjecting the person to distorted thinking and behaviors. Brain imaging studies have shown changes to the areas of the brain that relate to judgement, decision-making, learning, memory, and behavioral control. As a result, the person with the disorder **may be aware of their problem but unable to stop.**

Studies have also shown that people who struggle with a mental illness or disability are far more likely to develop a reliance on drugs and/or alcohol as a form of self-medication.

Dual Diagnosis vs Co-Occurring

In your role as a care provider, you may hear either of these terms used to describe the people you are caring for. However, there is currently some debate regarding the diagnostic applications of these terms, as they tend to be used interchangeably.

Dual Diagnosis refers to a person who has been diagnosed with two or more developmental disabilities or mental illnesses

Co-Occurring is the term associated with a person who is living with a mental illness or developmental disability **and** a substance use disorder.

SECTION 5: Providing Mental Health Services

To provide quality support to the people we serve, Caregivers must be familiar with several important components to receiving mental health services. These aspects work together so that the person receiving assistance gets the best possible quality of life.

Person-Centered Planning (PCP)

The Family/Person-Centered Planning process is guaranteed by the Michigan Mental Health Code to all families/individuals receiving publicly funded mental health services. The PCP process is meant to put individuals (and families with minor children) in control of their treatment. PCP is an open-ended discussion between the Supports Coordinator, Therapist, Nurse, or other professionals and the person receiving services that continues throughout the year so to ensure that the person is receiving the correct and adequate supports needed to achieve their goals.

Input from the person is essential to the process. Each person or family is entitled to make their own choices regarding services. Some people may require assistance in identifying available choices, while others may need help making realistic choices. Regardless, the person/family for whom the plan is developed chooses who they want to attend the planning meeting.

A Person-Centered Plan is a flexible document and must be changed as the person's needs and wishes change. It must also change if the person served is not satisfied. It is the responsibility of caregivers to honor the person/family's wishes, just as it is the responsibility of the person/family supported to participate to achieve the goals and objectives.

The PCP process identifies specific objectives for the person's services based on what the person/family wants and what needs have been identified. Areas covered include:

- Housing
- Clothing
- Health
- Employment and/or education
- Legal
- Transportation
- Relationship
- Recreation

Trauma Informed Services

Substance Abuse and Mental Health Services Administration (SAMSHA) defines trauma as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being."

Traumatic events can vary wildly in their duration and intensity, including but not limited to physical, emotional, or sexual assault, neglect, serious accident, illness, or medical procedure, victim of or witness to violence, bullying, disasters, forced displacement, war, grief, and system-induced trauma or re-traumatization.

Secondary trauma: trauma-related stress reactions and symptoms resulting from exposure to another person's traumatic experience. Secondary trauma can occur among service providers across all behavioral health setting, but especially in situations where a professional is working closely with a traumatized individual.

It is vital that we as caregivers understand the history of the people we serve in order to avoid re-traumatizing them or causing undue distress.

Some common triggers for those who have experienced trauma may include:

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

Caregivers need to understand that the people we serve are often coping the best way that they know how. Our job is to build relationships based on trust and create an environment where we are sensitive to trauma and what may trigger it. Caregivers are a core component of creating a safe and positive space in which an individual may feel safe and heard.

Self Determination

As we covered earlier, the history of mental health services is a dark one that put the person with a mental illness or disability under the complete control of caregivers and professionals. The person had no voice in their treatment and as a result was often the victim of abuse or neglect.

Self-determination means that we give control of treatment back to the person, where it rightfully should be. It means that the person served has the right to actively engage in their services, as well as control the resources available to them.

An important aspect of managing one's own services is the control of their budget and resources. The person receiving services should have direct control over their finances. In many cases an individual or organization known as a fiscal intermediary may assist the person in matters such as paying bills, hiring staff, or locating support services in the community.

The Recovery Model

The recovery model arose in the 1970's as a grassroots movement in response to the deplorable conditions in state run institutions. This philosophy advocates that everyone, regardless of how severe their mental illness or disability, should be able to experience positive identity, hope, empowerment, wellbeing, and social inclusion.

An effective program based on the recovery model will include the following elements:

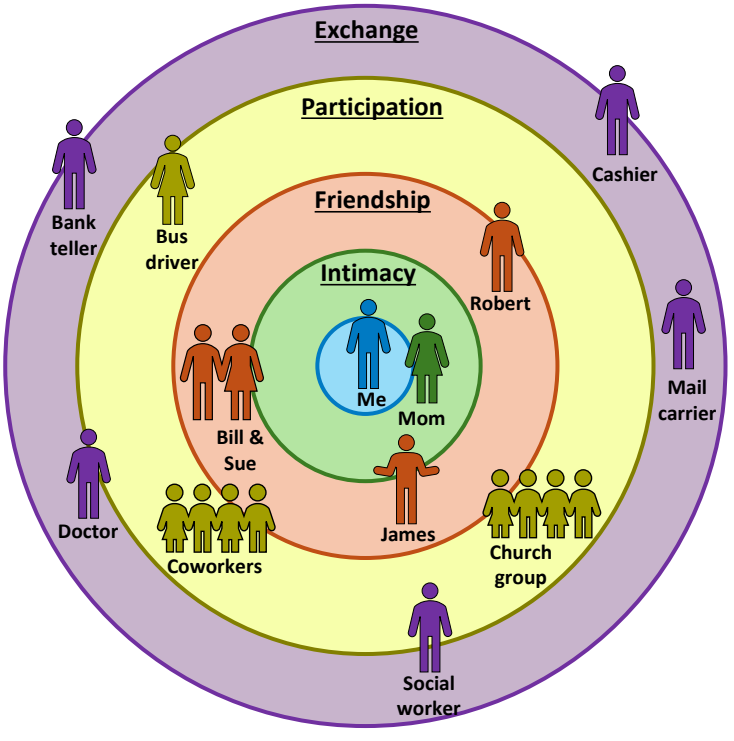
- The person receiving services actively participates in the process, rather than being a passive recipient of treatment
- The process is directed by meaningful activities, community participation, respect for cultural perspectives, and the support of friends/family.
- The program is based in optimism and encouragement, building on the person's strengths
- A trusting and respectful relationship between the person supported and caregivers

Natural Supports

Natural supports are the supportive connections and relationships we enjoy in our own lives. Family, friends, neighbors, coworkers, classmates, members of clubs or churches we may attend, or people in the community we interact with every day. Most people do not have to think about these relationships, they simply exist.

For many people living with a mental illness or disability these connections are less available. The stigma of disability may keep others at a distance. For some of those we provide care for their most frequent interactions on a regular basis are either people with similar disabilities or people who are paid to be in their lives (caregivers, clinicians, councilors, etc.)

A Circle of Support



First Circle: Intimacy
These are the people you cannot imagine living without

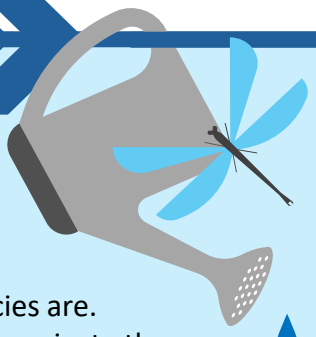
Second Circle: Friendship
These are good friends (that almost made it in the first circle)

Third Circle: Participation
People, organizations, clubs, groups, etc. that you are involved with

Fourth Circle: Exchange
People who provide services in your life

Part of our responsibility in the lives of the people we support is teaching them how natural relationships develop on a respectful and mutual basis. This begins with the nature of our relationships with them. Because their disability may limit independent access to the community, we may need to create opportunities for them to get to know others. In that aspect we become role models for those in the community on how to relate to the people we serve.

A Culture of Gentleness



The Culture of Gentleness model, or "Gentle Teaching," functions on the principle that all individuals need to feel emotionally and physically safe in order to thrive. Most counseling or intervention strategies focus on what the individual needs to change or what the individual's deficiencies are. Culture of Gentleness puts the focus on us as caregivers and how we can navigate the situation in a way that supports the person while also establishing a foundation of trust.

When an individual feels loved and valued the result is a sense of:

Safety
Feeling protected and supported without fear of harm or rejection

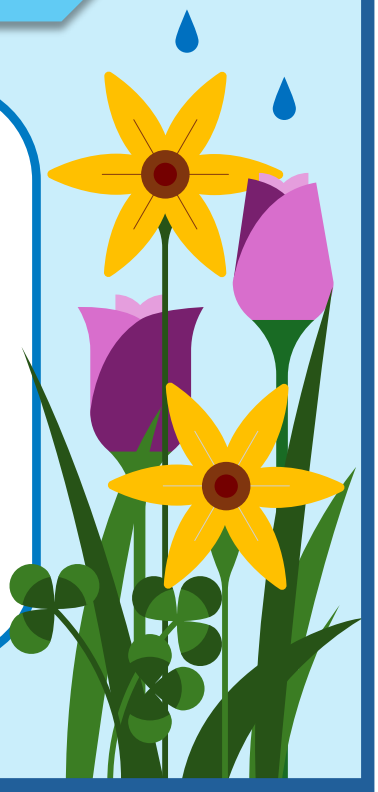
Belonging
Being part of a community where they feel accepted and included

Worthiness
Recognizing their inherent value and deservingness of love, caring, and respect

Caregiver's Toolbox

There are many tools and techniques that we as caregivers can utilize in order to foster a safe and loving environment.

- Greet and treat the individual with respect
- Speak kindly
- Use eye contact
- Respect boundaries
- Remain calm
- Positive reinforcement
- Active listening
- Reduce demands
- Slow down
- Reduce transitions
- Active observation



Person-First Language

The words we use to communicate and/or describe another person has a huge impact on our relationship with that person. The simple act of choosing words more carefully can go a long way toward strengthening relationships. Person-First Language puts the emphasis on the person instead of the disability.

We have a duty as professionals and as caregivers to use language that positively represents the individuals we serve.

Person-First Phrases	Negative Terms/Phrases
Person with a physical disability	Cripple, lame, deformed, invalid
Person with an intellectual, cognitive, or developmental disability	Slow, simple, retard, defective, special needs, afflicted
Person with a mental illness, person with a psychiatric disability	Crazy, nuts, psychotic, psycho, whack job, mental patient, insane
Person without a disability	Normal person, healthy person
Person who has…, person who experienced…, person with…	Victim of…, suffers from…, stricken with…
Person who is unable to hear and/or speak	Mute, dumb, deaf and dumb, impaired, deaf mute
Person with cerebral palsy	Palsied, spastic, spaz, CP victim
Person of short stature, dwarf, little person	Midget
Person with Down Syndrome	Mongoloid
Person living with a substance use disorder/challenge	Addict, junkie, druggie
Person who has a mobility impairment, person who uses a wheelchair	Quad, gimp, cripple, wheelchair bound, confined to a wheelchair

SECTION 6: Documentation

One of the most important responsibilities for any caregiver is recording events and observations of the person served, as well as any action taken by the caregiver. In this section we will look at different types of documents you may encounter, rules for documenting, and why it is so important to take clear and objective notes.

"If you didn't document it, it didn't happen."

This phrase is one that is said often in relation to caregiving of any variety, from direct care in a small home all the way up to administration of a large hospital. And for good reason. Documentation is how progress is measured and how it is determined which changes need to be made. The best way to do this is to write unbiased notes based on what was witnessed.

Documentation Guidelines

Evaluative Writing VS **Descriptive Writing**

Evaluative Writing: in clinical documentation this is in reference to your own opinion or assessment of events. This can be harmful, especially when interpreting signs, symptoms, or reasons for behavioral challenges. In some instances, it may be necessary to give your evaluation of events. In cases such as this it is important that you explain very clearly that this is your own opinion or estimation.

Example: *"Tim was aggressive towards others."*

Descriptive Writing: this relates to what you have seen, heard, or physically felt. Writing what you saw a person do (or even what you looked for but did not see) is descriptive. Quoting what you heard a person say is descriptive. It should also convey any actions you took and what you said.

Example: *"Tim raised his voice during a conversation with peer, said 'Leave me alone!' and walked away quickly."*

Why does documentation matter?

State Rules

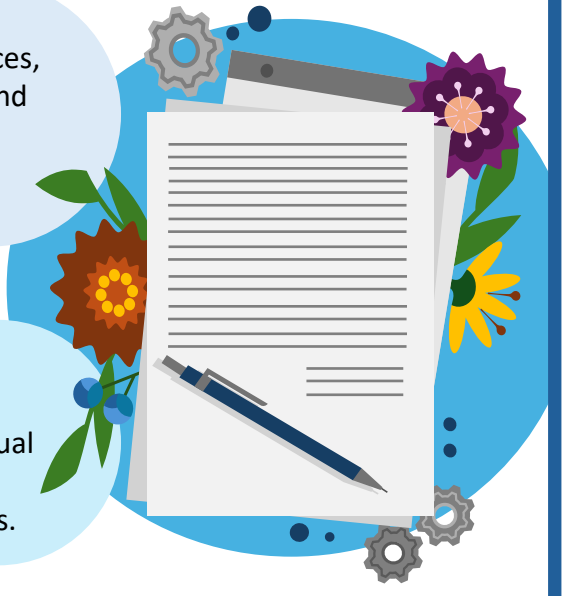
The Department of Licensing and Regulatory Affairs (LARA) and the Michigan Department of Health and Human Services (MDHHS) both set strict standards for documentation in a direct care setting. Part of this effort is to ensure a continuity of care, but another critical component is billing for services.

Safety & Well-Being

Communication between staff is critical to providing a stable and safe environment for the people we serve. Objective documentation provides the next shift with any changes they may need to be aware of (such as new symptoms, obstacles they encountered, medication changes). This allows caregivers to respond to quickly and appropriately with a working knowledge of the situation.

Person-Centered Care

Thorough documentation will help caregivers to understand and support each person's preferences, routines, and goals. By recording observations and interactions objectively, staff can address their biases and ensure that care remains respectful, individualized, and consistent across shifts.



Legal Security

In a situation that centers around abuse, negligence, or other criminal aspects objective documentation is a critical safeguard. Clear, factual notes can demonstrate that staff acted appropriately and followed established protocols.

Tracking Goals & Progress

Each person receiving services through Community Mental Health will have an Individualized Plan of Service (IPOS) outlining goals and strategies for support. Documenting on efforts and progress made, as well as the person's response, will assist the person's primary worker to identify what is working and what is not, allowing them to make necessary adjustments.

Types of Documents

While caring for an individual receiving services, there are a number of documents you may be required to complete. Below is a list of the most common types of forms/notes completed by direct care providers.

Personal Care Log

Versions of the Personal Care/Community Living Supports Log vary wildly depending on the person's living arrangements. The purpose of this log is to document how an individual's Plan of Service is implemented on each shift. The form typically covers different aspects of daily life (personal hygiene activities, meals and preparation, medications, housekeeping activities, etc.)

Recipient Rights Complaint

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

Incident Report

An Incident Report (IR) or Critical Incident Report (CIR) records events and observations tied to a specific event that impacts the health and well-being of the person served. A few examples of what might require an IR include:

- Accidents
- Illness
- Medication errors
- Injuries
- Hospitalizations
- Adverse encounters within the community

Medical Chronology

More commonly known as a "medical summary" or "medical record," this document is used to track a person's medical appointments, procedures, treatments, diagnostic changes, referrals, etc.

Medication Administration Record

This document records the administration of prescribed medications to the person supported. It can also be used to document certain health treatments or any over the counter (OTC) medications given and for what symptoms. In the event a medication is refused, missed, or a medication error occurs, the event is recorded in the Medication Record, Medical Chronology, and an Incident Report. Each time medication is administered the caregiver makes a notation in the record.

Staff Communication Book

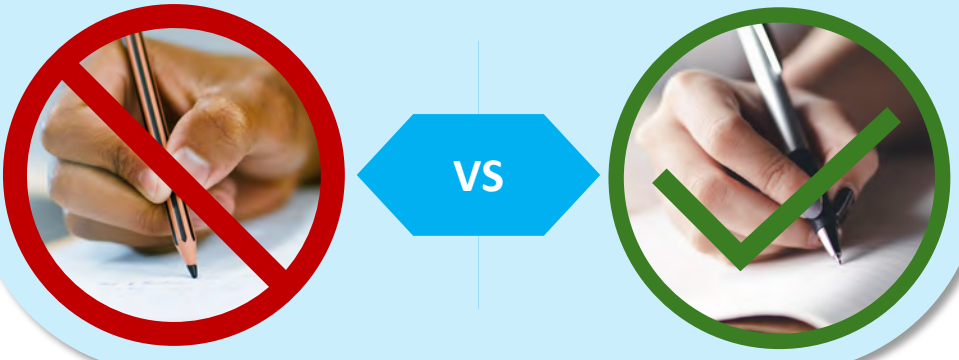
Most Adult Foster Care homes or facilities will have a staff logbook. These notes typically contain a less detailed summary of what happened that shift, as well as any information that may need to be communicated to other staff unrelated to the folks living there.

Example: *There is a leak beneath the kitchen sink. A plumber will be out first thing in the morning.*

Rules for Documentation

1. What you write should always be clear, complete, and accurate. Include as many observations/details as possible regarding the event you are documenting. If you are writing by hand, it should be legible and large enough to be easily read.

2. You should always document in permanent ink. The documentation you provide is considered a legal and clinical document and thus should only be recorded in dark blue or black ink. Never document using a pencil or erasable ink.



3. When documenting in one person's record you must respect the privacy and protect the confidentiality of other people in the home. Never include the **Protected Health Information (PHI)** of another individual.

4. It should always be clear who the writer of the document is. You may be asked to print and/or sign your name or initial your notes.

5. The first time you mention any other caregiver or clinical professional they should always be identified by their full name and title. If you mention the same person again in the same document, you can refer to them only by name.

6 It should always be clear who the writer of the document is. You may be asked to print and/or sign your name or initial your notes.

7 If you make a mistake in your writing, no matter how small, correct it as follows: draw a single line through the mistake, write the word "error," write the date and your initials, then write the correction.

Thomas would like to go to Walmart on ~~Wednesday~~ error, 12/10/24, DR, Thursday after work.

8 On forms in which you are the only person documenting draw a single line through any blank space at the end of an area where you describe events. On a form where several people might also document, only draw a line through any extra space on the last line.

Thomas has gained weight since his last visit.
The doc asks that we encourage healthy meal choices.

9 Anything written is part of the person's permanent record. You should never change what someone else wrote and what you wrote should never be changed by anyone else. If events cannot be agreed upon each person should document separately.

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

SECTION 7: Glossary

In this section you will find a reference of terms, titles, and acronyms related to providing care, many of which have been covered previously.

Assertive Community Treatment Team (ACT): A team of professionals that provide support coordination on a more structured and daily basis, often going to the person in order to provide treatment.

Activities of Daily Living (ADL): Self-care activities that the person receiving services may require assistance. These can range from hands on assistance, such as with dressing, bathing, or eating, or can include wider tasks like cooking or housekeeping

Adult Foster Care (AFC): A home or facility that provides care for individuals who are unable to care for themselves.

Case Management: A range of services provided to assist and support people receiving services in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services.

Case Manager (Supports Coordinator, Primary Worker, Case Worker, Targeted Case Manager): A person assigned to assist someone receiving services and facilitates any resources needed to achieve set goals.

CMH, CMHA: Abbreviation for Community Mental Health or Community Mental Health Authority

Community Mental Health: The system intended to provide public mental health services directly to those in need of assistance in the communities where they reside.

Consumer: A member of the community receiving services from a CMH or CMHA

Crisis Residential Services: A short-term alternative to inpatient hospitalization provided in a licensed residential setting.

DD: Abbreviation for Developmental Disabilities

Direct Care Worker (DCW, Personal Care Worker, Direct Care Staff, Home Health Aide, Personal Care Aide, Direct Support Professional): An employee whose primary responsibilities are to provide support and personal assistance to people with disabilities and mental illnesses.

Environmental Modifications: Physical changes to a person's home, car, or work environment that are of direct medical or corrective benefit to the person. Modifications ensure access, protect health and safety, or enable greater independence for a person with physical disabilities.

Fiscal Intermediary (Payee, Rep payee, Conservator): Someone appointed to assist with the managing of financial decisions and care. This can be an organization, or an individual appointed by the court.

Guardian (Personal Advocate): A person who has been appointed by a judge to take care of a minor child or incompetent adult (both called "ward") personally and/or manage that person's affairs. There are different types of guardianships, varying in degrees of authority over the specified person.

Individual Plan of Service (IPOS): The plan developed at the Person-Centered Planning meeting.

Licensing and Regulatory Affairs (LARA): The Department of Licensing and Regulatory Affairs is a principal department in the Michigan executive branch of government that oversees employment, professional licensing, construction, and commerce.

Michigan Department of Health and Human Services (MDHHS): Abbreviations for Michigan Department of Human Services/Michigan Department of Health and Human Services, the state agency responsible for improving the health, safety, and well-being of Michigan residents by overseeing a wide range of public assistance, health policy, and human services programs.

Michigan Mental Health Code (MMHC): The state law that governs public mental health services provided to adults and children with mental illness, serious emotional disturbance and developmental disabilities by local community mental health services programs and in state facilities.

Medication Review: The name for an appointment with a psychiatrist in order to evaluate and monitor medicines used to treat a person's mental health condition, their effects, and the need for continuing or changing their medicines.

MI: Abbreviation for Mental Illness

Occupational Therapist: Certified professionals who help individuals in the areas of fine and gross motor development, visual motor integration, visual perception, neuromuscular control, response to sensory stimuli, bilateral coordination, and motor planning. Some occupational therapists have training in sensory integration therapy.

Occupational Therapy (OT): The evaluation by an occupational therapist of an individuals' ability to do things in order to take care of themselves every day, and treatments to help increase these abilities

Office of Recipient Rights (ORR, RR): The department of Community Mental Health that is responsible for protecting the rights of people who receive public mental health services

Person-Centered Plan (PCP): A meeting intended to plan a person's treatment goals

Primary Care Provider (PCP): A person's regular doctor or health care provider.

Psychiatrist: A medical doctor who specializes in treating mental disorders and conditions and may prescribe medications.

Psychologist: A healthcare professional who can perform testing and provide talk therapy.

Psychotherapy (Talk Therapy): A process in which a person talks with a psychiatrist, psychologist, social worker, or licensed counselor about a mental health condition.

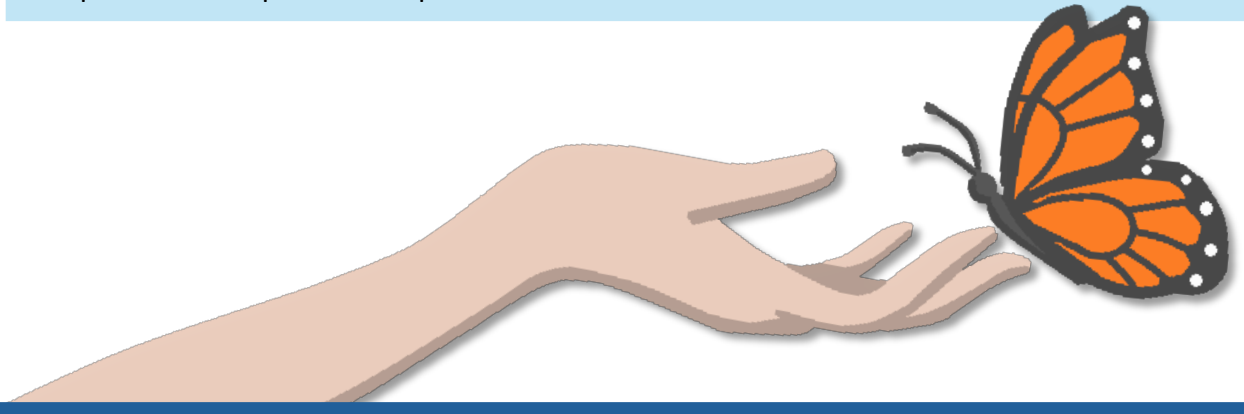
Stigma: A mark of shame or disgrace. When people are treated unkindly, as if they have a stigma, they might feel embarrassed.

Substance Abuse: is an unhealthy pattern of drug, alcohol or other chemical use that may lead to relationship, education, work, mental and/or physical problems

Support Staff: Personnel whose primary job responsibilities do not include administrative or direct service functions. Support staff includes building maintenance, IT support, reception, and accounting.

Therapist: a person who is professionally trained and/or skilled in the practice of a particular type of therapy.

Therapy Services: services that can significantly improve, develop and restore a person's condition. Therapy services are designed to restore physical functions that have been lost through disease or a medical event. Therapy services can be performed in the hospital or home by licensed physical, occupational and speech therapists.



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