



Introduction to Developmental Disabilities

INSTRUCTOR GUIDE

October 2026

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Module 0. Manual Guide

0.1. Acknowledgments and Partners

The curriculum was originally created by NAPSA in collaboration with the Academy for Professional Excellence. It was then used as a foundation for training content and materials developed by NAPSA under the grant for the National APS Training Center.

The creation of this curriculum was the result of a collaborative effort between Adult Protective Services professionals, professional educators, and NAPSA members. NAPSA would like to thank the following:

Committees

NAPSA Education Committee

NAPSA Curriculum Development Committee

NAPSA Curriculum Review Committee

NAPSA Disability Advisory Group

No AI was used in the development of this curriculum.

0.2. Course Summary

In this interactive and engaging introductory training, participants will gain a basic understanding of developmental disabilities. This understanding will enhance their ability to conduct investigations and develop effective strength-based service plans when working with adults with developmental disabilities.

0.3. Target Audience

The course is intended for new APS professionals but is also applicable to allied disciplines and partners that work with adults with developmental disabilities (law enforcement, conservatorship investigators, workers in aging networks). This training is also appropriate for tenured staff who require knowledge or skill review.

0.4. Course Requirements

There are no course requirements. It may be helpful for participants to have some experience of working with adults with developmental disabilities and service planning.

0.5. Goal

The purpose of this training is to enable APS professionals and allied professionals to have a better understanding of developmental disabilities, accessibility, and communication, and improve service planning that leverages the strengths of individuals with developmental disabilities.

0.6. Learning Objectives

After completing this course, participants will be able to:

- Describe the characteristics of some common developmental disabilities
- Identify communication disorders related to developmental disabilities
- Identify factors that put people with developmental disabilities at disproportionate risk of abuse or neglect
- List best practices to conduct more effective interviews with people with developmental disabilities
- Describe strength-based service planning considerations for people with developmental disabilities

0.7. Course Length

This curriculum was developed as a 4-hour training. It is recommended that time be permitted for two 15-minute breaks, determined by the trainer's discretion.

0.8. Trainer Preparation

This instructor-led curriculum is designed for both classroom delivery and virtual delivery.

The optimal size for this training is 20-25 participants.

Suggestions for virtual delivery:

- Have a moderator or co-host who can focus on the virtual aspects (chat, creating breakout groups, etc.) Some individuals will be more comfortable coming off mute to speak, but other participants may prefer to use the chat box exclusively.
- Consider accessibility features, such as auto-captioning, transcriptions, or even real-time American Sign Language (ASL) interpretation where applicable.

Module 1. Welcome and Overview

Time: 20 minutes

Associated Objective: None

Purpose: Welcome and introduction of the course. This section includes the introduction of the trainer, participants, and the purpose and background of the course.

Facilitation Instructions: Follow the talking points and associated prompts.

Tools: PowerPoint Presentation

Slide 1: Welcome



Do: Welcome participants to the course and introduce yourself by name, job title, organization, experience, and qualifications as the trainer.

Review the following housekeeping items:

- Respect everyone's opinions, each other's time, and speakers.
- Timeliness: be on time for breaks.
- Confidentiality: at any point when we discuss real cases, do not share names or identifying information.
- Sensitive Content Warning: Content and discussion today may activate feelings based on personal or professional experiences. Please do what you need to do to safely engage in the training today.

Virtual Additions

- Always keep your microphone on mute unless instructed otherwise.
- Use the raise hand option to ask questions, and reactions to interact.
- Post any questions in the chat box that need additional clarification or information.
- Explain the process for breakout groups, including any prompts that learners need to accept to enter or leave the group and how they can request help

Slide 2: Learning Objectives

Learning Objectives

After completing this course, participants will be able to:

- Describe the characteristics of some common developmental disabilities
- Identify communication disorders related to developmental disabilities
- Identify factors that put people with developmental disabilities at disproportionate risk of abuse or neglect
- List best practices to conduct more effective interviews with people with developmental disabilities
- Describe strength-based service planning considerations for people with developmental disabilities



Discuss the learning objectives:

After completing this course, participants will be able to:

- Describe the characteristics of some common developmental disabilities.
- Identify communication disorders related to developmental disabilities.
- Identify factors that put people with developmental disabilities at disproportionate risk of abuse or neglect.
- List best practices to conduct more effective interviews with people with developmental disabilities.
- Describe strength-based service planning considerations for people with developmental disabilities.

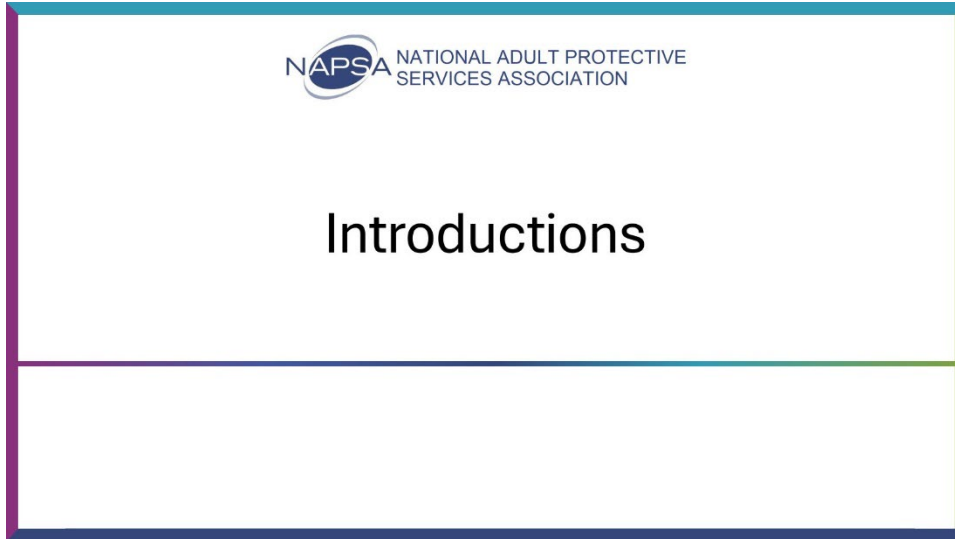
Explain class expectations: what they will learn, upcoming activities, length of class, number of breaks, etc.

1.1. Introductions

Time: 10 minutes

Method: Will vary depending on selected activity

Slide 3: Introductions



Do: Facilitate an icebreaker to help participants feel comfortable interacting in class. There is flexibility in this activity, as adjustments must be made based on class size and participants' familiarity with one another. The trainer may use an icebreaker of their choice. Examples include:

- Invite all participants to state their name, job role, and, if applicable, organization
- If in a virtual environment, invite all participants to pick an emoji to describe their mood, energy level, or level of excitement about the training (this can be a useful way to introduce emoji reactions and use of the chat function as well)
- Invite learners to introduce themselves, then describe an accessible/adaptive tool or practice they use or appreciate. (For examples, curb cuts make it easier to cross the street with a stroller, automatic door-open buttons are great when you don't have a free hand for the doorknob, closed captions on videos make it easier to understand what's being said, jar openers allow you to open a jar with one hand, reading glasses or reading magnifiers.)

Module 2. Developmental, Cognitive, and Intellectual Disabilities

Time: 40 minutes

Associated Objectives:

- Describe the characteristics of some common developmental disabilities.

Facilitation Instructions: Follow the talking points and associated prompts. Prepare the video.

Tools: PowerPoint presentation, participant guide

Slide 4: Developmental Disabilities

Developmental Disabilities

Developmental disability, cognitive disability, and intellectual disability

- NOT interchangeable
- NOT mutually exclusive
- NOT limited to younger populations – the average life expectancy for someone with a developmental disability is 70!

(Aging with Developmental Disabilities citation)

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Trainer note: During the lecture portion, it is advised that you encourage participation via the “Raise Hand” or chat features, accept questions, and encourage discussion.

Say: You may have heard a few different names for different categories of disability. It’s easy to get them confused! However, that confusion can lead you to make assumptions or even planning decisions that aren’t right for the individual, their ability level, or their situation.

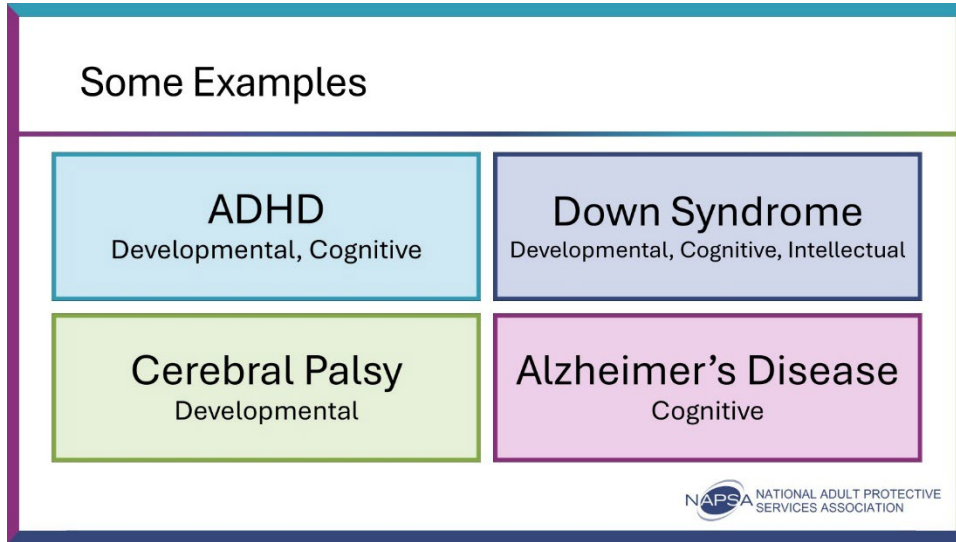
This training is focused on developmental disabilities. This is a broad category that varies widely from person to person.

So, to help you categorize, we’ll be looking at three categories: developmental disabilities, cognitive disabilities, and intellectual disabilities. These are not interchangeable. They are also not mutually exclusive, which means that some conditions can meet the criteria for more than one type of disability, or even all three.

And, with the right supports and care, the average life expectancy for someone with a developmental disability is 70!

(Association on Aging with Developmental Disabilities, n.d.)

Slide 5: Some Examples



Say: Here are a few examples to help illustrate the point:

- Attention Deficit Hyperactivity Disorder, or ADHD, is both a developmental disability and a cognitive disability
- Down Syndrome is all three: a developmental disability, a cognitive disability, and an intellectual disability
- Cerebral Palsy is a developmental disability that does not, by itself, include cognitive or intellectual disability
- And Alzheimer's Disease is a cognitive disability, but is *not* a developmental disability.

On the next slides, you'll get definitions and examples for each type of disability. You're welcome to pause and ask questions at any time.

Slide 6: Definitions: Developmental Disability

Definitions: Developmental Disability

Developmental Disability: one of a group of conditions:

- Physical, learning, language, or behavioral impairment
- Begins during the child's development
- Likely to continue throughout the person's life
- Results in substantial functional limitations in many areas, including: receptive and expressive language, learning, self-direction, ADLs, IADLs

(Centers for Disease Control and Prevention, 2026)

Say: We're going to explore multiple developmental disabilities today, but a preliminary list of examples includes: Autism Spectrum Disorder, Cerebral Palsy, Down Syndrome, ADHD, and Epilepsy. As you can tell, developmental disabilities encompass a wide range of conditions.

A developmental disability is one of a group of conditions characterized by:

- Physical, learning, language, or behavioral impairment
- that begins during the child's development (which usually means before birth, but can also occur after birth due to injury, infection, or other events)
- Is likely to continue throughout the person's life
- And results in substantial functional limitations in multiple areas, including receptive and expressive language, learning, self-direction, ADLs, and IADLs.

Now you can see why Alzheimer's Disease isn't classified as a developmental disability.

(Centers for Disease Control and Prevention, 2026)

Slide 7: ADLs and IADLs

ADLs and IADLs	
Activities of Daily Living	Instrumental Activities of Daily Living
The fundamental tasks required for personal care, maintaining health, and basic functioning • Eating • Hygiene • Mobility • Dressing • Toileting	More complex tasks that support independent living • Housekeeping • Communication • Meal preparation • Transportation • Medication management
 NAPSA NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION (Congressional Research Service, 2010)	

Say: Usually we break out acronyms, but you'll hear the phrase "ADLs and IADLs" a lot, if you aren't already very familiar with it. These two terms reference groups of tasks.

ADLs, or Activities of Daily Living, are the fundamental tasks a person needs to be able to do to live: eating, maintaining personal hygiene (such as bathing and grooming), moving, dressing, toileting and continence, and so on.

IADLs, or Instrumental Activities of Daily Living, are more complex tasks that tend to require planning, like housekeeping, communication such as using a phone, meal preparation, transportation, and managing medication.

Developmental disabilities can result in limitations in a person's ability to perform ADLs or IADLs. But bear in mind, ability will vary from person to person, even when people share the same diagnosis.

Ask: Before we move on, are there any questions so far?

Allow the participants to speak or use the chat feature.

(Congressional Research Service, 2010)

Slide 8: Definitions: Cognitive Disability

Definitions: Cognitive Disability

Cognitive Disability: an umbrella term for any impairment in mental processing

- Can occur at any age
- Can affect one skill or many
- Examples:
 - Attention Deficit Hyperactivity Disorder (ADHD)
 - Dyslexia
 - Traumatic Brain Injury (TBI)
 - Neurocognitive disorders like Alzheimer's Disease

(Neurolaunch, 2026)

Say: Let's look at some cognitive disabilities. This is an umbrella term for any impairment in mental processing. Cognitive disabilities can occur at any age, and may impact one skill or many. For example:

- Attention Deficit Hyperactivity Disorder, or ADHD, is a developmental cognitive disability that impacts attention, impulse control, time management, and emotional regulation. While we tend to think of ADHD as a children's disorder, about 5% of adults in the United States live with ADHD.
- Dyslexia is a developmental cognitive disability that is characterized by difficulties with reading, spelling, and writing. Someone with dyslexia has trouble processing and decoding words, and may also have trouble organizing their thoughts.
- Traumatic Brain Injury can cause cognitive impairments, including memory, attention, problem-solving ability, and executive function.
- Neurocognitive disorders like Alzheimer's Disease, which impact memory, focusing or sustaining attention, speaking or finding words, organizing, planning, and reasoning.

Neither TBI nor Alzheimer's Disease is a developmental disability.

Ask: Any questions about the information you've gotten so far?

Trainer note: *If there is any confusion about executive function, define it: a set of mental skills that include working memory, or the ability to hold information in your head, like remembering a phone number while dialing it; cognitive flexibility, or the ability to change plans or strategies; and the ability to focus, or suppress impulses and keep from being distracted in the moment. (Neurolaunch, 2026)*

Slide 9: Definitions: Intellectual Disability

Definitions: Intellectual Disability

Intellectual Disability: a specific diagnosis that involves limitations in both intellectual functioning and adaptive behavior

- Under the umbrella of Cognitive Disability
- Usually diagnosed before the individual turns 18
- Often diagnoses will include severity level
- Examples:
 - Down Syndrome
 - Fetal Alcohol Syndrome (under Fetal Alcohol Spectrum Disorder)
 - Fragile X Syndrome

(Neurolaunch, 2026; CDC, 2026)

Say: Some cognitive disabilities are also intellectual disabilities. An intellectual disability is a specific diagnosis that involves limitations in:

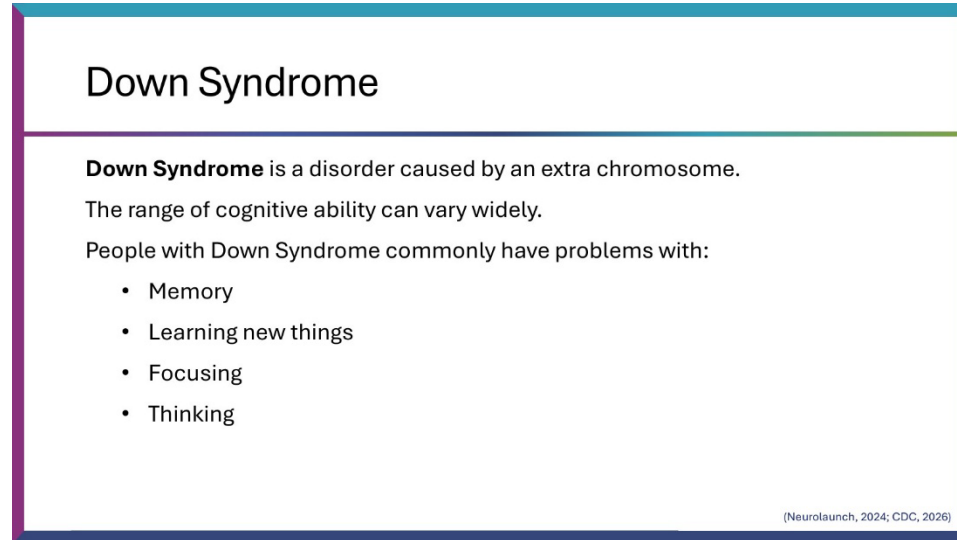
- Intellectual functioning, or the ability to process information, solve problems, think abstractly, and adapt to new situations,
- And adaptive behavior, or the basic skills of everyday life, like reading, basic math, telling time, understanding money, understanding social cues, personal hygiene, cooking, and so on.

Usually, intellectual disabilities are diagnosed by the age of 18. Diagnoses may include a severity level, like mild, moderate, profound, or severe. These severity levels are based on characteristics, support needs, and IQ range. These are diagnostic criteria, and do not mean the person is automatically unable to communicate their desires, make decisions, or describe their experiences. Also, bear in mind that IQ tests are not an absolute measure of someone's intelligence or potential, and IQ levels are only referenced here as general benchmarks.

Some examples of developmental intellectual disabilities include Down Syndrome, Fetal Alcohol Syndrome, and Fragile X Syndrome. While we're going to review the characteristics of each example, remember that each person is unique, and these lists are not prescriptive. Each individual may possess some or all of these characteristics, and to varying degrees, if at all.

(Neurolaunch, 2026; CDC, 2026)

Slide 10: Down Syndrome



Down Syndrome

Down Syndrome is a disorder caused by an extra chromosome.

The range of cognitive ability can vary widely.

People with Down Syndrome commonly have problems with:

- Memory
- Learning new things
- Focusing
- Thinking

(Neurolaunch, 2024; CDC, 2026)

Say: Down Syndrome is a disorder caused by an extra chromosome. Even though Down Syndrome is a developmental intellectual disability, the range of cognitive ability can vary widely. Some individuals with Down Syndrome have an IQ consistent with people without Down Syndrome. Commonly, people with Down Syndrome have problems with memory, learning new things, focusing, or thinking. Those living with Down Syndrome are more likely to experience certain physical conditions, including sleep apnea, hearing loss, and heart defects.

(Neurolaunch, 2024; CDC, 2026)

Slide 11: Fetal Alcohol Syndrome

Fetal Alcohol Syndrome

Fetal Alcohol Syndrome is a condition under the umbrella of Fetal Alcohol Spectrum Disorder (FASD).

Fetal Alcohol Syndrome represents the most severe end of FASD

People with Fetal Alcohol Syndrome commonly have problems with:

- Central nervous system and physical growth
- Learning
- Memory
- Attention span
- Communication

(Neurolaunch, 2026; CDC, 2026)

Say: Fetal Alcohol Syndrome is a condition under the umbrella of Fetal Alcohol Spectrum Disorder, or FASD. FASD is an umbrella term for conditions caused by prenatal alcohol exposure. Fetal Alcohol Syndrome represents the farthest end of the spectrum. People with Fetal Alcohol Syndrome can have problems with their Central Nervous System and growth, learning, memory, attention span, or communication.

While we've grouped FAS under intellectual disabilities, the severity of the condition is a spectrum. Not everyone with FAS is impacted to the point where they are considered to be living with an intellectual disability. At the same time, prenatal alcohol exposure is the leading known cause of intellectual disability.

(Neurolaunch, 2026; CDC, 2026)

Slide 12: Fragile X Syndrome

Fragile X Syndrome

Fragile X Syndrome is the most common inherited cause of intellectual disability.

One in three people with Fragile X Syndrome also lives with Autism.

People with Fragile X Syndrome may have behaviors like:

- Sensory sensitivities
- Difficulty with eye contact
- Insistence on routine

(Neurolaunch, 2026; CDC, 2026)

Say: Fragile X Syndrome is the most common inherited cause of intellectual disability, resulting from a silenced gene on the X chromosome. The symptoms are generally more severe in men, who only have one X chromosome to draw from. They may experience delayed speech and language development and difficulty with problem-solving.

One in three people with Fragile X Syndrome also lives with Autism, and many of the behaviors we commonly associate with Autism are common to Fragile X Syndrome as well. Someone with Fragile X Syndrome may have sensory sensitivities, may have difficulty making eye contact, and may insist on routine.

Ask: Any questions about the information you've gotten so far?

(Neurolaunch, 2026; CDC, 2026)

Slides 13 through 18: Other Developmental Disabilities

Other Developmental Disabilities

Non-Intellectual Developmental Disabilities:

- Autism Spectrum Disorder (ASD)
- Cerebral Palsy
- Epilepsy
- Muscular Dystrophy
- Tourette Syndrome

(Reference and User Services Association, 2020)



Other Developmental Disabilities

Non-Intellectual Developmental Disabilities:

- Autism Spectrum Disorder (ASD)
- Cerebral Palsy
- Epilepsy
- Muscular Dystrophy
- Tourette Syndrome

Autism Spectrum Disorder (ASD)

- Caused by differences in the brain
- Problems with social communication
- Restricted or repetitive behaviors
- Language, speech, learning delays
- Potential co-occurring intellectual disability

(CDC, 2020)

Other Developmental Disabilities

Non-Intellectual Developmental Disabilities:

- Autism Spectrum Disorder (ASD)
- Cerebral Palsy
- Epilepsy
- Muscular Dystrophy
- Tourette Syndrome

Cerebral Palsy

- Impacts the brain and nervous system
- Abnormal muscle tone, movement, and posture
- Stiff muscles and exaggerated reflexes

(CDC, 2020)

Other Developmental Disabilities

Non-Intellectual Developmental Disabilities:

- Autism Spectrum Disorder (ASD)
- Cerebral Palsy
- Epilepsy
- Muscular Dystrophy
- Tourette Syndrome

Epilepsy

- Generalized seizures involve the entire brain, others involve only parts
- Some seizures are grand mal, others are subtle
- Seizures may leave people confused, tired, anxious, nauseated

A seizure longer than five minutes is a medical emergency.

(CDC, 2020)

Other Developmental Disabilities

Non-Intellectual Developmental Disabilities:

- Autism Spectrum Disorder (ASD)
- Cerebral Palsy
- Epilepsy
- Muscular Dystrophy
- Tourette Syndrome

Muscular Dystrophy

- More than 30 disabilities that weaken skeletal muscles
- Severity will vary
- Progressive difficulty walking or climbing stairs
- Muscle weakness
- Frequent falls or clumsiness
- Difficulty breathing or swallowing

(CDC, 2020)

Other Developmental Disabilities

Non-Intellectual Developmental Disabilities:

- Autism Spectrum Disorder (ASD)
- Cerebral Palsy
- Epilepsy
- Muscular Dystrophy
- Tourette Syndrome

Tourette Syndrome

- Impacts the brain and nervous system
- Sudden, involuntary movements or sounds, called tics
- Tics can be simple or complex
- Not often severe enough to prevent someone from attending school or work

(CDC, 2020)

Say: Finally, there are many developmental disabilities that do not automatically include a cognitive or intellectual component. Examples include:

(Trainer note: advance through the next slides as you read each description)

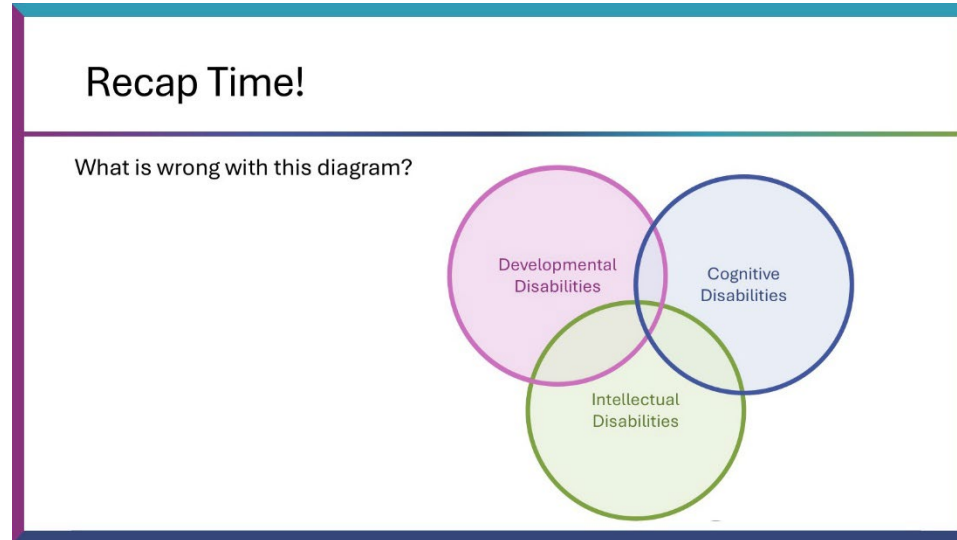
- **Autism Spectrum Disorder**, or ASD. Autism is a developmental disability caused by differences in the brain. People with Autism often have problems with

social communication, and restricted or repetitive behaviors or interests. Depending on the individual, there may be language, speech, or learning delays, or even a co-occurring intellectual disability. However, a diagnosis of Autism does not automatically mean the person lives with a cognitive disability.

- **Cerebral Palsy** is a developmental disability that impacts the brain and nervous system, that leads to abnormal muscle tone, movement, and posture. People with Cerebral Palsy can have widely varied symptoms, but the most common include stiff muscles and exaggerated reflexes. Some individuals with Cerebral Palsy may also have an intellectual disability.
- **Epilepsy** is a condition characterized by seizures or convulsions. Some seizures, called generalized seizures, involve the entire brain. Others, called focal or partial seizures, only impact one area of the brain. Some seizures are more like the type dramatized on TV – the grand mal, where the individual loses consciousness, falls to the ground, and experiences a period of jerking movements. Others are so brief and subtle it may just appear as though the person is just blinking rapidly, or chewing invisible gum. After a seizure, people may be confused, tired, anxious, nauseated, or otherwise impacted. Note that a seizure longer than five minutes, or difficulty breathing after a seizure, are medical emergencies.
- **Muscular Dystrophy** is a group of over 30 developmental disabilities that progressively weaken skeletal muscles. The severity will vary, but in general people will experience progressive difficulty walking or climbing stairs, muscle weakness, frequent falls or clumsiness, and difficulties with breathing or swallowing.
- **Tourette Syndrome** is a developmental disability that impacts the brain and nervous system, causing sudden, involuntary movements or sounds, called tics. Tics can be motor, or involuntary movements like shrugging, blinking, or grimacing; or vocal, like sniffing or repeating words, or even phrases. While tics can interfere with social interactions and daily activities, they aren't often severe enough to prevent someone from attending school or work.

(Reference and User Services Association, 2020; CDC, 2026)

Slide 19: Recap Time!

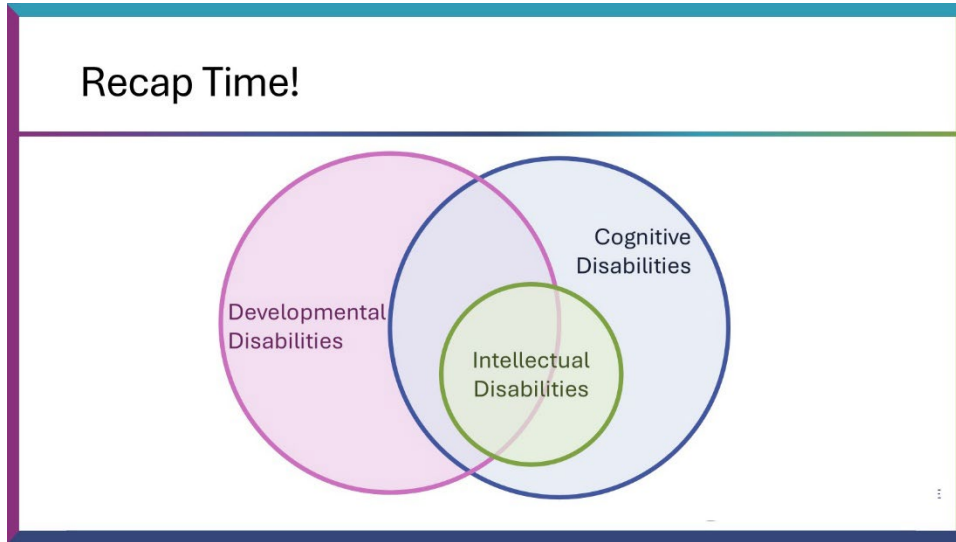


Ask: Take a look at this diagram – it shows developmental disabilities, cognitive disabilities, and intellectual disabilities as three distinct categories, with some conditions having the qualities of two, or even all three categories. Given the information we’ve reviewed, what’s incorrect about it?

Direct participants to use the chat feature or share their responses.

Possible answers: Intellectual disabilities are a category within the broader umbrella of cognitive disabilities. Some participants may bring up the scale, relative size of the circles, or the amount of overlap between the circles.

Slide 20: Recap Time!



Say: The reality looks a lot more like this: intellectual disabilities are part of the broader category of cognitive disabilities. Some disabilities are developmental disabilities without a cognitive or intellectual component, some disabilities may include both developmental and cognitive disabilities, and still more may include all three. On the other side, not all cognitive or intellectual disabilities are developmental disabilities.

Slide 21: Distinctions and Expectations

Distinctions and Expectations

Why bother to make distinctions between types of disabilities?

Have you learned something you weren't expecting so far?



Ask: So, why is it important that we spent all this time looking at all of these disabilities and differentiating between them? Has anything about these distinctions been new to you?

Direct participants to use the chat feature or share their responses.

To help seed responses: Consider what we expect people to be able to do, and how that is impacted by a disability or diagnosis. Does what we've discussed so far go against any stereotypes you might have heard about people with developmental disabilities? Could making an assumption damage rapport? What about least restrictive approaches, or decision-making ability?

Possible answers: If we assume someone with a developmental disability *automatically* also lives with an intellectual disability, we aren't seeing the whole person. Making assumptions about someone's ability level, even when they have an intellectual disability, closes avenues toward rapport and meaningful information. Disabilities do not inherently make someone more violent, but some disabilities that cause involuntary movement have been interpreted as aggression.

Slide 22: Person-First Language

Person-First Language

Levels of severity and IQ are diagnostic information. They do not promote dignity, autonomy, or respect for the individual.

When you are talking to or about people, use **Person-First Language**:

- She lives with cerebral palsy and uses a wheelchair
- He was born with Down Syndrome and has some hearing loss

Avoid:

- He's a high-functioning Autistic
- She's living with a birth defect that keeps her bedbound

(NIH, 2025)

 **NAPSA** NATIONAL ADULT PROTECTIVE SERVICES ASSOCIATION

Say: You might have noticed that some of these disabilities included information about diagnostic criteria, like levels of severity or IQ. This language really doesn't promote dignity, autonomy, or respect for each person as a unique individual. It can be comfortable or easy to rely on more medical, impersonal language, but that strips the humanity away from the people you're working with. You lose sight of the individual, their needs and desires.

Instead, use person-first language. Person-first language emphasizes the person over the condition, by describing what the person "has" rather than what they "are". Just this linguistic change helps put the person before their diagnoses or disabilities. For example:

- **She lives with cerebral palsy and uses a wheelchair.** This example has two person-first elements; first, that she lives with her diagnosis, rather than being defined by, a victim of, or suffering from it. Second, she uses a wheelchair as a tool to get around, but it isn't a defining part of who she is as a person.
- **He was born with Down Syndrome and has some hearing loss.**

On the other side, we want to avoid statements like:

- **He's a high-functioning Autistic.** First, the description of severity is a subjective value judgment about someone's ability that places greater need at the "worse" end of the scale. Second, we don't want to describe anyone as "a thing".
- **She's living with a birth defect that keeps her bedbound.** Nobody is born defective; this is a medical term that describes humans like objects. And,

“bedbound” is another term to avoid; she has limited mobility, or she may need assistance with transfers.

(NIH, 2025)

Module 3. Communication Considerations

Time: 80 minutes

Associated Objectives:

- Identify communication disorders related to developmental disabilities
- List best practices to conduct more effective interviews with people with developmental disabilities

Facilitation Instructions: Follow the talking points and associated prompts.

Tools: PowerPoint Presentation, participant guide, breakout groups

Slide 23: Communication Considerations



Say: Some disabilities will impact the ways people communicate or receive the communication of others. Let's look at some considerations to keep in mind when that's the case.

3.1. Video: Building Bridges: Interacting with Adults Who Have Developmental Disabilities

Time: 5 minutes

Method: Video

Slide 24: Video: Building Bridges: Interacting with Adults Who Have Developmental Disabilities



Say: To introduce this section, we'll watch a video produced by the Cleveland Clinic. While the intended audience of this video is healthcare professionals, the communication strategies apply across all disciplines.

Play the Video: <https://www.youtube.com/watch?v=eGfG7J3ibdl&t=64s> [from 1:04 through the end]

Note: The video link is embedded in the PowerPoint and can be clicked to play inside the presentation. The direct link is also provided in case you would rather open the video in the background.

Slide 25: Two Types of Communication

Two Types of Communication	
Verbal	Non-Verbal
Includes spoken, written, and signed language. • Receptive: the ability to understand words and sentences; the “input” • Expressive: the ability to communicate thoughts and feelings; the “output”	• Body language • Facial expressions • Gestures • Eye contact
(Max Planck Institute for Human Cognitive and Brain Sciences, 2021)	

Say: There are two primary forms of communication we'll look at.

- **Verbal** communication includes spoken, written, and signed language. Verbal communication involves two forms of language:
 - **Receptive language**, or what we can consider the input, is the ability to understand words and sentences as we hear, read, or view them in real time.
 - **Expressive language** is the output, the ability to communicate thoughts and feelings.
- **Non-verbal** communication is the way we speak without words: body language, facial expressions, gestures, and eye contact. Sometimes, body language can be a major indicator of something you need to investigate further; if someone is holding their body in a way that's unusual for them, if they are tense or stiff, favoring an area, or moving in ways that are different than what's normal, that can indicate abuse or injury. Even when someone isn't able to *tell* us something's wrong, someone who knows them well can observe when their behavior changes over time, or in response to an event.

(Max Planck Institute for Human Cognitive and Brain Sciences, 2021)

Slide 26: Differences and Disorders

Differences and Disorders

Communication Difference: a way to communicate that is different from verbal speech and hearing.

Communication Disorder: an illness or condition that impacts a person's ability to communicate, which may or may not respond to treatment or progress over time.

(American Speech-Language-Hearing Association, 1993)

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Say: Before we get into some disorders related to communication, let's pause and talk about communication differences. When we discussed verbal communication, we included signed language – this is a different way to communicate, not a disorder. When we talk about communication, we want to be careful to differentiate between different forms of communication, such as signed language, using text, or assistive tools, and communication disorders. Disorders are, specifically, an illness or condition that impacts someone's ability to communicate, whether it's in their brain or their physical body, that can be treated or progress over time.

(American Speech-Language-Hearing Association, 1993)

Slide 27: Developmental Communication Disorders

Developmental Communication Disorders

- Social Communication Disorder
- Language Disorders
- Speech Sound Disorders
- Stuttering (Childhood-onset Fluency Disorder)

Note: Communication ability levels may vary even among people with the same diagnoses or communication differences

Say: Now, let's talk about some communication disorders related to developmental disabilities. Note that each of these is not exclusive to a single developmental disability, and may occur in a variety of contexts, or even alone.

- **Social communication disorder** impacts social interaction, social understanding, and language. People will experience communication challenges with social context, unspoken rules, or language that is ambiguous. People may have trouble understanding the cultural rules we follow, such as whether to make eye contact, the importance placed on personal space, or how to determine someone's mood from their facial expressions. And remember, cultural norms will vary.
- **Language disorders** impact the two types of language we mentioned before – expressive, receptive, or both. People may have trouble understanding instructions or questions, may use gestures instead of verbal communication, may have limited vocabularies, or have trouble constructing long sentences.
- **Speech Sound disorders** are difficulties in producing speech sounds, including difficulties with coordinating the jaw, tongue, and lips for speech. In some people, such as people with cerebral palsy, these disorders are likely to persist into adulthood.
- **Stuttering** is a neurological speech disorder that can be developmental, or can be acquired after a neurological event like a stroke. Stuttering is characterized by interrupted speech, and people who stutter may repeat sounds, syllables, or whole words. Some individuals will also move involuntarily.

These are all disorders that can improve *or progress* over time, depending on the person's health, abilities, and any interventions or medical treatment they receive. Each

of these disorders can vary in severity between people. And, it's important to remember that these disorders are *not* intellectual disabilities!

Slide 28: Tools that Support Communication

Tools That Support Communication

Augmentative communication devices supplement existing speech.

Alternative communication devices are used when speech is not present or functional.

When someone uses AAC:

- Learn about the device or method
- Tailor your questions to their experience level
- Slow down, allow for silence
- Do not touch any accessibility tool without that person's permission

(American Speech-Language-Hearing Association, n.d.)

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Say: Some people will use devices or tools that help them communicate. We call these Augmentative and Alternative Communication devices, or AAC devices for short.

- **Augmentative communication devices** supplement existing speech. For example, after having a stroke, someone may be able to speak in short phrases, but use a text-to-speech app for longer passages.
- **Alternative communication devices** are used in place of speech. For example, that same text-to-speech app could be used as someone's primary method of communication.

When someone uses an AAC device, take the time to learn about it. This will also help you tailor your questions to the experience level and comfort level the person has with using the device. They may be new to the device or need more time. Being comfortable with silence allows the person to gather their thoughts and communicate more comfortably.

And finally, as with any accessibility tool, don't touch it unless you have been asked to!

(American Speech-Language-Hearing Association, n.d.)

Slide 29: Types of AAC Devices

Types of AAC Devices

AAC Devices exist across varying levels of technology:

- Paper and pencil
- Gestures and body language
- Picture or symbol boards (analog or digital)
- Devices that produce voice or written output
- Eye tracking or other input technology
- Text-to-speech devices



Say: AAC devices don't have to be expensive or high-tech; they exist across all levels of technology. The no-tech version is a paper and pencil, or the use of gesture and body language. For some people, this may mean they will touch you, or will attempt to touch you, to lead you to something or to show you something. It's up to your discretion as a professional to maintain appropriate personal space.

Picture or symbol boards, which can either be physical or on a digital device, can help people communicate by indicating the picture for what they'd like to say.

And then, there are high-tech options, like text-to-speech devices, other devices that produce spoken or written output, that may take many types of input. Some people may use joysticks, eye tracking, or puff-and-blow devices with these tools.

Slide 30: Hearing Loss and Deafness

Hearing Loss and Deafness

Hearing Loss: a partial or total inability to hear sounds, caused by genetics, aging, illnesses, or exposure to loud noises

Deafness: having little to no hearing, under the umbrella of hearing loss.

A cultural note: Some people identify as Deaf, or as part of the Deaf community. Others prefer deaf or hearing impaired.

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Say: Hearing loss may occur as a result of aging, injury, or together with physical disability. Some people are born with low or no hearing. Deafness falls under the umbrella of hearing loss. In general, you will want to refer to these individuals as “people with hearing loss” or “people who are deaf.”

A cultural consideration comes into play here: Some folks identify as part of the Deaf community, and others may use “deaf” or the more outdated term, “hearing impaired”. Regardless of how someone refers to themselves, it’s best practice to start with person-first language.

Slide 31: Supports for Hearing Loss and Deafness

Supports For Hearing Loss and Deafness

Some individuals use hearing support devices like hearing aids or volume amplifying devices. Others may have cochlear implants.

Deaf individuals may use an American Sign Language (ASL) interpreter and in some cases a Certified Deaf Interpreter (CDI):

- Prepare the interpreter(s) ahead of time
- Avoid using family or collaterals to interpret
- During the interview, speak to the person, not the interpreter
- The CDI does not replace the ASL interpreter



Say: Some people use hearing support devices like hearing aids or volume amplifying devices. Others may have cochlear implants.

If the individual communicates using sign language, most commonly American Sign Language (ASL), it's best practice to communicate with the assistance of an ASL interpreter. Here's what you need to bear in mind:

- Whenever possible, prepare the interpreter ahead of time with the questions you're planning to ask and the information they're likely to need to interpret.
- Unless you're in an emergency situation, it's recommended that you do not use family or collaterals to interpret for you. Interpreters should not inject their own opinions, thoughts, or ideas. In situations where you need a person's words to be conveyed exactly, rely on a professional interpreter.
- And, once you're ready to go, speak to the person, not the interpreter. It can be tempting to make eye contact with the interpreter or treat them as a third party to the conversation. It's better to have the interpreter sit or stand beside you, if space allows, so the person you're communicating with can see both of you.

Another person who may be involved is a Certified Deaf Interpreter (CDI). These are people with lived experience of hearing loss, who may even be deaf themselves. They're trained to help ensure clear communication in conjunction with a hearing interpreter. CDIs are rare, but can be of great assistance, especially if the person you're trying to interview is:

- Not fluent in sign
- Also living with low or no vision

- Or, has other unique communication needs.

Slide 32: Planning for the Interview

Planning for the Interview

Plan your interviews in advance:

- What questions will you ask?
- What are the time considerations?
- Is an interpreter needed?
- What considerations related to the person's ability to communicate, receive information, or consider their answers need to be made?



Say: Whenever possible, your preparation should include as thorough an understanding as you can get of the person's communication abilities, needs, and tools. Based on the information you receive from the intake process, plan your interviews as much as possible. What questions do you need to ask of the person? Are you able to allow for a slower pace, with extra time if needed? Do you need an interpreter?

Are there other considerations related to the person's ability to communicate, receive information, or consider their answers?

Ask: Does your agency's intake process make a point to ask about communication needs?

Allow for responses.

Slide 33: Interviewing Best Practices

Interviewing Best Practices

- Speak directly to the person, even when they use an interpreter or device
- Match their pace and communication level
- Use plain language and avoid jargon
- Maintain an age-appropriate, respectful tone and volume level
- Keep your body language and face neutral
- Choose a quiet, low-distraction setting
- Repeat what you heard to make sure you understand
- Do not assume a difference in or difficulty with communication means the person is unintelligent or untrustworthy
- Meet the individual where they are



Say: Once in the interview, keep these best practices in mind:

- Speak directly to the person you're interviewing, even when they use an interpreter or a device
- Be mindful to use plain language and avoid jargon wherever possible.
- Match their pace and communication level. If the person speaks in smaller sentences, do the same. If the person speaks more slowly, it's alright to slow down too.
- Maintain an age-appropriate, respectful tone and volume level.
- Keep your body language and face neutral.
- Choose a quiet setting with few distractions, or get the individual's permission to turn off the TV or radio if there is one.
- Repeat what you hear to make sure you understand. This doesn't mean repeating word-for-word – restate just a little differently to make sure you and the person you're interviewing understand one another.
- Do not assume that a difference in or difficulty with communication means the person is unintelligent or untrustworthy.
- And finally, meet the individual where they are. These are general suggestions, but everyone will be different.

Slide 34: Salient Information and Intellectual Disability

Salient Information and Intellectual Disability

Salient: most noticeable or important

In general, people with intellectual disabilities will think concretely and will have trouble with storing and retrieving memories.

Instead of a specific chronology of events, someone with an intellectual disability may describe what was salient to them... whether or not that relates to your investigation.

- “Pokémon was on TV”
- “I saw Jimmy”
- “I got ice cream”

(Cambridge Dictionary, n.d.)

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Say: It can be helpful to consider what information is most salient to the person, meaning what’s most noticeable or important. People communicate and process information differently; people with intellectual disabilities may be more likely to describe an experience based on what stands out most to them. This can lead people to assume that someone with an intellectual disability is attempting to lie or be vague, when really the miscommunication has to do with what is salient.

In general, people with intellectual disabilities will think concretely, and will have trouble storing and retrieving memories. They may describe events in order of saliency rather than chronology. What might be most important is their favorite TV show, a visit from a friend, or a special treat. It may be helpful for you to anchor your questions based on these salient events to try and get more information from the person.

(Cambridge Dictionary, n.d.)

Slide 35: Socially-Desired Responses

Socially-Desired Responses

Socially-Desired Response: a guess, rather than a genuine answer, intended to please the asker

Avoid:

- Body language that reinforces answers or emotions
- Sarcasm, slang, or jargon the person may not understand
- Rushing through your questions

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Say: Often, people with intellectual disabilities learn to give socially-desired responses when they're not sure of the right thing to say. Socially-desired responses can also be a way for someone who isn't sure what you're talking about—whether they don't speak your language or don't understand the terms you're using—to make you satisfied enough with the conversation to leave them alone.

Your body language, posture, or even the responses you give, can influence a socially-desired response. If, for example, you nod or smile to indicate you're listening, someone might interpret that as positive reinforcement for the *type* of answer they gave, and prioritize pleasing you.

To avoid this, your focus on the truth is paramount: avoid body language that reinforces any answers or emotions. Remain supportive but neutral at all times. Avoid sarcasm, slang, or jargon so the person is always on the same page with what you're talking about. Giving the person a little extra time to think, and checking for understanding are also helpful practices.

3.2. Activity: Keep It Simple

Time: 20 minutes

Method: Breakout Groups

Note: This activity is timed for breakout groups of no more than three people. If the class is not divisible by three, prioritize groups of two so everyone can participate

Slide 36: Keep it Simple, Short, and Neutral

Activity: Keep it Simple, Short, and Neutral	
Speaker	Listeners
Explain ONE of the following: • What APS is, what APS does, and what APS does not do OR • The same for their profession or agency Use simple, concrete language. If there is jargon, an acronym, or any slang, explain it.	Remain neutral during the explanation: • Do not nod • Do not smile • Do not laugh (even if they are funny!) You may ask clarifying questions
Each speaker may speak for five minutes.	

Say: This activity will help you put both concepts into practice: speaking without sarcasm, slang, or jargon, *and* listening without prompting a social response. We're going to break into groups of three. In each group, one person will speak, and the other two will listen. Each person in the group will have the opportunity to be the speaker once.

- The **Speaker** will explain what APS is, what APS does, and what APS does *not* do, according to their agency. If the speaker is not an APS professional, they should explain their own profession or agency.

The speaker must use simple, concrete language. If there is jargon, any acronym, or any slang, the speaker must explain it. Jargon includes terminology that is specific to the profession, like "due diligence", "hard copy", or "AP / alleged perpetrator"

- The **Listeners** must remain neutral during the explanation. Don't smile, don't nod, don't give any encouraging or discouraging body language. If something is not explained clearly, ask clarifying questions. Make sure you understand and don't get lost in the explanation.

After five minutes, that speaker is done and it's time for the next one. Once everybody has had a chance to be speaker, I'll bring you out of the breakout rooms and we'll debrief.

Do: After 20 minutes, close the breakout rooms.

Slide 37: Report Back

Report Back

- When you were speaker, how was it trying to describe things concretely?
- When you were a listener, how did it feel to remain completely neutral?



Ask: When you were speaker, how was it trying to describe things concretely?

Once there has been chat response or discussion, ask the next question:

Ask: When you were a listener, how did it feel to remain completely neutral?

Allow for more responses. Guide the learners toward the content of the next slide.

Slide 38: The Takeaway

The Takeaway	
When we're speaking...	When we're listening...
It takes intention to avoid slang, sarcasm, and jargon (even APS jargon!)	People with intellectual disabilities may give "socially desired responses" even when they aren't certain they've heard or understood your question. When we display positive, affirming body language, this can be misinterpreted as reinforcing a certain type of answer.
Communicate intentionally to ensure understanding.	

Say: It takes intention to avoid slang, sarcasm, and jargon, even APS jargon!

And, as listeners, it takes intention not to prompt socially desired responses. When we display positive, affirming body language, that can be misinterpreted if we aren't careful. Even nodding to show we've heard someone, can be misinterpreted by someone with an intellectual disability as our saying "yes, that's what I want."

Slide 39: How Do You Ask Questions?

How Do You Ask Questions?	
Avoid:	Do:
• Leading questions "He brought you to work, right?" • Questions posed in the negative "You don't like cake, do you?" • Socially-desired responses • Filling in the blanks • Finishing someone's sentences • Restating simple language more technically	• Use concrete language • Start broad, then narrow the focus • Try Yes or No, or Multiple Choice questions (with the option for "something else") • Check for understanding • Ensure informed consent
	

Say: We should also be intentional with the ways we structure questions.

Avoid:

- Leading questions, like "He brought you to work, right?" or "You're scared of her, aren't you?"
- Questions posed in the negative, like "You don't like cake, do you?"
- Anything that might solicit a socially-desired response
- Filling in the blanks when someone pauses or makes a vague statement
- Finishing someone's sentences for them
- Restating simple language in a more technical way. For example, if someone says "I saw he had bruises in the shape of a hand on his arm," don't agree, "Yes, those contusions support the allegation of physical abuse."

Do:

- Use concrete language, like we tried in our activity
- Try starting with broad questions, then narrowing your focus to elicit more complete information. For example, starting with "Did you see Billy on Tuesday?", then "Did you go somewhere with Billy?", then "Where did you go?", and so on.
- If more open-ended questions are too broad, try Yes or No questions, or offer multiple choice questions, as long as you always provide the option for the person to answer "something else" or "not any of those".

- Take the time to make sure they understand your questions, and you understand their answers!
- And finally, ensure you have informed consent, not only for the conversation, but throughout all of your involvement with that person.

Module 4. Risk and Service Planning

Time: 60 minutes

Associated Objectives:

- Identify factors that put the population of people with disabilities at disproportionate risk of abuse or neglect
- Describe strength-based service planning considerations for people with physical disabilities

Facilitation Instructions: Follow the talking points and associated prompts. Prepare for breakout room activity.

Tools: PowerPoint Presentation, participant guide, breakout groups

Slide 40: Risk and Service Planning



Say: Adults with developmental disabilities are at disproportionate risk of abuse and neglect. We're going to talk briefly about some of the reasons why that's the case, and then move on to a strengths focus for service planning.

Slide 41: Factors that Influence Risk

Factors that Influence Risk

- Being socialized to accept touch
- Difficulty telling the difference between appropriate and inappropriate
- Lack of abuse awareness training
- Lack of sexual education and opportunities for healthy relationships
- Expectations of compliance
- Being seen by others as less credible
- Communication differences or challenges



Say: These are some factors that create a disproportionate risk for abuse when someone lives with a developmental disability. However, we've got to be clear that these are only risk factors, and will not apply to every person, in every situation, or even necessarily be related to the abuse. For example, if someone with cerebral palsy is experiencing a romance scam, none of these risk factors may apply!

That said, here are some things to keep in mind. People with developmental disabilities:

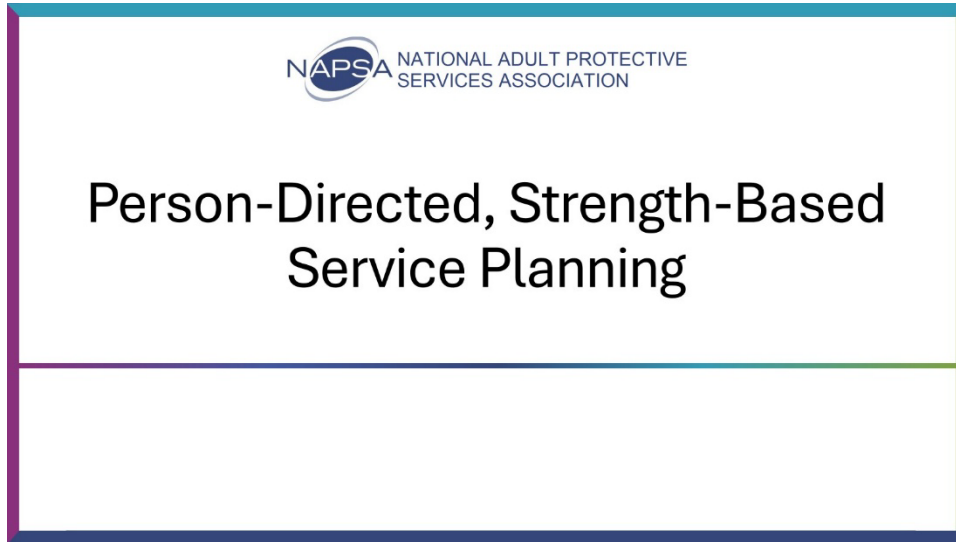
- Are socialized to accept touch from family, caregivers, medical professionals, or peers.
- May have difficulty telling the difference between appropriate and inappropriate social interactions.
- May not have received education on abuse awareness.
- May not have received sexual education, or many opportunities for healthy romantic relationships.
- Live with the expectation that they will be compliant with medical providers, therapists, parents, caregivers, and so on.
- May be seen by others as less credible, especially if they have trouble with memories or recounting events chronologically
- May have difficulties expressing their desires, giving or revoking informed consent, or asking for help, especially if they live with a difference or disorder or communication.

Ask: As we start moving into service planning, which of these listed factors can be mitigated? How would you start?

Treat this as a full-class discussion and encourage conversation. If any of the learners has personal experience, allow them to share their stories.

Some examples: Lead by example with appropriate social interactions – maintain appropriate physical boundaries and respect. Define or explain abuse as relates to the allegations or the person's experience. Provide education on what a healthy, respectful relationship looks like. Promote autonomy and take the individual's desires into account. Even if someone has trouble with memories, take their statements seriously and verify them against other sources.

Slide 42: Person-Directed, Strength-Based Service Planning



Say: To mitigate risk, we call on strength. Regardless of someone's ability level, whether or not they can make decisions with or without support, they must have a voice in their own service planning. Person-directed, strength-based service planning respects the person and their strengths while increasing safety and well-being.

Slide 43: What is Person-Directed Service Planning?

What is Person-Directed Service Planning?

Person-Directed: places the individual at the center of all decisions about their lives

- Look at what is important to the person to help increase their safety
- Look at the real desires or needs at the core of their positions
- Ask the person about their values and preferences to guide what services you suggest

(Federal Register, 2023)

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Say: Person-directed service planning supports a focus on strengths by placing the individual at the center of all decisions about their life. It supports fully informed decision-making, preserves autonomy, and remains flexible so that the plan and the people can change over time.

We should look at what is important to the individual to help increase their safety.

When someone states a position, opinion, or goal, what is the real desire or need at the root of that goal? It might not match what we think it is; for example, if someone decides to quit smoking, perhaps we might think it's for their health, when really *their* goal is to obtain housing in a smoke-free building.

Take the time to ask the person about their values and preferences to guide what services you suggest.

When the individual is in charge of their own goals, they might make choices that their family, their community, or you disagree with.

(Federal Register, 2023)

Slide 44: Least-Restrictive Alternatives

Least-Restrictive Alternatives

The principle of the **Least-Restrictive Alternative** states that any intervention, treatment, or action should impose the minimum necessary restrictions on a person's rights or freedoms.

- Protect individual rights and autonomy
- Tailor each intervention to the specific person's needs
- Minimize social and physical isolation
- Avoid unnecessary restrictions or institutionalization
- Preserve the right to make as many decisions as possible

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Say: When someone lives with a physical disability, sometimes the people around them will be tempted to escalate the intensity of the supports they need, whether these are physical, mental, or psychological supports.

When service planning with anyone, regardless of whether or not they live with a developmental disability, remember the principle of Least-Restrictive Alternative: any intervention, treatment, or action taken should impose the minimum necessary restrictions on a person's rights or freedoms.

Least-Restrictive interventions protect the individual's right and autonomy by tailoring each intervention to meet the specific person's unique needs. This helps to minimize social and physical isolation ,and avoid unnecessary restrictions or institutionalization.

This goes hand-in-hand with preserving the person's right to make as many decisions about their life as they are able to.

Slide 45: Resources and Services

Resources and Services

APS cannot determine eligibility, but can assist with applications

- What community programs or local services are available?
- Are there state initiatives or programs?



Say: APS can't determine eligibility for services, but we *can* help with applications.

Use this to pivot to local resources and services that are available.

Ask: What local services, initiatives, or programs do you know about?

Share local resources if you have them. Allow the learners to share the information they have and learn from one another.

Some examples could include: adult day programs, support groups, meal delivery, task assistance (for example, BeMyEyes), supported employment, residential/in-home supports, transportation support, assistive technology access, case management or service coordination, other ways to participate in the community (not just others with their same disability).

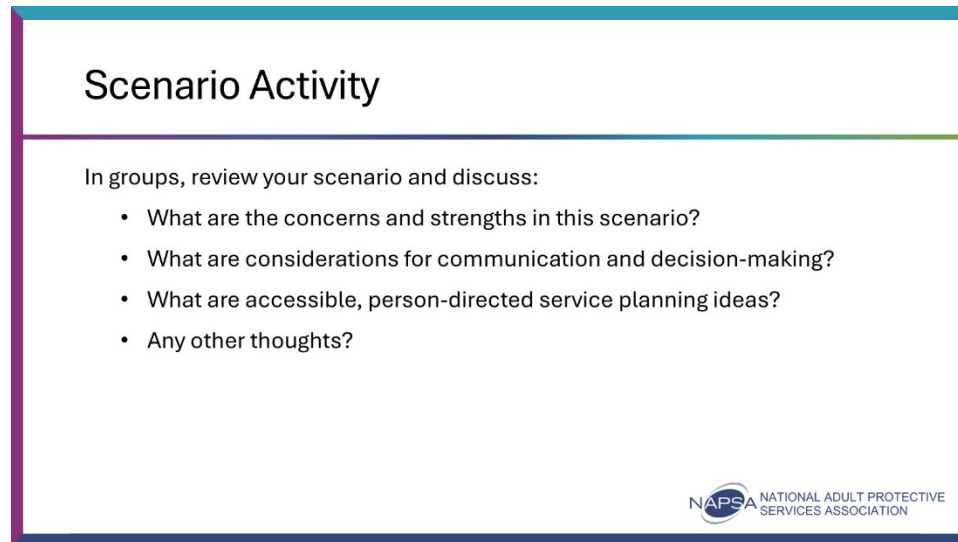
4.1. Case Scenario Activity (Breakout Groups)

Time: 45 minutes

Method: Group discussion, breakout groups

Note: There are three scenarios. Break the learners into groups of no more than six people. If there are more than eighteen participants, allow multiple breakout groups to review the same scenario.

Slide 46: Scenario Activity



Scenario Activity

In groups, review your scenario and discuss:

- What are the concerns and strengths in this scenario?
- What are considerations for communication and decision-making?
- What are accessible, person-directed service planning ideas?
- Any other thoughts?

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Say: For this activity, you'll go into breakout groups to discuss a case scenario. The questions can be found in your participant guide, along with the full case scenario. Once you've read through the scenario, discuss these questions as a group:

1. **Concerns and Strengths**
What risk factors are evident in the scenario? What are the strengths?
2. **Communication and Decision-Making**
What do you want to keep in mind when it comes to effective, respectful communication? Are there any concerns about the person's ability to make decisions?
3. **Person-Directed Service Planning**
Talk through some of the initial thoughts or questions you have for an accessible, person-directed service plan. Include the ways you plan to include the person in service planning!

These scenarios are brief, so you won't have as much information as you'd uncover in a real investigation.

Each group will have fifteen minutes to review and discuss. Be sure to designate a new spokesperson because when we come back, each group will be asked to summarize their discussions.

Do: After 12 minutes, send a “three-minute warning” chat to the breakout groups. After 15 minutes, close out the breakout groups.

Trainer Note: *The training guide includes possible answers to each question, which may help generate discussion if participants are having difficulties with any of the scenarios or questions.*

Slide 47: Case Scenario 1: Spencer

Case Scenario 1: Spencer

- 35, lives with Autism
- Limited vocabulary, uses digital AAC device with pictures
- Lives with mother, Teenie, and mom's new boyfriend, Ralph
- Reporter is aunt Tammi
- Spencer has a small group of "safe" foods
- Spencer now cries and gags when given "safe" foods
- Slams AAC device on table when he cries
- Swollen lips, bruise on his cheek



Do: Review each of the three questions for the case scenario as a group. Ask the spokesperson (or spokespeople, if multiple groups) to share their group's answers to each question. Some suggested answers are provided below:

1. Concerns and strengths

Possible Answers: Concerns include: Bruising and swelling on the face or around the mouth, mom's boyfriend is new to the family dynamic and has threatened to hit Spencer in the past, mom seems resigned and not aware of Spencer's signals of distress, Spencer's limited safe foods are now unsafe, is he eating? Is he being force-fed? Are there bigger patterns of problems indicated by Spencer's mother's reaction? Has his communication style changed recently?

Strengths include: Spencer uses his AAC device to communicate, he is communicating distress in his own way, he has an attentive aunt.

2. Communication and decision-making

Possible Answers: Communication considerations include: how can we coordinate a visit to interview Spencer alone? Does his AAC device support the kind of conversation we need to have? Should we try to focus on yes or no questions? Prepare for unreciprocated body language – Spencer may not make eye contact, may appear distracted, may wander. He may need more time to answer, or may need you to ask questions in different ways.

Decision-making considerations include: Spencer is capable of communicating with his device, but when he gets overwhelmed or upset, he doesn't use it. In the moment, if Spencer is overwhelmed, he may need time, routine, or other factors that increase his feeling of safety so he can communicate calmly – this will also impact his ability to make decisions. There are still ways to determine whether Spencer is thinking through his

decisions – even with an AAC device, getting to the reasons behind his choices is possible.

3. Person-directed, accessible service planning

Possible Answers: First, Spencer urgently needs a medical assessment for the bruising around his mouth. What helps Spencer feel safe, fulfilled, or happy? What are his preferences, and where can he be connected to community? What supports can be implemented in the home to keep Spencer safe, even if mom's boyfriend sticks around? A visiting aide, some forms of therapy, more visits from aunt Tammi?

Slide 48: Case Scenario 2: Van

Case Scenario 2: Van

- 27, has Down Syndrome
- Lives independently with “brother”
- Reporter is grocery store manager, Yancy
- Van has been coming to work with bruises on hands and arms
- Van states “normal brother fights”
- Called Yancy for a ride to work
- Black eye, had been crying
- Walker usually drives Van to work, wouldn’t get up
- Refused to go see a doctor



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Do: Review each of the three questions for the case scenario as a group. Ask the spokesperson (or spokespeople, if multiple groups) to share their group’s answers to each question. Some suggested answers are provided below:

1. Concerns and strengths

Possible Answers: Concerns include: Van has multiple bruises and is now without his usual transportation. Van’s hygiene and punctuality have changed, and his roommate won’t get up. Does this mean Walker was harmed, or that he just refused to get out of bed? “Play-fighting” between adults is suspicious, is this a name for something more serious happening? Does Van think they’re playing, or is this a way to minimize what he’s experiencing?

Strengths include: Van seems capable of living independently and taking care of himself. While he uses supports (like getting a ride from Walker) he’s able to manage time and tasks at work. His manager Yancy helped with transportation in an emergency. His relationship with Walker can also be a strength – he has had a long-term, close friendship with someone who has been a natural supporter for some time.

2. Communication and decision-making

Possible Answers: Communication considerations include: Make sure to speak to Van alone, without Walker present in the apartment. Match Van’s sentence length, complexity, and pacing. Be sure not to talk down to or infantilize Van, because he’s a grown adult with a job. Ask for definitions of “normal brother fights” – does “normal” mean common, or does it imply that sometimes there are worse brother fights?

Decision-Making considerations include: Do not assume that Van’s Down Syndrome impairs his ability to understand, reason through, and communicate decisions. Prioritize preserving Van’s autonomy. (For example, Van refused to go to the doctor when Yancy

asked if he wanted to go. Did he do that because he thought he wasn't injured, because he wanted to keep Walker from getting in trouble, or... because his primary mode of transportation didn't get up that morning and he didn't want to walk?)

3. Person-directed, accessible service planning

Possible Answers: What would Van like to see happen? How could Van and Walker fight less often? Steps could include connecting Van to a transportation service to help increase his independence. Would Van consider living apart from Walker? Preserving Van's independence as much as possible – least-restrictive alternatives if Walker isn't a safe option for assistance: ridesharing apps, independent travel, using public transit?

Slide 49: Case Scenario 3: Jenna

Case Scenario 3: Jenna

- 61, has Cerebral Palsy
- Limited mobility in her arms, walks short distances without her motorized wheelchair
- Speech is imprecise
- Lives alone and works remotely
- Missed multiple OT appointments
- When she arrived, she was pushed in a regular wheelchair by an older man
- Jenna was stiffer, more uncomfortable, tense, “not herself”
- Man was impatient, annoyed, berated Jenna on the way out



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Do: Review each of the three questions for the case scenario as a group. Ask the spokesperson (or spokespersons, if multiple groups) to share their group’s answers to each question. Some suggested answers are provided below:

1. Concerns and strengths

Possible Answers: Concerns include: Jenna missed OT appointments, is without her usual mobility device, seemed to have increased physical discomfort. The man with her berated her. Someone who has seen Jenna frequently described her as “not herself”. The status of Jenna’s motorized wheelchair is unknown (was it sold?).

Strengths include: Jenna is capable of living alone and has her own source of income. She has an interest in fantasy fiction and copyediting. Jenna is communicating and doing what she can to protect herself in the moment; we don’t know what Jenna’s plans are, but we can see what she is doing right now.

2. Communication and decision-making

Possible Answers: Communication considerations: Jenna may be comfortable speaking with you, or may choose to use text to communicate – provide her with options. A concern may be whether or not the man is present when you attempt to speak with Jenna.

Decision-making considerations include: Do not assume that a diagnosis of cerebral palsy, or missing important OT appointments, indicates that Jenna is not capable of making decisions. She may have barriers to transportation, she may be relying on someone for physical support as well as transportation support. She may be choosing to get her needs met, even if the person doing so is being unpleasant.

3. Person-directed, accessible service planning

Possible Answers: Investigate the reason for her missed appointments to determine the remedy. Also, we want to learn more about Jenna's relationship with the man to explore if she has any concerns. What would Jenna like to see? While Jenna is connected through remote work, does she have people who can support her in person?

Module 5. Wrap Up

Time: 20 minutes

Associated Objectives: None

Purpose: Identify how to apply knowledge gained from the training to practice

Facilitation instructions: Follow the talking points and associated prompts

Tools: PowerPoint presentation, participant guide, group discussion

Slide 50: Key Points

Key Points

- Developmental disabilities, cognitive disabilities, and intellectual disabilities are unique categories. Some diagnoses include all three.
- Individuals with cognitive or intellectual disabilities have the right to autonomy and the ability to make the decisions they are capable of making.
- Some communication difficulties commonly occur in people with developmental disabilities.
- Adults with developmental disabilities are at disproportionate risk for abuse and neglect.
- When interviewing an adult with a disability, build in more time, patience, and flexibility.
- Least-restrictive alternatives preserve independence, choice, and autonomy to the greatest extent possible while also increasing well-being and safety.
- Service planning should focus on strengths, not deficits.



Summarize key points from the training, including:

- Developmental disabilities, cognitive disabilities, and intellectual disabilities are unique categories. Some diagnoses include all three.
- Individuals with cognitive or intellectual disabilities have the right to autonomy and the ability to make the decisions they are capable of making.
- Some communication difficulties commonly occur in people with developmental disabilities.
- Adults with developmental disabilities are at disproportionate risk for abuse and neglect.
- When interviewing an adult with a disability, build in more time, patience, and flexibility.
- Least-restrictive alternatives preserve independence, choice, and autonomy to the greatest extent possible while also increasing well-being and safety.
- Service planning should focus on strengths, not deficits.

Slide 51: P-I-E Wrap-Up

P-I-E Wrap-Up

- **P – Priceless piece of information.**
What has been the most important piece of information to you today?
- **I – Item to implement.**
What is something you intend to implement from our time today?
- **E – Encouragement I received.**
What is something you were already doing that you are encouraged to keep doing?



Say: Based on what we have talked about during our time together, I want you to answer a few questions.

1. **P – Priceless piece of information.** What has been the most important piece of information to you today?
2. **I – Item to implement.** What is something you intend to implement from our time today?
3. **E – Encouragement I received.** What is something that you are already doing that you are encouraged to keep on doing?

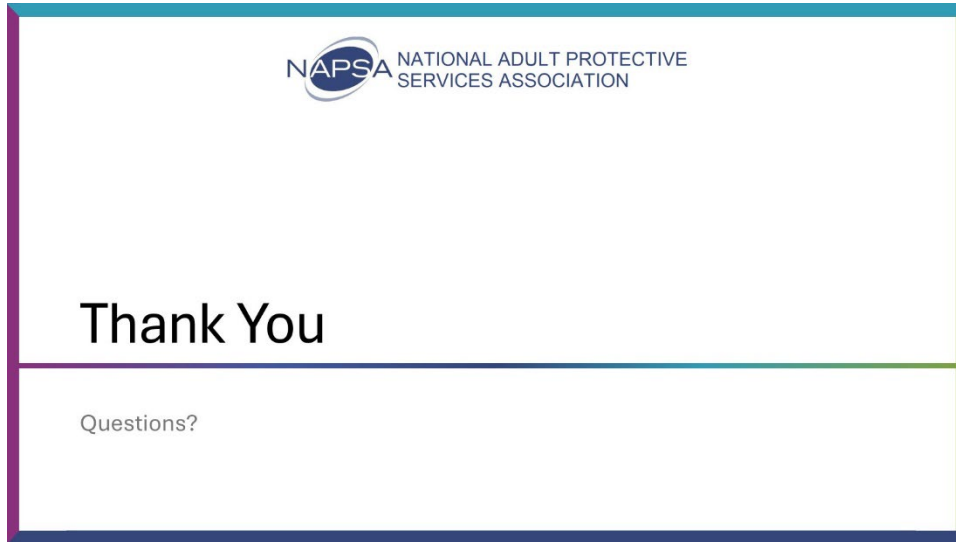
You have 5 minutes to answer the questions on your own.

Do: Once complete, ask for volunteers to share what they wrote down. Request the participants to use the “Raise Hand” feature to volunteer to speak.

Use the following questions for debrief:

- What were some of the key words that you heard while you shared?
- What were the common themes that kept coming up?

Slide 52: Thank you!



Say: Thank you for your time and participation today.

If you have time for further questions, or have any end-of-day housekeeping, do so here.

Appendix A: Case Scenario Activity (Trainer Copy)

Case Scenario 1: Spencer

Spencer is a 35-year-old man living with Autism. His vocabulary is limited and he tends to use his own words for certain familiar or important items. He uses a digital AAC device as his primary method of communication; when he taps a picture, the device speaks. Spencer lives with his mother, Teenie, and her new boyfriend, Ralph.

Spencer's aunt Tammi reported the concern to APS. Tammi reports that Spencer has a small pool of "safe foods" he will eat. (Safe foods are predictable, low-stress foods that accommodate sensory needs, low energy, or physical limitations.) If he is presented with a food outside of the "safe" group, he will react with disgust, gag, or even vomit. On a recent visit, Tammi observed that Spencer gagged and cried even when presented with a meal only made of safe foods. When Tammi tried to coax him into eating, he began rocking in his seat and hitting his AAC tablet against the table. Spencer's mother didn't react beyond saying, "He'll tire himself out." Ralph said, "He knows what'll happen if he doesn't."

According to Tammi, Spencer's lips seemed swollen, and she saw a bruise on his cheek. She's concerned that Ralph might be "manhandling" Spencer. According to Tammi, Ralph has repeatedly complained about Spencer being a picky eater, and she's seen him raise his hand and threaten to strike Spencer before.

Discussion Questions:

1. Concerns and strengths

Possible Answers: Concerns include: Bruising and swelling on the face or around the mouth, mom's boyfriend is new to the family dynamic and has threatened to hit Spencer in the past, mom seems resigned and not aware of Spencer's signals of distress, Spencer's limited safe foods are now unsafe, is he eating? Is he being force-fed? Are there bigger patterns of problems indicated by Spencer's mother's reaction? Has his communication style changed recently?

Strengths include: Spencer uses his AAC device to communicate, he is communicating distress in his own way, he has an attentive aunt.

2. Communication and decision-making

Possible Answers: Communication considerations include: how can we coordinate a visit to interview Spencer alone? Does his AAC device support the kind of conversation we need to have? Should we try to focus on yes or no questions? Prepare for unreciprocated body language – Spencer may not make eye contact, may appear distracted, may wander. He may need more time to answer, or may need you to ask questions in different ways.

Decision-making considerations include: Spencer is capable of communicating with his device, but when he gets overwhelmed or upset, he doesn't use it. In the moment, if Spencer is overwhelmed, he may need time, routine, or other factors that increase his feeling of safety so he can communicate calmly – this will also impact his ability to make decisions. There are still ways to determine whether Spencer is thinking through his decisions – even with an AAC device, getting to the reasons behind his choices is possible.

3. Person-directed, accessible service planning

Possible Answers: First, Spencer urgently needs a medical assessment for the bruising around his mouth. What helps Spencer feel safe, fulfilled, or happy? What are his preferences, and where can he be connected to community? What supports can be implemented in the home to keep Spencer safe, even if mom's boyfriend sticks around? A visiting aide, some forms of therapy, more visits from aunt Tammi?

Case Scenario 2: Van

Van is 27 years old and has Down Syndrome. He lives independently with his roommate, Walker. They've been buddies since high school, but Van describes Walker as his brother.

The reporter is Yancy, the manager at the grocery store where Van works. Van is usually punctual, clean, and appropriately dressed. For the last couple of weeks, Van has been coming to work with bruises on his hands and arms. He said he was okay, that he and his brother are just getting into "normal brother fights".

This morning, Van called Yancy and asked if he could give Van a ride to work. When Yancy arrived, he found Van sitting on the front steps of his apartment building with a black eye. Van had clearly been crying, but he insisted that he and his brother just had another normal brother fight and he was ready to work. Van's shirt was not tucked in, and he smelled like body odor. Van told Yancy that his brother "can drive" him to work, but he was sleeping and wouldn't get up.

When Yancy suggested Van go see a doctor, Van refused.

Discussion Questions:

1. Concerns and strengths

Possible Answers: Concerns include: Van has multiple bruises and is now without his usual transportation. Van's hygiene and punctuality have changed, and his roommate won't get up. Does this mean Walker was harmed, or that he just refused to get out of bed? "Play-fighting" between adults is suspicious, is this a name for something more serious happening? Does Van think they're playing, or is this a way to minimize what he's experiencing?

Strengths include: Van seems capable of living independently and taking care of himself. While he uses supports (like getting a ride from Walker) he's able to manage time and tasks at work. His manager Yancy helped with transportation in an emergency. His relationship with Walker can also be a strength – he has had a long-term, close friendship with someone who has been a natural supporter for some time.

2. Communication and decision-making

Possible Answers: Communication considerations include: Make sure to speak to Van alone, without Walker present in the apartment. Match Van's sentence length, complexity, and pacing. Be sure not to talk down to or infantilize Van, because he's a grown adult with a job. Ask for definitions of "normal brother fights" – does "normal" mean common, or does it imply that sometimes there are worse brother fights?

Decision-Making considerations include: Do not assume that Van's Down Syndrome impairs his ability to understand, reason through, and communicate decisions. Prioritize preserving Van's autonomy. (For example, Van refused to go to the doctor when Yancy

asked if he wanted to go. Did he do that because he thought he wasn't injured, because he wanted to keep Walker from getting in trouble, or... because his primary mode of transportation didn't get up that morning and he didn't want to walk?)

3. Person-directed, accessible service planning

Possible Answers: What would Van like to see happen? How could Van and Walker fight less often? Steps could include connecting Van to a transportation service to help increase his independence. Would Van consider living apart from Walker? Preserving Van's independence as much as possible – least-restrictive alternatives if Walker isn't a safe option for assistance: ridesharing apps, independent travel, using public transit?

Case Scenario 3: Jenna

Jenna is 61 years old and lives with Cerebral Palsy. She has limited mobility in her arms and only walks short distances without the assistance of her motorized wheelchair. Jenna's speech is imprecise and often sounds slurred. She lives alone and works remotely as a copyeditor for a fantasy fiction publishing agency.

The reporter is Jenna's occupational therapist (OT), Iman. She suspects that Jenna may be experiencing abuse.

Jenna has missed multiple therapy appointments without notice. When Iman emailed to follow up, Jenna replied that she accidentally kept forgetting to plug in her wheelchair and couldn't get far without it. When Jenna finally attended an appointment, she arrived in a regular wheelchair, pushed by a man who looked to be in his forties or early fifties.

During the appointment, Jenna appeared stiffer and more uncomfortable than usual. It seemed as though Jenna couldn't relax in her seat. Iman described her as "tense" and "not herself." However, Jenna denied any issues.

According to the receptionist, the man waited impatiently throughout the appointment, repeatedly attempted to use his e-cigarette indoors, and scoffed when Jenna emerged. He yanked the wheelchair away from Iman. As the pair left, both Iman and the receptionist overheard the man berating Jenna, calling her a cruel name and blaming her for wasting his time and money.

Discussion Questions:

1. Concerns and strengths

Possible Answers: Concerns include: Jenna missed OT appointments, is without her usual mobility device, seemed to have increased physical discomfort. The man with her berated her. Someone who has seen Jenna frequently described her as "not herself". The status of Jenna's motorized wheelchair is unknown (was it sold?).

Strengths include: Jenna is capable of living alone and has her own source of income. She has an interest in fantasy fiction and copyediting. Jenna is communicating and doing what she can to protect herself in the moment; we don't know what Jenna's plans are, but we can see what she is doing right now.

2. Communication and decision-making

Possible Answers: Communication considerations: Jenna may be comfortable speaking with you, or may choose to use text to communicate – provide her with options. A concern may be whether or not the man is present when you attempt to speak with Jenna.

Decision-making considerations include: Do not assume that a diagnosis of cerebral palsy, or missing important OT appointments, indicates that Jenna is not capable of making decisions. She may have barriers to transportation, she may be relying on

someone for physical support as well as transportation support. She may be choosing to get her needs met, even if the person doing so is being unpleasant.

3. Person-directed, accessible service planning

Possible Answers: Investigate the reason for her missed appointments to determine the remedy. Also, we want to learn more about Jenna's relationship with the man to explore if she has any concerns. What would Jenna like to see? While Jenna is connected through remote work, does she have people who can support her in person?

Appendix B: Case Scenario Activity (Participant Copy)

Case Scenario 1: Spencer

Spencer is a 35-year-old man living with Autism. His vocabulary is limited and he tends to use his own words for certain familiar or important items. He uses a digital AAC device as his primary method of communication; when he taps a picture, the device speaks. Spencer lives with his mother, Teenie, and her new boyfriend, Ralph.

Spencer's aunt Tammi reported the concern to APS. Tammi reports that Spencer has a small pool of "safe foods" he will eat. (Safe foods are predictable, low-stress foods that accommodate sensory needs, low energy, or physical limitations.) If he is presented with a food outside of the "safe" group, he will react with disgust, gag, or even vomit. On a recent visit, Tammi observed that Spencer gagged and cried even when presented with a meal only made of safe foods. When Tammi tried to coax him into eating, he began rocking in his seat and hitting his AAC tablet against the table. Spencer's mother didn't react beyond saying, "He'll tire himself out." Ralph said, "He knows what'll happen if he doesn't."

According to Tammi, Spencer's lips seemed swollen, and she saw a bruise on his cheek. She's concerned that Ralph might be "manhandling" Spencer. According to Tammi, Ralph has repeatedly complained about Spencer being a picky eater, and she's seen him raise his hand and threaten to strike Spencer before.

Discussion Questions:

1. What are some of the concerns and strengths in this scenario?
2. What are considerations for communication and decision-making?
3. What are your ideas for accessible, person-directed service planning?

Case Scenario 2: Van

Van is 27 years old and has Down Syndrome. He lives independently with his roommate, Walker. They've been buddies since high school, but Van describes Walker as his brother.

The reporter is Yancy, the manager at the grocery store where Van works. Van is usually punctual, clean, and appropriately dressed. For the last couple of weeks, Van has been coming to work with bruises on his hands and arms. He said he was okay, that he and his brother are just getting into "normal brother fights".

This morning, Van called Yancy and asked if he could give Van a ride to work. When Yancy arrived, he found Van sitting on the front steps of his apartment building with a black eye. Van had clearly been crying, but he insisted that he and his brother just had another normal brother fight and he was ready to work. Van's shirt was not tucked in, and he smelled like body odor. Van told Yancy that his brother "can drive" him to work, but he was sleeping and wouldn't get up.

When Yancy suggested Van go see a doctor, Van refused.

Discussion Questions:

1. What are some of the concerns and strengths in this scenario?
2. What are considerations for communication and decision-making?
3. What are your ideas for accessible, person-directed service planning?

Case Scenario 3: Jenna

Jenna is 61 years old and lives with Cerebral Palsy. She has limited mobility in her arms and only walks short distances without the assistance of her motorized wheelchair. Jenna's speech is imprecise and often sounds slurred. She lives alone and works remotely as a copyeditor for a fantasy fiction publishing agency.

The reporter is Jenna's occupational therapist (OT), Iman. She suspects that Jenna may be experiencing abuse.

Jenna has missed multiple therapy appointments without notice. When Iman emailed to follow up, Jenna replied that she accidentally kept forgetting to plug in her wheelchair and couldn't get far without it. When Jenna finally attended an appointment, she arrived in a regular wheelchair, pushed by a man who looked to be in his forties or early fifties.

During the appointment, Jenna appeared stiffer and more uncomfortable than usual. It seemed as though Jenna couldn't relax in her seat. Iman described her as "tense" and "not herself." However, Jenna denied any issues.

According to the receptionist, the man waited impatiently throughout the appointment, repeatedly attempted to use his e-cigarette indoors, and scoffed when Jenna emerged. He yanked the wheelchair away from Iman. As the pair left, both Iman and the receptionist overheard the man berating Jenna, calling her a cruel name and blaming her for wasting his time and money.

Discussion Questions:

1. What are some of the concerns and strengths in this scenario?
2. What are considerations for communication and decision-making?
3. What are your ideas for accessible, person-directed service planning?

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