Access Series

Understanding Persons with Mental Health and Developmental Disabilities

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Access Series

Understanding Persons with Mental Health and Developmental Disabilities

Access Series:
Understanding
Mental Health and
Developmental
Disabilities

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Mieux comprendre les personnes qui ont une déficience psychique ou intellectuelle

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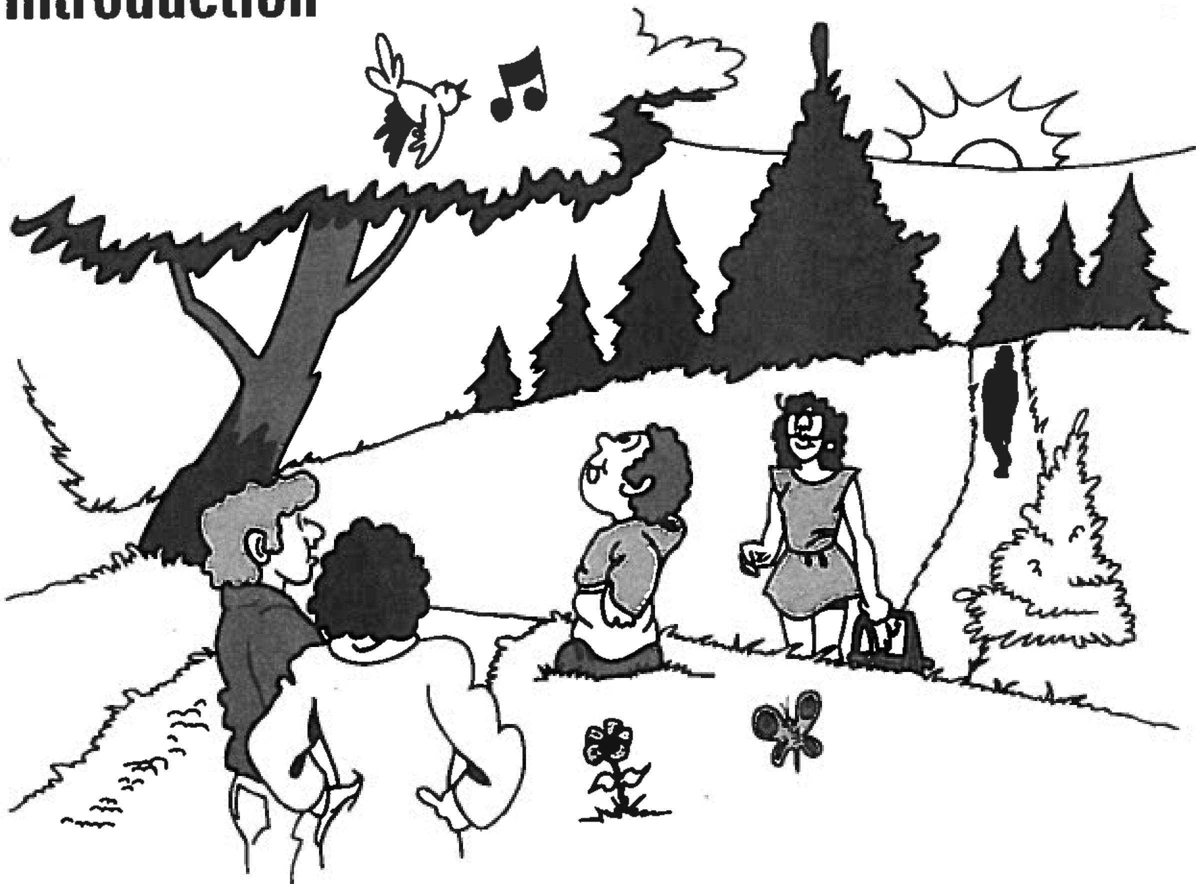
Introduction



Parks Canada is dedicated to providing good service to all visitors – including those who have disabilities. In a 1992 news release, Parks Canada made a commitment to meet the needs of persons with hearing, mental, mobility, speech, and visual impairments. To date, Parks Canada's projects have included the purchase and installation of over 90 Telephone Devices for the Deaf (TTYs), the provision of information in alternative format for people who have visual impairments, and the implementation of retrofit projects to increase access for mobility impaired persons to facilities.

Parks Canada is now looking to improve its services for persons who have mental health and developmental disabilities. This booklet is a step in that direction. The purpose is to provide information about these disabilities as well as tips and techniques on providing visitors who have mental health and developmental disabilities with the best possible service.

The information in this booklet is meant to inform Parks staff about mental health and developmental disabilities. It is not the role of Parks staff to diagnose and treat everyone that enters a park or site. Therefore, this information should be used by staff to maintain an open mind, and make better decisions when interacting with people who have mental health and developmental disabilities.

Since this booklet has information about two major disability groups, it has been divided into two sections. The first section begins with a short overview of mental health disabilities. The following four sections attend individually to the most common types of mental health disabilities. These sections discuss prevalence, characteristics, and tips on intervention for each of these four mental health disabilities: Schizophrenia, Affective Disorders, Anxiety Disorders, and Personality Disorders.

The second segment deals with tips on dealing with persons who have developmental disabilities. When groups or individuals with developmental disabilities visit parks and sites, staff may feel unsure about how to serve them. This booklet can be used as a resource by employees who have questions about this disability. It shows some good techniques on how to interact successfully with people who have developmental disabilities.

At the end of the booklet there are four appendices. Appendix A contains statistics by province on mental health and developmental disabilities combined, and Appendix B, an article from the Globe and Mail on this topic. If Parks employees would like to get more information, Appendix C and D contain addresses of Canadian agencies that represent people who have mental health disabilities and those who have developmental disabilities.

1.0 Mental Health Disabilities - General

People who have mental health disabilities form a significant part of the Canadian population. **One** in **three** Canadians will experience a mental health disability and **one** in **eight** Canadians will require professional care.

This section begins by refuting some common misconceptions regarding mental health disabilities. It then gives a simplified definition of mental health disabilities, and discusses proper terminology.

1.1 Myths and Mental Health Disabilities

1. **Myth:** "People who have a mental health disability are violent and dangerous"

   Reality: As a group, people who have a mental health disability are no more violent than anyone else. They are often portrayed as violent in the media and mainstream entertainment. However, these are usually extreme or fictional cases.

2. **Myth:** "People who have a mental health disability are less intelligent"

   Reality: A person with a mental health disability usually has an average or above average level of intelligence.

3. **Myth:** "A developmental disability is a form of a mental health disability"

   Reality: Mental health disabilities are fundamentally different from developmental disabilities. Developmental disabilities are permanent conditions in which intellectual and social development is impaired.

4. **Myth:** "Schizophrenics have multiple personalities"

   Reality: The term schizophrenia means "the splitting of the mind", however, it was coined to describe the inability of schizophrenics to think clearly, or act decisively. A multiple personality syndrome is very rare and significantly different from true schizophrenia.

5. **Myth:** "Mental health disabilities affect only certain types of people"

   Reality: Mental health disabilities affect one in three people. Race, gender or social class have nothing to do with who will develop this type of disability.

6. **Myth:** "It is obvious when someone has a mental health disability"

   Reality: It is not easy to tell if someone has a mental health disability. A person with a mental health disability may be coping well enough to not display any symptoms. It is also possible that someone may display eccentric or unusual behaviour by choice, rather than as a result of a mental health disability.

1.2 What is a Mental Health Disability?

Mental health disabilities do not fit easily into a narrow definition. They affect a large number of people in varying degrees of severity. In subsequent sections, this booklet will discuss the different types of mental health disabilities more specifically. Here is a general definition of a mental health disability.

Definition: A mental health disability is a state of mind or emotion that affects one's ability to function in society. By "function in society", it is meant that mental health disabilities may cause individuals to do or say unusual and socially unacceptable things, or that they may have difficulty in their relations with other people.

1.3 Terminology

Being sensitive to persons who have disabilities begins by using proper terminology. Referring to a disability by using correct words and phrases helps develop positive attitudes.

For example, use **"person who has a mental health disability"** or **"person who has a mental illness"**– not "mental patient", "crazy", or "insane".

Be sure you refer to them as a **"person"** who **"has"** a disability, not as a "mentally disabled person". The focus should be on the person, not on the disability.

1.4 How Parks Canada employees can work with people who have a Mental Health Disability

As Parks Canada provides a service to the general public, Parks employees can expect to encounter members of the public who have a mental health disability. These individuals may visit a park or site individually or in a group, perhaps from a hospital or a group home. Depending on the situation, Parks employees may or may not know whether a visitor has a mental health disability. It is not up to Parks employees to try to diagnose people as they enter the park. It is best to be open minded, and if unusual behaviour occurs, realize that a mental health disability is a possible explanation for that behaviour.

Mental health disabilities do not, however, excuse unacceptable behaviour. If a visitor is acting in a manner that adversely affects a park's or site's interpretation, try to correct that behaviour. Later in this booklet, suggestions are made on how to intervene when confronted with different types of mental health disability behaviours.

2.0 Schizophrenia

Schizophrenia is perhaps the most serious type of mental health disability. It affects 1% of the population. The characteristics most often associated with mental health disabilities, are those displayed by people who have schizophrenia; e.g. muttering to one-self, or being unusually paranoid. As mentioned in the myth section, schizophrenia is not "a split personality", it is a disease that is understood to be associated with a chemical imbalance in the brain. There is still much that is unknown about the disease. This section will describe some of the characteristics and behaviours of people who have schizophrenia, and list some possible methods of interaction with them.

***Note:** The characteristics and behaviours described below may occur differently from one individual to the next, in varying degrees of frequency and severity.*

2.1 Characteristics of Schizophrenia

1. **Delusions:** A delusion is defined as a "fixed false belief". People experiencing delusions may have paranoid delusions in which they feel like they are being persecuted by everyone around them. What is called a *grandiose* delusion may cause someone who has schizophrenia to believe that they have special abilities and powers.

Possible Behaviours:

(i) A person who is experiencing delusions may display extremely paranoid behaviour, and be suspicious of everyone and everything.

(ii) Someone who claims to be Jesus resurrected or that he/she is able to fly, is probably experiencing grandiose delusions.

2. **Hallucinations:** A hallucination causes a person to be subjected to non-existent experiences with his/her senses. It can occur with one or more of the five senses but most commonly, one will hear sounds that do not exist, e.g. a voice, or voices speaking to them. A hallucination may not be schizophrenic if it is caused by a hallucinogenic drug.

Possible Behaviours:

(i) A person experiencing a hallucination may begin to laugh for no apparent reason, or display unusual behaviour in response to non-existent voices.

(ii) A hallucination may support someone's paranoid delusions if, for example, they believe that their food tastes poisoned.

3. **Confused Thoughts:** A person who has schizophrenia will often have many thoughts at once and be unable to put them together in sequence. This may cause difficulty in speech.

Possible Behaviours:

(i) The following is an example of speech of someone experiencing confused thoughts:

I had to go to school the other day, and school isn't very good because remembering is very hard to do, you know its like your head will be full, what I mean is that filling up a book is hard to do but school makes you remember.

4. **Aloofness:** A person who has schizophrenia may appear aloof or withdrawn from other people. This is a characteristic that is often the secondary result of an inability to communicate clearly.

Possible Behaviours:

(i) In a crowded room, people who have schizophrenia might withdraw into themselves and avoid any contact with other people.

5. **Altered sense of self:** Schizophrenia can cause a person to have an unusual perception of themselves. For example, a person who has schizophrenia may believe that they are looking at themselves when they see someone else. This altered sense of self may also take the form of visual hallucinations when the person who has schizophrenia believes that they see changes in their body.

Possible Behaviours:

(i) A person that is experiencing an altered sense of self might be affected by actions done to other people or things. For example, if an owner is scolding their dog, a person who has schizophrenia might be watching and believe that *they* are being scolded.

(ii) A person who has schizophrenia may look at their hands and claim that they are larger than they used to be.

2.2 How Parks Canada employees can work with people who have Schizophrenia

If a visitor is displaying one of the above characteristics, it is possible that they have schizophrenia (it is very difficult to tell for *sure* without a long period of observation). If an unusual behaviour is observed, the following are examples of ineffective and effective ways of dealing with those behaviours.

Tips on intervention

Delusions: If someone is having delusions, it is not useful to tell them that what they are saying is crazy, and that they should stop thinking in that way. Arguing over the truth of the delusions will get nowhere. Accept that they believe in their delusions, and agree to disagree with them.

Example: A person believes that he/she has created the forest.

Ineffective response: "Sorry, a human being cannot create a forest, it occurs over time with natural succession."

Effective Response: "That's interesting, but I don't think that's how the forest was created. Let's not worry about it right now." In other words, be polite and acknowledge their perceptions, then move on.

Hallucinations: Hallucinations are much the same as delusions in that people experiencing them firmly believe that what they are hearing or feeling is real. It is not useful to argue with them or to try to convince them that they are not sensing anything. It is better to simply explain to the person that others around them do not hear or see what they are sensing.

Example: A person hears voices while visiting a historic site.

Ineffective response: "Nobody is speaking other than us. I can't understand why you hear voices."

Effective Response: "That's interesting that you can hear voices. The rest of us here don't hear them. Try to ignore them for now and maybe we can talk about it once we have finished the tour."

Confused Speech: It can be quite difficult to understand what people who have schizophrenia are saying, if their speech is confused. Instead of spending a lot of time deciphering what someone is saying, it may be better to ask them to write down what they would like.

Example: A person who has schizophrenia is trying to get some information from a staff member in a visitor centre.

Ineffective response: "Okay you want information on the field house?... no... uh, you're looking for the washroom?... no eh? um..."

Effective Response: "I'm sorry, I don't understand what you are trying to tell me. Perhaps you could write it down."

General: There is no formula for solving every problem, but generally there will be few, if any, serious situations. If a person who has schizophrenia (or is showing symptoms of schizophrenia) has a crisis in which they may harm themselves or someone else, try to get help; do not attempt to deal with the situation yourself. Treat it as a medical emergency.

3.0 Affective Disorders

Affective disorders are more commonly known as depression or manic depression. They disrupt people's relation to their environment. The three main types of affective disorders are:

- Depression
- Manic disorders
- Manic depression

Depression is the most common of affective disorders. About 15% of the population can expect to experience a significant depression in their lifetime (4% of the population will experience chronic depression their whole lives). Manic disorders or manic depression are more rare, but still affect about 1% of the population.

3.1 Characteristics of Depression

1. **Depressed mood:** Since most of us have experienced "being depressed" at some point in our lives, we are familiar with what it is like to be depressed. Someone who is experiencing a significant depression will experience a depressed feeling for a long period of time, yet may not have any reason for feeling the way he/she does.

   Possible Behaviours:

   (i) A person experiencing depression may be full of despair and feel hopeless. Nothing anyone does or says can break this dark mood.

   (ii) Depression may cause someone to begin crying for no apparent reason.

2. **Loss of Interest:** Depression can cause someone to lose interest in activities or experiences that they previously enjoyed.

   Possible behaviours:

   (i) People who used to really enjoy nature hikes may become uninterested and it may be difficult for their companions to get them out of the house.

3. **Low Self Esteem:** People experiencing severe depression will have low self esteem and lack confidence in themselves.

   Possible behaviours:

   (i) A person experiencing depression will often believe that he/she is incapable or unworthy of accomplishing any task.

3.2 Characteristics of Manic-Depression and Manic Disorder

Manic-depression is also known as a bipolar disorder, because it is characterized by mood swings from depression to mania. A *manic disorder* is a mental health disability in which a person experiences mania most of the time. The following are some characteristics of people who have a manic disorder, or people who are in a "up" stage of manic-depression.

1. **Excessively Good Mood:** A manic disorder is an affective disorder like depression. However, whereas people who are depressed are excessively unhappy, people who have a manic disorder are incredibly happy and enthusiastic. This euphoria knows no bounds and nothing can bring it down.

   Possible behaviours:

   (i) Someone who has just been told that a close friend has died may show little grief and have a "these things happen" attitude.

2. **Increased Levels of Energy:** People who have manic disorders can go for days with very little sleep while participating in a large number of activities. They may also appear to be in constant motion, with anxious and repeated movements.

   Possible behaviours:

   (i) People with manic disorders may play a sport for many hours, without a break. They may put their energy into their work and put in a twenty-four hour day.

   (ii) Pacing, twitching and repeated movements are common among people who experience a manic disorder.

3. **High Self Esteem:** People who have manic disorders often have an elevated self-esteem, and believe that they are capable of anything. This elevated self-esteem can cause someone to believe that they are an expert on any topic. Manic disorders can also lead to grandiose delusions.

   Possible behaviours:

   (i) A person with a manic disorder may give extensive advice to someone on a complex subject, such as ecosystem management, when they really have very little knowledge of that topic.

   (ii) Someone who has a manic disorder may really believe that it is their duty as a special person to solve all of the problems in the world.

4. **Poor Judgement:** Inflated self-esteem and high energy levels can lead someone who has a manic disorder to make bad decisions.

Possible behaviours:

(i) A person with a manic disorder may impulsively spend large amounts of money on something that they do not need and probably cannot afford.

(ii) High energy levels may cause someone to decide that they will run the forty kilometres to the next city, instead of taking their car.

5. **Rapid Speech:** People who have manic disorders become hyperactive in their mind as well as their body. They experience many thoughts at once and will, in turn, speak at a rapid rate. Following their conversation can be difficult because they will often begin a new sentence before finishing the last one.

Possible behaviours:

(i) Speech by a person who has a manic disorder may contain many run-on sentences, and can be so quick that it is impossible to understand.

3.3 How Parks Canada employees can work with people who have Affective Disorders

Whether it is by medication, support networks or by coping techniques, many people with affective disorders can lead fairly normal lives. In a park or site situation, it would be difficult for a Parks employee to tell if a visitor has an affective disorder or is just experiencing an everyday sad or hyper spell. The following tips relate to extreme behaviours of affective disorders.

Depression:

- If someone is depressed, avoid quizzing them on why they are depressed. They may not know why themselves.
- It is not helpful to convince someone that they should not be depressed. It may cause them to experience guilt or blame.
- A good way to help someone cope with an affective disorder is simply to listen. Talking about depression may help.

Manic Symptoms:

- Someone that is experiencing a manic disorder is often stimulated by conflict or attention. Giving them a chance to stand out in a group or get into a heated debate will often aggravate their symptoms.
- Severe cases of manic disorder are often accompanied by paranoid and grandiose delusions. Try not to counter their ideas if it appears that they will become aggressive. As in the case of schizophrenia, agree to disagree.

4.0 Anxiety Disorders

Like affective disorders, anxiety disorders are quite common. 2% to 8% of the population will experience an anxiety disorder. This type of disorder causes psychological and physical symptoms.

The four major types of anxiety disorders are:

- Panic Disorder
- Generalized Anxiety Disorder
- Obsessive Compulsive Disorder
- Phobia

Many of us experience symptoms of these disorders, (for example, having a phobia of snakes, or keeping an obsessively tidy house). However, unless those symptoms have a negative effect on the way we live our lives, they do not constitute an anxiety disorder.

4.1 Characteristics of a Panic Disorder

A person who has a panic disorder will experience recurrent attacks of panic and anxiety. Common symptoms of these attacks are:

- shortness of breath
- pounding heart
- dizziness
- trembling
- sweating
- a general feeling of anxiety within their environment

These panic attacks usually last a few minutes. If they occur frequently, and cause significant negative effects on the person experiencing them, they are classified as a panic disorder. As you will read below, these panic attacks are often symptoms of other anxiety disorders.

4.2 Characteristics of a Phobic Disorder

Phobias are quite common to everyone and usually do not drastically affect someone's life. Sometimes, however, a phobia can cause frequent states of anxiety and have a dramatic effect on someone's relationship to their environment. The most common "serious" phobia is *Agoraphobia;* the fear of public and open spaces. This disorder is characterized by panic attacks like those previously described. These panic attacks can occur on crowded streets, in traffic or wherever there are a lot of people. In severe cases, people become completely housebound, for fear of experiencing panic attacks when they go out.

4.3 Characteristics of an Obsessive-Compulsive Disorder

The characteristics of an obsessive-compulsive disorder are repetitive thoughts and actions. Obsessions are repetitive thoughts and compulsions, repetitive actions. Someone who has an obsession with something will make up rituals (compulsions) to compensate, or counter those obsessions. For example, someone may have a troubling obsession with cleanliness, and therefore wash their hands over and over again. Common compulsions are:

- Hand Washing
- Counting
- Repeatedly checking a lock on a door or the time on a watch
- Touching something

Most of us have little rituals that we may feel are compulsive. However, when someone has an obsessive-compulsive disorder, the need to do rituals can cause a large amount of anxiety. For example, when a compulsive behaviour is disrupted and results in a panic attack.

4.4 How Parks Canada employees can work with people who have Anxiety Disorders

Panic Attack: Someone who is having a panic attack may have difficulty breathing, pace back and forth, or display other symptoms previously described. To help this person:

- Encourage them to breath slowly
- Reassure them that it will pass soon

Phobia: If someone is having a panic attack caused by a phobia:

- Remove them from the object of their phobia (if possible)
- Reassure them that they will not be harmed by it
- Do not try to convince them that their phobia is unreasonable
- Try to accommodate the person's phobia by avoiding situations that may cause a panic attack

Generally, the best way for Parks Canada staff to work with people who have anxiety disorders is to create a climate of confidence.

5.0 Personality Disorders

Everyone has their own personality, and sometimes relationships between people can be impaired if personalities conflict. What is known as a personality disorder can seriously affect how someone relates with all other people.

A personality disorder is characterized by traits in a personality that are so extreme that they significantly affect a person's relationships with others.

The personality disorders that will be discussed here are:

- Histrionic
- Narcissistic
- Antisocial
- Paranoid
- Schizoid

5.1 Characteristics of Personality Disorders

1. **Histrionic Personality Disorder**: This type of disorder is characterized by a person who is overly dramatic. A person with a histrionic personality disorder will always try to be the centre of attention. If they feel they are not getting enough attention, they may try to pull a "stunt" in order to get it.

2. **Narcissistic Personality Disorder**: A person who has a narcissistic personality disorder often has a large ego and needs other people's admiration and attention. Someone who has this disorder may try to dominate an interpretive talk by trying to show off "knowledge" of a particular aspect of a presentation.

3. **Antisocial Personality Disorder (Sociopathy)**: Antisocial personality disorders are characterized by someone who has a long history of lying, stealing, or basically displaying a resistance towards authority. People who have an antisocial personality disorder are often able to play on other people's weaknesses and manipulate or hurt them.

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4. Paranoid Personality Disorder: Someone who has a paranoid personality disorder is usually a mistrustful person, who always expects the worst out of people. When making a visit to a park or historic site, a person with this disability may appear cold and aloof, and feel easily threatened.

5. Schizoid Personality Disorder: A person who has a schizoid personality disorder is often unable to feel much warmth and emotion. They are usually someone who can be described as a "loner", keeping mostly to themselves.

5.2 How Parks Canada employees can work with people who have Personality Disorders

Very few cases of personality disorders are diagnosed, because people who have them generally do not believe that anything is wrong. For that reason, it is difficult to set out specific tips on how to work with people who have this disability. The following is a general rule.

Because everyone has their own style of handling different people (the one that they are most comfortable with), it is best to suggest that Parks Canada employees stay with their *own* style when working with visitors who have personality disorders. Simply remember that personality disorders *are* recognized disabilities and that a polite accommodating attitude is the best.

6.0 Developmental Disabilities: General

This section is designed to give a quick background about developmental disabilities in general; e.g. what is the prevalence of the disability and the correct terminology when referring to a person who has one.

6.1 Prevalence

Persons who have developmental disabilities form a large segment of the Canadian population. There are nine times more of them than people who have cerebral palsy and fifteen times more than people who are totaly blind (Brown, 1988).

The frequency of mental health and developmental disabilities combined can be seen in the following statistics (taken from the 1991 Health and Activity Limitation Survey):

- At 43%, it is the largest reported disability group among persons between the ages of 15 and 34.
- Persons with these disabilities make up about 3% of the Canadian population.
- There are 744,510 people with mental health and developmental disabilities between the ages of fifteen and sixty-four that live in households in Canada. That is 248,945 more than surveyed in 1986 (HALS, 1986).

Note: This does not necessarily mean that this population is rising at a tremendous rate; just that more people, today, are reporting these disabilities.

These numbers show that persons who have mental health and developmental disabilities form a significant portion of the Canadian population. If Parks Canada is to fulfil its promise of making national parks and historic sites accessible to all Canadians, it must take the needs of this segment of the population into consideration.

Statistics (by province) throughout Canada appear in Appendix A.

6.2 Terminology

A first step in being sensitive to persons with disabilities, is to use correct terminology when referring to them. Using correct words and phrases helps develop positive attitudes.

Use **"person with a developmental disability"** or **"person who has a developmental disability"**- not "retarded", "mentally retarded", or "mentally challenged", (Active Living Alliance, 1990).

7.0 Developmental Disabilities – A Definition and Causes

7.1 What is a Developmental Disability?

Of all disabilities, developmental disabilities are among the most difficult to define. The lack of a single definition is due to the enormous diversity in causes, characterstics and degree of disability.

Definition: The Americian Association on Mental Deficiency describes a developmental disability as a "significantly subaverage general intellectual functioning, existing concurrently with deficits in adaptive behaviour, and manifested during the developmental period" (Grossman, 1983). The extent to which a person is disabled depends on his or her ability to "meet the standards of personal independence and social responsibility expected of their age and cultural group" (Grossman, 1983). In simpler terms, people who have this disability develop at a slower rate than non-disabled persons.

A method that experts use to determine wheither or not a person has a developmental disability is the Intelligence Quotient (IQ). IQ is an intelligence rating arrived at with intelligence tests. Anyone with an IQ below 70 is said to have a developmental disability.

The World Health Organization has established four levels of developmental disability based on IQ levels:

- Profound: IQ between 0-20
- Severe: IQ between 20-30
- Moderate: IQ between 30-50
- Mild: IQ between 50-70, (Landsdown, 1987).

A very important point is that eighty-eight percent of those who have developmental disabilities have mild intellectual impairments (Brown, 1988). These people are able to learn to read and acquire practical skills, and many hold jobs. Intellectual impairments may or may not hinder other aspects of a person's development.

7.2 What causes a Developmental Disability?

A developmental disability can be caused during three stages in life; prenatal (in the fetal stage), perinatal (during birth), or postnatal (after birth).

- Prenatal: Causes include subnormal chromosomes and genes, or the effects of Rubella (German Measles).
- Perinatal: Causes include anoxia (oxygen impairment), or complications at birth.
- Postnatal: Causes include lead poisoning, head injury, or anoxia.

These are only a few of many possible causes. Experts state that there are over two hundred and fifty known causes. Unfortunately, the known causes only account for about one quarter of the known cases (Brown, 1988).

8.0 Developmental Disabilities and Parks Canada

8.1 Why do persons who have Developmental Disabilities visit national parks and historic sites?

The reasons that developmentally disabled persons have for visiting parks are really no different than they are for anyone else. Persons who have developmental disabilities travel to parks to experience, enjoy and learn about new environments.

It is important that they experience outings that are natural to all people to learn how to act in everyday situations. Any new social setting will allow persons with developmental disabilities to interact with other people, and see how other people interact with each other (as a non-disabled person would during his/her developing stages).

The wish of any person who has a developmental disability is to be integrated into a society that will treat them as it would treat anyone else. Ideally, their visits should not only be a learning experience for themselves, but for everyone they meet.

8.2 How can Parks staff best work with persons who have Developmental Disabilities?

The hints mentioned here are meant to give the reader an idea of possible techniques to use when interacting with visitors who have developmental disabilities. As no two situations will be alike, these suggestions are only meant as a guide. In any situation involving someone who has a developmental disability, it is very important to show flexibility, patience, and a positive attitude.

SUGGESTIONS

1. Assumptions :

Parks staff should not concern themselves with whether persons with developmental disabilities can handle the situations provided by our service. Instead, make these three general assumptions:

- If there are groups or individuals with developmental disabilities visiting a park or site, somebody has already decided that they can handle it.
- If the person has a profound developmental disability, they will have someone with them.
- If the person with a developmental disability is alone, they have been taught to manage themselves in that type of situation, (Beechel, 1975).

TIP: Do not overprotect visitors who have developmental disabilities.

2. Appropriate information :
When giving a presentation, try to give it at a level that is suitable for the intelligence level of the audience, ensuring that the presentation of the material is appropriate for their age level, (Handidactis, 1986).

TIP: When presenting to a group, it is suggested to ask the group leader the comparable school grade level of comprehension of the participants. Tailor the program on that basis.

3. Simple Language :
Although you should not use childish language, it is important to use simple, straightforward language. Persons with developmental disabilities may not comprehend words like... comprehend, so use everyday words like...understand. Similarly, persons with developmental disabilities may not understand complex ideas such as symbolism or metaphors. Keep everything straightforward, and present things that are visible and tangible, (Landsdown, 1980).

TIP: Do not present two ideas or concepts in the same sentence. If asking questions, keep them simple and straightforward.

WARNING:

- Use the appropriate tone of voice and language for the age level with which you are dealing. Do not use childish language if the participants are not children.
- There will probably be a varying degree of comprehension within the group. Therefore, do not limit the scope of the material: offer choices.

TIP: Try to recognize the capabilities and potentials of each person and adapt to them.

4. Pace :
Visitors with developmental disabilities process information at a slower rate than non-disabled visitors. It is important to control the pace of a presentation. If you are unsure, don't be afraid to ask if you are talking too fast, or too slow.

TIP: Make sure you are presenting your talk at a suitable pace by asking.

WARNING:

If you are giving a presentation to an integrated group, try not to single out the persons who have developmental disabilities.

5. Repetition :
Repetition is a good technique to use when giving a presentation; it helps to check the pace. You may introduce what **will** be said, say it, and then review what **was** said. This will allow the visitors more time to absorb the information, (Brown, 1988).

TIP: Use repetition in presentations.

6. Senses :
National parks and historic sites provide wonderful settings for persons with developmental disabilities to experience aspects of the environment. Nature is something that surrounds us, that we can see and touch. Interpreters should try and involve as many senses as possible when interpreting to persons with developmental disabilities. Let them hug a tree, taste spring water, or smell pine cones.

Similarly, those working in historic sites should try and provide objects that participants can touch, or see up close. Historic significance may not impress them, but objects or sights that are appealing to the senses will, (Beechel, 1975).

TIP: Involve as many senses as possible in your presentation.

7. Motivation :
Tangible evidence of success will go a long way in motivating persons with developmental disabilities. Something like a certificate of success certifying that they completed a trail or visited the home of a former prime minister, will have a positive effect, (Beechel, 1975).

TIP: Use tangible motivators whenever possible.

8. Feedback :
An important reason that persons with developmental disabilities visit heritage sites is for new experiences and interactions in new settings. Although they may not always provide feedback on having gained anything from the experience, Parks staff should be reassured that being out and active is of great benefit to visitors with developmental disabilities.

TIP: Do not be concerned if positive feedback is not made apparent.

9. Behaviour :
Do not let visitors with developmental disabilities, get away with unacceptable behaviour. If they are acting in a way that you would not accept from a non-disabled visitor, correct that behaviour. This is not always easy to do, but it is best for all concerned, (Handidactis, 1986).

TIP: Do not tolerate unacceptable behaviour

10. Written Material :
When making a presentation to persons who have developmental disabilities, the use of visual aids can be helpful in making points. Here are some hints when preparing the material:

1. Use pictures and illustrations whenever possible.
2. Keep words and sentences short and simple.
3. Define words when special terms have to be used, (Brown, 1988).

TIP: Use visual aids, but keep them simple.

11. Working with Agencies :
The most effective way of assessing the needs of persons with developmental disabilities is to speak to local agencies that work with this particular group.

This dialogue can occur when an organization books a group for a visit. In addition to the regular booking procedure, one should ask specific questions regarding the visitors, (West, 1986).

Here are some good questions to ask when booking a group with developmental disabilities:

1. What is(are) the disability(ies) of the group members?
2. What is the comparable school grade of comprehension of the visitors?
3. Are you doing any preparatory work previous to the groups visit? Would you like any information regarding our park or site in advance?
4. What elements of the park or site would you like to see highlighted?
5. Are there any special activities that you might like to do?

TIP: When booking a group with developmental disabilities, ask specific questions.

Parks and sites staff are also welcome to approach local agencies first. Let the agency know that Parks Canada is interested in improving its service to persons with developmental disabilities, and would like input on how it could do so.

This type of discussion will be beneficial to both parties. It will encourage agencies to increase their visitation to national parks and historic sites and, thus, provide the necessary exposure to help Parks Canada improve its services to people with developmental disabilities (West, 1986).

After a visit by an agency, try to get feedback from the leader as to how things went and what could be improved.

TIP: Try to establish cooperative ventures between parks or sites and local agencies.

(There is a list of agencies across Canada in Appendix D).

Quiz

Check Learning: Once you have read the material in this booklet, you should be able to answer the following questions.

		TRUE	FALSE
1.	Developmental disabilities occur about as often as cerebral palsy.	❑	❑
2.	Persons with mental health and developmental disabilities make up about 0.3% of the Canadian population.	❑	❑
3.	Acceptable terms for this disability are developmentally disabled and developmentally challenged.	❑	❑
4.	Persons with developmental disabilities have an IQ of less than 50.	❑	❑
5.	People who have developmental disabilities cannot read.	❑	❑
6.	Known causes account for only 1/4 of cases.	❑	❑
7.	Persons who have developmental disabilities visit parks primarily to learn facts about Canada's nature and history.	❑	❑
8.	Interpreters should find out the comparable school age of the group, and then present using the tone of voice and language appropriate for that age.	❑	❑
9.	It is good to repeat things when presenting to persons who have developmental disabilities.	❑	❑
10.	When booking groups of developmentally disabled persons, it is not necessary to change regular booking procedure.	❑	❑

References

Books:

Andreasen, Nancy C. *The Broken Brain: The Biological Revolution in Psychiatry*. New York: Harper and Row Publishers. 1984.

Bernheim, Kayla F. et al. *The Caring Family: Living with Chronic Mental Illness*. New York: Random House. 1982.

Grossman, H.J. *Classification in Mental Retardation*. Washington, DC: American Association on Mental Deficiency.

Kennedy, Dan et al. *Special Recreation: Opportunities for Persons with Disabilities.* Toronto: Saunders College Publishing. 1987.

Landsdown, Richard. *More Than Sympathy.* New York: Tavistock Publications. 1980.

Seizer, A. et al. *Working with the Person with Schizophrenia.* New York: New York University Press. 1989.

Zigler, Edward et Robert Hodapp. *Understanding Mental Retardation*. New York: Cambridge University Press. 1986.

Articles:

Beechel, Jaque. "Interpretation for Handicapped Persons". *The Journal of Environmental Education*. 6(4), 1975.

"Stigma must be cured first." *Globe and Mail,* 3 Dec. 1993, page C8.

West, Patric C. "Interorganizational Linkage and Outdoor Recreation for Persons with Physical and Mental Disabilities". *Therapeudic Recreation Journal.* 20(1). 1986.

Publications:

Active Living Alliance, and Canadian Department of Fitness and Amateur Sport, "Words with Dignity", 1990.

Brown, Patricia J. "Interpreting for Park Visitors with Learning Impairments". Association for Retarded Citizens of Arizona. 1988.

Canadian Mental Health Association (CMHA), "Frontline Workers' Training", Ottawa-Carleton Branch, 1990.

Department of the Secretary of State of Canada, "A Way With Words: Guidelines and Appropriate Terminology for the Portrayal of Persons with Disabilities", Minister of Supply and Services Canada, 1991.

Handidactis: "Serving Clients with Disabilities: Participants Guide". Handidactis Incorporated, 525 Dominion St., Montreal, Quebec, H3J 2B7.

Statistics Canada, "The Daily: 1991 Health and Activity Limitations Survey", 1991.

Appendix A: Statistics by Province-Mental Health and Developmental Disabilities

Persons with Mental Health and Developmental Disabilities, Age 15-64

	Institutions	Households	Total PMHDD	CDNS: %
Newfoundland	695	8,205	8,900	0.03%
P.E.I.	205	3,435	3,640	0.01%
Nova Scotia	1,670	28,355	30,025	0.11%
New Brunswick	1,090	24,710	25,800	0.10%
Quebec	14,345	156,550	170,895	0.63%
Ontario	14,125	292,975	307,100	1.14%
Manitoba	1,740	26,120	27,860	0.10%
Saskatchewan	1,465	27,745	29,210	0.11%
Alberta	2,915	79,445	82,360	0.31%
B.C.	3,925	94,770	98,695	0.37%
Yukon Territory	10	680	690	0.00%
N.W. Territories	30	1,520	1,550	0.01%
Canada	**42,215**	**744,510**	**786,725**	**2.91%**

PMHDD = **Persons with Mental Health and Developmental Disabilities**
CDNS: % = **Percentage of total Canadian population**

** Taken from the 1991 Health and Activities Limitations Survey, Statistics Canada*

Appendix B: An Article from the Globe and Mail

Stigma must be cured first

Mental illness is so common it really isn't an unseen disability. There's nothing to be ashamed of

AMONG the new attitudes that have developed about people with disabilities in the past few years is our new approach to mental illness. Slowly, but surely, we are realizing that there is nothing wrong with admitting to mental illness, that it is one of the most common and treatable diseases we have.

No one is immune to mental illness. One in three Canadians will experience a mental illness sometime in their lives, one in eight seriously enough to require professional care. (Mental illnesses include a broad range of disorders or illnesses that have psychological or behavioural symptoms and reduce our capability to cope with daily life.)

With so many Canadians having some form of mental illness, it really isn't an unseen disability. To the naked eye, perhaps, it is not recognized in the way a blindness or immobility is, but it is certainly as prevalent.

And yet, mental illnesses have for generations been shrouded in silence.

That, thankfully, may finally be ending.

The Canadian Mental Health Association is launching an anti-stigma campaign aimed at breaking the silence.

"I think people are beginning to talk about their personal demons and difficulties and it's terribly important," said Glenn Thompson, Executive Director of the CMHA's Ontario Division. "It's magnificent. It's about time."

Specific mental illnesses include depression, phobias, anxiety disorders, manic depression and schizophrenia. The two most commonly encountered mental illnesses are depression and anxiety disorders. In many cases, these can be accurately diagnosed and successfully treated.

A great deal of progress is being made. Treatment techniques and facilities have improved tremendously. New medications are helping; research is ongoing and encouraging. And treatment in institutions is giving way to more cost-effective programs based on community facilities and community support.

Increasingly, people with a mental illness are able to get treatment without long periods of hospitalization, which can be an enormous expense to the health system. In Ontario, for instance, about 58 people in 100,000 are accommodated in hospital for mental illness; the government has set a goal of 30 in 100,000 within 10 years.

The major shift, of course, is in preventive medicine. Improved case management and improved crisis management will help keep people with mental illnesses from having to use psychiatric hospitals or even general hospitals as often. Serious mental illness is usually episodic. Recognizing early signs, helping families cope with family members who have a mental illness, keeping mentally ill people employed and in supported housing in the community are ways that mental illness is being attacked.

Another major change has been patient involvement and patient-led programs.

"There is a tremendous involvement by people who are mentally ill in planning and delivering programs," Thompson said. "People are now not being shuffled off to a back corner, they're involved."

Reintegration into society is tremendously important for those people who have been hospitalized with a mental illness. Unfortunately, there is sometimes local opposition to the establishment of group homes in residential neighbourhoods. However, the fears are based on the old prejudices and myths about people who have or have had a mental illness. The fears don't hold water and many former residents of group homes are now living independently, have solid employment and are involved in community work.

The Canadian Mental Health Association offers a checklist to emotional well-being:

☐ Be aware of people and events around you.

☐ Be responsive and adjust when circumstances are beyond your control.

☐ Take initiative to influence your life whenever possible.

☐ Tell a friend. Don't keep anxieties bottled up.

☐ Find the humorous side of a difficult situation.

☐ Set goals and aim for reachable targets.

☐ Help others and you'll feel good about yourself.

Appendix C: Agencies that represent people with Mental Health Disabilities across Canada

The following is a listing of Canadian Mental Health Association contacts across Canada, if a park or site would like more information on mental health disabilities.

Atlantic Provinces

Executive director
CMHA- New Brunswick Division
65, rue Brunswick
Fredericton, N.B.
E3B 1G5

Executive Director
CMHA-Nova Scotia Division
63 King Street
Dartmouth, Nova Scotia
B2Y 2R7

Executive Director
CMHA-Newfoundland Division
St-John's, Nfld.
A1C 1A5

Executive Director
CMHA-Prince Edward Island Division
170 Fitzroy Street
P.O. Box 785
Charlottetown, P.E.I.
C1A 7L9

Quebec

Co-ordinator
ACSM-Québec Division
550 rue Sherbrooke ouest
Suite 310
Montréal, Québec
H3A 1B9

Ontario

Acting Executive Director
CMHA-Ontario Division
56 Wellesley Street West
4th Floor
Toronto, Ontario
M5R 2S3

Prairies and North West Territories

Executive Director
CMHA-Saskatchewan Division
1810 Albert Street
Regina, Saskatchewan
S4P 2S8

Executive Director
CMHA-North West Territories Division
Suite 204
5102 - 50th Avenue
Yellowknife, NWT
X1A 1S7

President
CMHA-Yukon Division
6 Bates Crescent
Whitehorse, Yukon
Y1A 4T8

Executive Director
CMHA-Manitoba Division
2-836 Ellice Avenue
Winnipeg Manitoba
R3G 0C2

Alberta

Executive Director
CMHA-Alberta Division
328 Capital Place 9707-110 St.
Edmonton, Alberta
T5K 2L9

British Columbia and Yukon

Executive Director
CMHA-B.C. Division
405-611 Alexander Street
Vancouver, B.C.
V6A 1E1

Appendix D: Agencies that work with people who have Developmental Disabilities

National

Canadian Association for Community Living
Kinsmen Building
4700 Keele Street
Downsview, Ontario
M3J 1P3.
Tel.: (416) 661-9611

By Region

Atlantic Provinces

Nova Scotia Association for Community Living
83 Portland Street
Dartmouth, Nova Scotia
B2Y 1H5
Tel.: (902) 469-1174
Fax: (902) 461-0196

New Brunswick Association for Community Living
86 York Street, 2nd Floor
Fredericton, New Brunswick
E3B 3N5
Tel.: (506) 458-8866
Fax: (506) 452-9791

Prince Edward Island Association for Community Living
P.O. Box 280
Charlettetown
Prince Edward Island
C1A 7K4
Tel.: (902) 566-4844
Fax: (902) 566-4844

Newfoundland Association for Community Living
P.O. Box 5433 (Harvey Road)
Room 215
Government Service Building
St John's, Newfoundland
A1C 5W4
Tel.: (709) 722-0790
Fax: (709) 722-1325

Québec

Association du Quebec pour l'intégration sociale
3038 Dandurand
Montréal, Québec
H1X 1P7
Tel.: (514) 725-7245
Fax: (514) 725-2796

Ontario

Ontario Association for Community Living
180 Duncan Mill Road
Suite 600
Don Mills, Ontario
M3B 1Z6
Tel.: (416) 447-4348
Fax: (416) 447-8974

Prairies and North West Territories

Association for Community Living-Manitoba
#1 - 90 Market Avenue
Winnipeg, Manitoba
R3B 0P3
Tel.: (204) 947-1118
Fax: (204) 949-1464

Saskatchewan Association for Community Living
3031 Louise Street
Saskatoon, Saskatchewan
S7J 3L1
Tel.: (306) 955-3344
Fax: (306) 373-3070

Yellowknife Association for Community Living
P.O.Box 981
4912 - 53rd Street.
Yellowknife, NWT
X1A 2N7
Tel.: (403) 920-2644
Fax: (403) 920-2348

Alberta

Alberta Association for Community Living
11724 Kingsway Avenue
Edmonton, Alberta
T5G 0X5
Tel.: (403) 451-3055
Fax.: (403) 453-5779

Calgary Association for the Mentally Handicapped
4631 Richardson Way S.W.
Calgary, Alberta
T3E 7B7
Tel.: (403) 240-3111
Fax: (403) 240-3230

British Columbia and Yukon

British Columbia Association for Community Living
#300 - 30 East 6th Avenue
Vancouver, B.C.
V5T 4P4
Tel.: (604) 875-1119
Fax: (604) 875-6744

Yukon Association for Community Living
P.O. Box 4853
409 Black Street
Whitehorse, Yukon
Y1A 4N6
Tel.: (403) 667-4606
Fax: (403) 667-4606