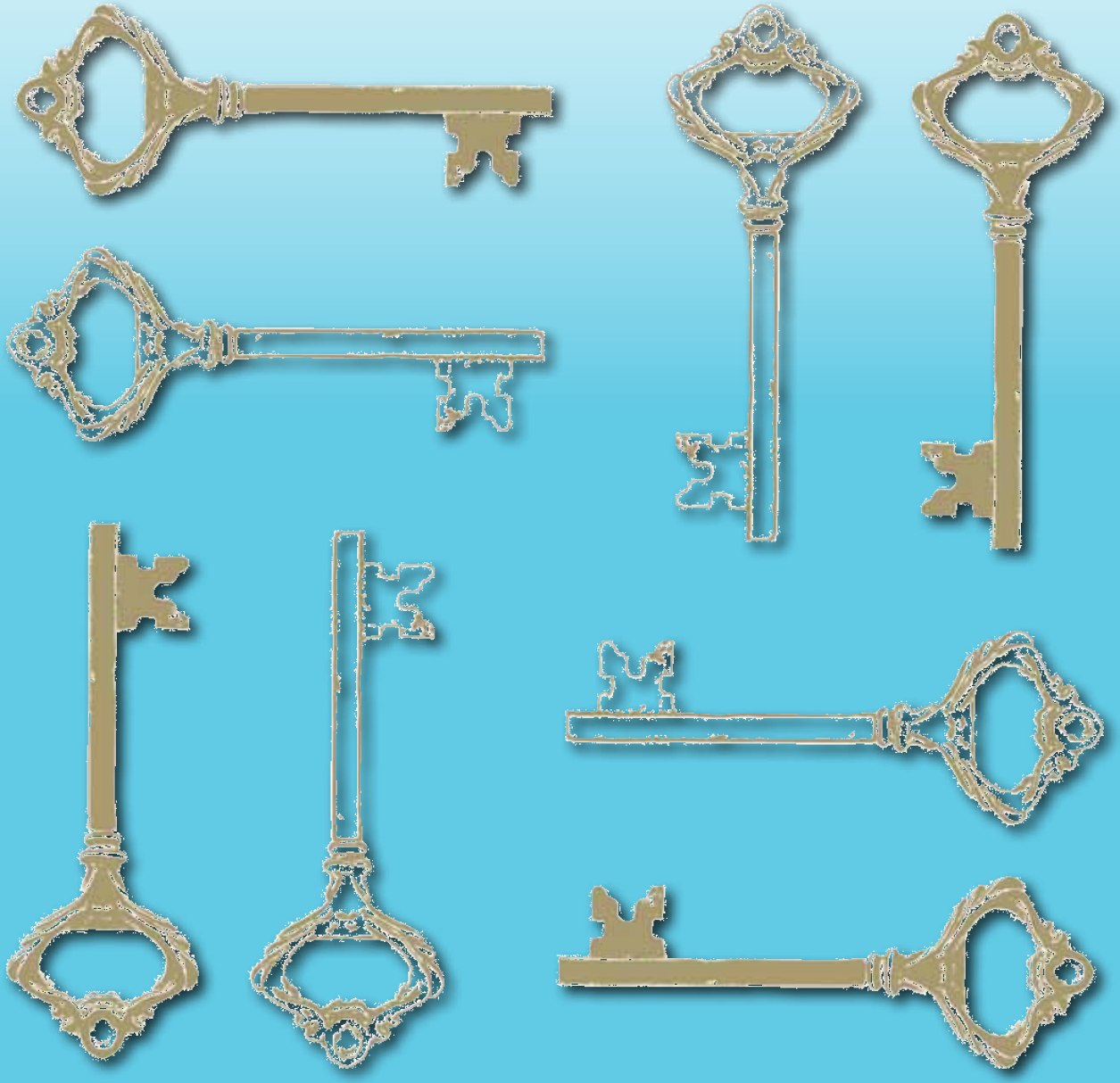
Access to Counseling Services

Required Training Materials
with Post-Test Competency Measures



Reviewed and Revised—January 2013

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1 Rights of the Persons Served

What are State Protection and Advocacy programs?

Each State, as well as the District of Columbia and the five Territories, has a Protection and Advocacy for Individuals with Mental Illness (PAIMI) program. PAIMI programs safeguard the rights of people with mental illness. Where problems are found, PAIMI programs pursue legal, administrative, and other remedies to ensure protection of rights for people with severe mental illness. People with disabilities who are not eligible for PAIMI services may be eligible for other programs within the Protection and Advocacy (P&A) system, such as the Protection and Advocacy for Individual Rights (PAIR) program or the Client Assistance Program (CAP).

What is an advance directive?

If you frequently seek and use mental health services, you may want to establish an advance directive. There are two general types of advance directives: instructional, such as living wills, and proxy, such as durable power of attorney. Each directive is a legal document that lets you describe what services you want to receive if an illness renders you unable to make decisions about your care. Give a copy of the directive to your usual service provider(s) so that it can become part of your medical record. Laws about advance directives vary from State to State. Work with a lawyer, paralegal, or advocate to write your advance directive.

What is informed consent'?

Informed consent refers to when a person agrees to undergo or participate in a medical or surgical procedure, treatment, or study after learning what is involved. Informed consent requires that a person know and fully understand the risks and benefits of a certain treatment or procedure.

Can I refuse treatment?

People generally have the right to consent to or refuse treatment. However, under certain conditions-such as when a person is considered a danger to self or others-he or she may be required to seek or receive treatment. This can include involuntary civil commitment, which can be for either outpatient or inpatient treatment, as well as forced medication. Laws about commitment vary by State. If you have questions about the commitment process in your State, contact your State P&A program or consumer or family organization.

What about managed care rights?

Many organizations have developed bills of rights for people with severe mental illnesses who are treated in a managed care setting. The Center for Mental Health Services (CMHS) has developed principles for managed care treatment. CMHS recommends that providers, managed care firms, and consumers consider these principles in their decision-making process. Most managed care firms have a process for grievances and appeals. Participants may appeal a treatment decision, question payment decisions, or file complaints about providers and facilities.

Do I have a right to privacy?

Mental health providers agree to keep your meetings and what you discuss confidential. This means that what you say—as well as your diagnosis and treatment—can't be disclosed to anyone, including family members, without your written consent.

☎ Resources

The following list is a basic guide to organizations that can help protect your rights. For more information on any of these issues and other aspects of mental illness, call SAMHSA's National Mental Health Information Center (NMHIC).

SAMHSA's National Mental Health Information Center
P.O. Box 42557
Washington, DC 20015
Telephone: 800-789-2647
Fax: 240-747-5470
(TDD): 866-889-2647
E-mail: nmhic-info@samhsa.hhs.gov
http://mentalhealth.samhsa.gov

American Bar Association
Commission on Mental and Physical Disability Law
740 15th Street NW, 9th Floor
Washington, DC 20005
Telephone: 202-662-1570
Fax: 202-662-1032
E-mail: cmpdl@abanet.org
www.abanet.org/disability

American Civil Liberties Union
of the National Capital Area
1400 20th Street NW
Washington, DC 20036
Telephone: 202-457-0800
www.aclu.org

Disability Rights Section
Civil Rights Division
U.S. Department of Justice
950 Pennsylvania Avenue, NW
Washington, D.C. 20530
Telephone: 800-514-0301
Fax: 202-307-1198
(TDD): 800-514-0383
www.usdoj.gov/crt/drssec.htm

Judge Bazelon Center for Mental Health Law
1101 15th Street NW, Suite 1212
Washington, DC 20005-5002
Telephone: 202-467-5730
Fax: 202-223-0409
www.bazelon.org

National Alliance for the Mentally Ill
Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
Telephone: 800-950-6264
Fax: 703-524-9094
www.nami.org

National Disability Rights Network
900 2nd Street NE, Suite 211
Washington, DC 20002
Telephone: 202-408-9514
Fax: 202-408-9520
(TDD): 202-408-9521
http://www.ndrn.org/

National Empowerment Center
599 Canal Street
Lawrence, MA 01840
Telephone: 800-769-3728
Fax: 978-681-6426
www.power2u.org

National Mental Health Association
2001 N. Beauregard Street - 12th Floor
Alexandria, VA 22311
Telephone: 800-969-NMHA (6642)
Fax: 703-684-5968
www.nmha.org

National Mental Health Consumer's Self-Help Clearinghouse
1211 Chestnut Street, Suite 1207
Philadelphia, PA 19107
Telephone: 800-553-4539
Fax: 215-636-6312
E-mail: info@mhselfhelp.org
www.mhselfhelp.org

National Rehabilitation Information Center
4200 Forbes Boulevard, Suite 202
Lanham, MD 20706
Telephone: 800-346-2742 or 301-459-5900
E-mail: naricinfo@heitechservices.com
www.naric.com

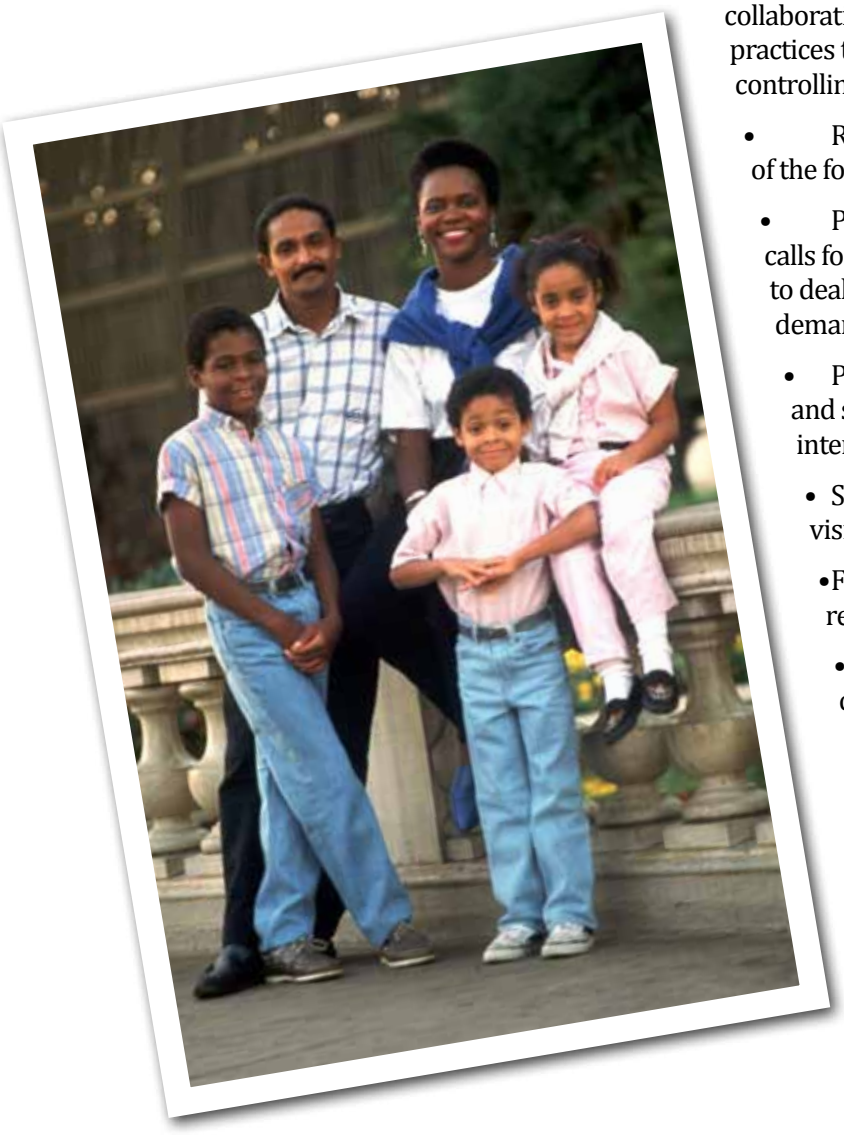
Synopsis of Participant Rights—
People have the right to...

- Be treated with dignity and respect
- Retain all rights, benefits, and privileges guaranteed by law except those lost through due process of law.
- Receive services suited to your condition in a safe, sanitary and humane treatment environment regardless of your race, religion, gender, ethnicity, age, degree of disability, handicapped condition, sexual orientation or legal status.
- Never be neglected or sexually, physically, verbally or otherwise abused.
- Be provided with prompt, competent, appropriate treatment services and an individualized treatment plan.
- Be given the opportunity to participate in your treatment planning, and may consent or refuse to consent to the proposed treatment.
- With your written permission, your family and/or significant others may be involved in your treatment and treatment planning.
- Have your records kept in a confidential manner.
- Refuse to participate in any research project or medical experiment without your informed consent, as defined by law. A refusal to participate in a research experiment will not affect the services available to you.
- Have the right to assert grievances with respect to alleged infringement on your rights.
- Request the opinion of an outside medical or psychiatric consultant, at your own expense, or request a new primary therapist be provided for an internal consultation at no cost.
- Not be retaliated against or subject to any adverse conditions or treatment services solely or partially because of having asserted your rights as stated above.

2 Person and Family-Centered Services

Person Centered Planning and Family Centered Planning are terms that mean the same thing. The term Person Centered Planning (PCP) is used when working with an adult individual who has a mental illness or a developmental disability. The term Family Centered Plan is used when working with a minor child who has a mental illness or developmental disability and his or her family.

- The person/family who is at the focus of the planning, and those who love the people, are the primary authorities on the family's life direction.
- The primary purpose of Person and Family-Centered Planning is to learn through shared action (i.e., the process is more than producing paperwork, it is about taking action to reach goals) and reflection/evaluation of that action.
- Person and Family-Centered Planning aims to change common patterns of community life (e.g., segregation and congregation of people with disabilities, devaluing stereotypes, inappropriately low expectations, denial of opportunity).



- Person and Family-Centered Planning requires collaborative action and fundamentally challenges practices that separate people and perpetuate controlling relationships.
- Respect for the dignity and completeness of the focus person or family.
- Person and Family-Centered Planning calls for sustained search for the effective ways to deal with difficult barriers and conflicting demands.
- Promotes and values individual services and supports, and clarifies individual interests and needs.
- Shaping services to support a person's vision of a valued lifestyle.
- Facilitates change in services to be more responsive to, the interests of people.
- Organize efforts in the community to include person, family, and direct support professionals.
- Focus on quality of life and emphasize dreams, desired outcomes, and meaningful experiences.
- Incorporate into policy and practice the recognition that the family is the constant in a child's life, while the service system and support persons fluctuate.

- Strive for family and professional collaboration in all settings (home, community, hospital, school), especially in the areas of care giving, program development, program implementation, program evaluation, program evolution, and policy formulation.
- Exchange complete and unbiased information between families and professionals in supportive manner at all times.
- Incorporate into policy and practice the recognition and honoring of cultural diversity, strengths, and individuality within and across all families: including, ethnic, racial, spiritual, social, economic, educational, and geographic diversity.
- Recognize and respect different methods of coping.
- Implement comprehensive policies and programs that provide developmental, educational, emotional, environmental, and financial supports which meet the diverse needs of families.
- Encourage family-to-family support and networking.
- Ensure that all service and support systems for children with disabilities and their families are flexible, accessible, and comprehensive in responding to diverse family identified needs.
- Appreciate families as families and children as children, recognizing that they possess a wide range of strengths, concerns, emotions, and aspirations beyond their need for specialized services and supports.

Mobility Disabilities

People who use wheelchairs, people with missing or shortened limbs, people with arthritis, some individuals with head injuries people with seizures, multiple sclerosis or some types of cerebral palsy, are a few of the many examples of physical disabilities or mobility disabilities.

The primary concern with mobility disabilities is access. People with physical or mobility disabilities may fatigue easily, take a longer time completing tasks, may have limited or no hand use or limited or no leg use.

Individuals who have mobility disabilities may need certain accommodations. Considerations and accommodations may include:

- An accessible location may be used by peoplel with physical or mobility disabilities in order to access facilities.
- Accessible parking may be used by people who have physical or mobility disabilities so they do not have as far to travel.
- Alternative phones may be used by people who have physical or mobility disabilities and include speakerphone or phone headset options.
- Assisted listening devices may be used by people who have physical or mobility disabilities in order to concentrate on the instructor's lecture without distraction from background noise.
- Breakout room may need to be reserved at the beginning of the semester by either the office of disability services or by the instructor, depending on the school. Some people may request a breakout room if a scribe or reader is needed for exams, quizzes or in-class assignments.
- Classroom accessibility for people who have physical or mobility disabilities is needed. The building in which the student's classes are held should be wheelchair accessible, as well as the route to the classrooms themselves. Classroom doors need to be wheelchair accessible, a wheelchair accessible desk and/or lab area needs to be set up. Wheelchair restrooms should also be available within the building.
- Computer accessibility options can be altered so that the computer is more physically accessible to some people.

Includes:

- Keyboard modifications
- Mouse for computers
- Document conversion may be used by someone who has a mobility or physical disability in order to gain information from textbooks without physically holding the book.

Types:

- Books on tape
- Book loan information
- Electronic text
- Scribes

Some people who have physical disabilities and cannot hold a book may request a reader for group assignments. A reader would read the book aloud to the individual.

Scan and read may be used by someonewith a physical or mobility disability. A book, worksheet, or handout can be scanned into a computer and then read aloud.

Screen reader capabilities of a computer may be used by someone with a mobility or physical disability in order to hear what is on the screen with less hand movements.

Verbal instructions and written materials such as assignments, due dates, group discussion and blackboard materials may need to be written out for participants with physical or mobility disabilities.

Tape recorder may be used by someone who has a physical or mobility disability for the use of notetaking in class.

Text to speech may be used by people who have physical or mobility disabilities in order to use their computer to read text, graphics or scanned materials on the computer screen with less hand movements.

Voice recognition software may be used by people who have physical or mobility disabilities in order to talk into a microphone, and in turn, what the student stays appears on the computer screen.

Word prediction software may be used by people who have physical or mobility disabilities in order to start typing a word, then selecting their word choice from a drop down menu in order to type with less hand movement.

Resources:

The Oklahoma Assistive Technology Center
University of Oklahoma Health Sciences Center
Department of Rehabilitation Sciences
College of Allied Health
1600 N. Phillips
Oklahoma City, OK 73104
(405) 271-3625; Tdd (405) 271-1705
Fax (405) 271-1707
(800) 700-OATC (6282)
http://www.theoatc.org

Oklahoma Department of Rehabilitation Services
Public Information Office
3535 N.W. 58th Street, Suite 500
Oklahoma City, OK 73112-4824
405-951-3400 Voice and TTY
800-845-8476 Voice and TTY
405-951-3529 Fax
www.okrehab.org

3 Preventing Workplace Violence

No one can predict human behavior and there is no specific profile of a potentially dangerous individual. However, indicators of increased risk of violent behavior are available. These indicators have been identified by the Federal Bureau of Investigation's National Center for the Analysis of Violent Crime, Profiling and Behavioral Assessment Unit in its analysis of past incidents of workplace violence. These are some of the indicators:

Violence in the workplace is a serious safety and health issue. Its most extreme form, homicide, is the fourth-leading cause of fatal occupational injury in the United States. According to the Bureau of Labor Statistics Census of Fatal Occupational Injuries (CFOI), there were 564 workplace homicides in 2005 in the United States, out of a total of 5,702 fatal work injuries.

- Direct or veiled threats of harm;
- Intimidating, belligerent, harassing, bullying, or other inappropriate and aggressive behavior;
- Numerous conflicts with supervisors and other employees;
- Bringing a weapon to the workplace, brandishing a weapon in the workplace, making inappropriate references to guns, or fascination with weapons;
- Statements showing fascination with incidents of workplace violence, statements indicating approval of the use of violence to resolve a problem, or statements indicating identification with perpetrators of workplace homicides;
- Statements indicating desperation (over family, financial, and other personal problems) to the point of contemplating suicide;
- Drug/alcohol abuse; and
- Extreme changes in behaviors.

Each of these behaviors is a clear sign that something is wrong. None should be ignored. By identifying the problem and dealing with it appropriately, managers may be able to prevent violence from happening. Agency planning groups should ensure that the appropriate staff member (or an incident response team) is prepared to assist supervisors and other employees in dealing with such situations. Some behaviors require immediate police or security involvement, others constitute actionable misconduct and require disciplinary action, and others indicate an immediate need for an Employee Assistance Program referral.

On the other hand, it is seldom (if ever) advisable to rely on what are inappropriately referred to as "profiles" or "early warning signs" to predict violent behavior. "Profiles" often suggest that people with certain characteristics, such as "loners" and "men in their forties," are potentially violent. This kind of categorization will not help you to predict violence, and it can lead to unfair and destructive stereotyping of employees.

The same can be said of reliance on "early warning signs" that include descriptions of problem situations such as "in therapy," "has had a death in the family," "suffers from mental illness," or "facing a RIF (reduction in force)." Everyone experiences stress, loss, or illness at some point in life. All but a very few people weather these storms without resorting to violence. Managers should, of course, be trained to deal with the kinds of difficulties mentioned here, such as bereavement or mental illness. However, this training should focus on supporting the employee in the workplace, and not in the context of, or on the potential for, workplace violence.

Your agency may use any or all of the following methods of resolving disputes and addressing grievances:

Facilitation

Facilitation techniques improve the flow of information in a meeting between parties to a dispute. The term "facilitator" is often used interchangeably with the term "mediator," but a facilitator does not typically become as involved in the substantive issues as does a mediator. The facilitator focuses more on the process involved in resolving a matter. Facilitation is most appropriate when the intensity of the parties' emotions about the issues in dispute are low to moderate, the parties or issues are not extremely polarized, or the parties have enough trust in each other that they can work together to develop a mutually acceptable solution.

Mediation

Mediation uses an impartial and neutral third party who has no decision-making authority. The objective of this intervention is to assist the parties to voluntarily reach an acceptable resolution of issues in dispute. Mediation is useful in highly polarized disputes where the parties have either been unable to initiate a productive dialogue, or in cases where the parties have been talking and have reached a seemingly insurmountable impasse.

A mediator, like a facilitator, makes primarily procedural suggestions regarding how parties can reach agreement. Occasionally, a mediator may suggest some substantive options as a means of encouraging the parties to expand the range of possible resolutions under consideration. A mediator often works with the parties individually to explore acceptable resolution options or to develop proposals that might move the parties closer to resolution.

Interest-Based Problem Solving

Interest-Based Problem Solving is a technique that creates effective solutions while improving the relationship between the parties. The process separates the person from the problem, explores all interests to define issues clearly, brainstorms possibilities and opportunities, and uses some mutually agreed upon standard to reach a solution. It is often used in collective bargaining between labor and management in place of traditional, position-based bargaining. However, as a technique, it can be effectively applied in many contexts where two or more parties are seeking to reach agreement.

Peer Review

Peer Review is a problem solving process in which an employee takes a dispute to a panel of fellow employees and managers for a decision. The decision may or may not be binding on the employee and/ or the employer, depending on the conditions of the particular process. If it is not binding on the employee, he or she would be able to seek relief in traditional forums for dispute resolution if dissatisfied with the decision under peer review. The principal objective of the method is to resolve disputes early before they become formal complaints or grievances.

10 Things We Can Do to Contribute to Internal, Interpersonal, and Organizational Peace

1. Spend some time each day quietly reflecting on how we would like to relate to ourselves and others.
2. Remember that all human beings have the same needs.
3. Check our intention to see if we are as interested in others getting their needs met as our own.
4. When asking someone to do something, check first to see if we are making a request or a demand.
5. Instead of saying what we DON'T want someone to do, say what we DO want the person to do.
6. Instead of saying what we want someone to BE, say what action we'd like the person to take that we hope will help the person be that way.
7. Before agreeing or disagreeing with anyone's opinions, try to tune in to what the person is feeling and needing.
8. Instead of saying "No," say what need of ours prevents us from saying "Yes."
9. If we are feeling upset, think about what need of ours is not being met, and what we could do to meet it, instead of thinking about what's wrong with others or ourselves.
10. Instead of praising someone who did something we like, express our gratitude by telling the person what need of ours that action met.

4 Confidentiality Requirements

What is a breach of confidentiality?

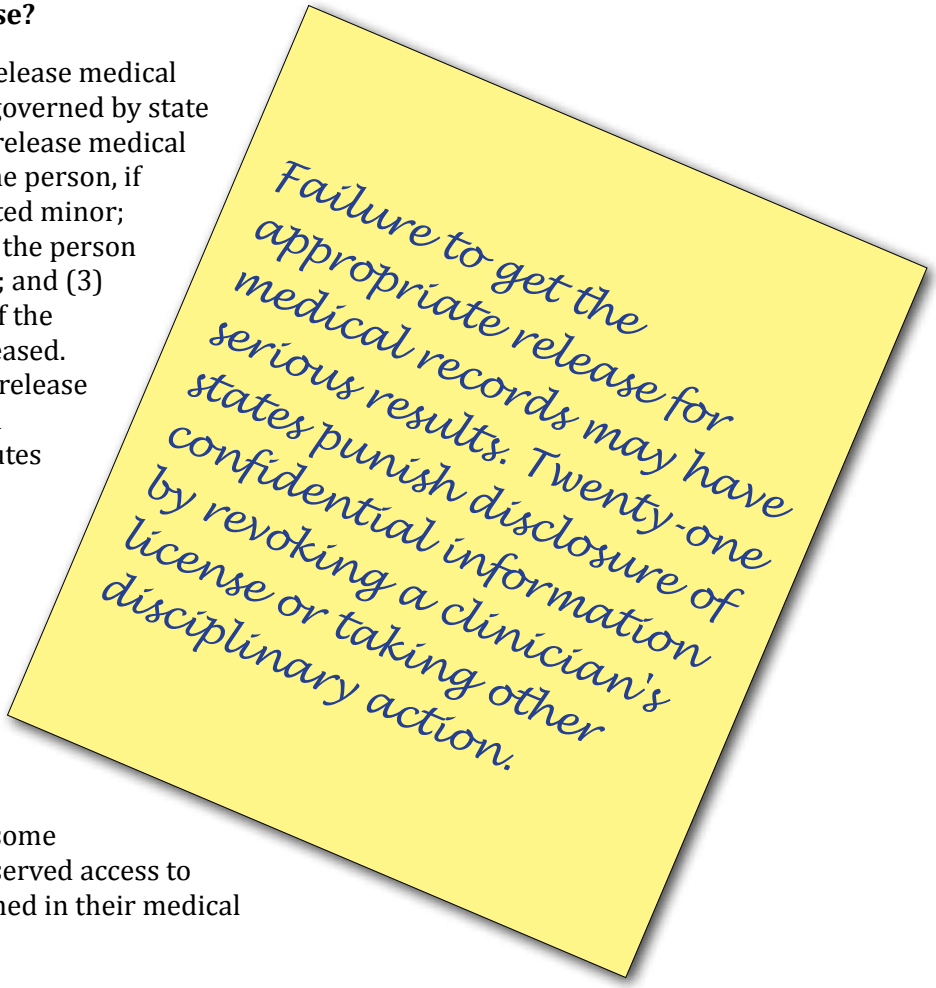
A breach of confidentiality is a disclosure to a third party, without a person's consent or court order, of private information that the employee has learned within the participant-employee relationship. Disclosure can be oral or written, by telephone or fax, or electronically, for example, via e-mail or health information networks. The medium is irrelevant, although special security requirements may apply to the electronic transfer of information.

Consent to release confidential or privileged information

The general rule regarding release of a person's clinical record is that information contained in a person's clinical record may be released to third parties only if the person has consented to such disclosure. The person's express authorization is required before records can be released to the following parties: person's attorney or insurance company; person's employer, unless a worker's compensation claim is involved; member of the person's family, except where the family member has been appointed the participant's attorney under a durable power of attorney for health care; government agencies; and other third parties. HIPAA has created additional person confidentiality considerations. Under the privacy regulations, covered entities may usually release protected health information without authorization only to facilitate treatment, payment or health care operations. Visit the AMA's HIPAA web page for further information.

Who can consent to the release?

Who may grant permission to release medical record information is likewise governed by state law. Generally, the authority to release medical information is granted to: (1) the person, if a competent adult or emancipated minor; (2) a legal guardian or parent if the person is incompetent or a minor child; and (3) the administrator or executor of the person's estate if person is deceased. The person's right to authorize release of medical records is codified in many state statutes. These statutes all state that medical records are confidential and cannot be disclosed, except in specifically provided circumstances. However, the extent of the person's right to access varies from state to state. Some states allow the health care professional or provider to determine person's right of access. In comparison, some states expressly grant persons served access to the medical information contained in their medical records.

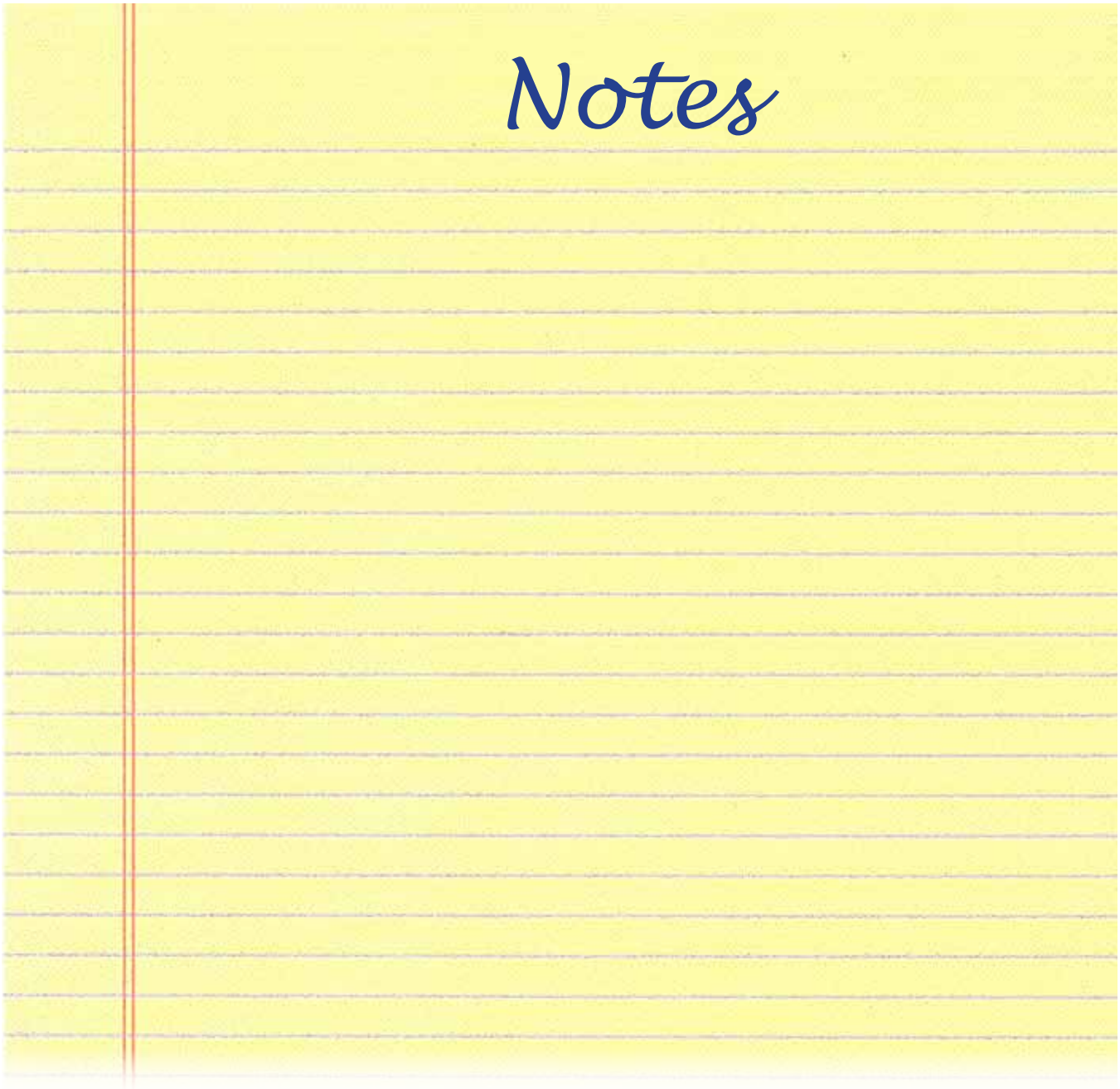


What has to be in the release?

Typical elements of a valid general release include:

- Person's name and identifying information;
- Address of the health care professional or institution directed to release the information;
- Description of the information to be released;
- Identity of the party to be furnished the information;
- Language authorizing release of information;
- Signature of person or authorized individual; and
- Time period for which release remains valid.

Some state laws add other elements, such as specifying on the form the reasons for disclosure or a caveat that the authorization may be revoked.



5 Cultural Competency

Culture: The set of shared attitudes, values, goals, and practices that characterizes an institution, organization or group.

What is cultural competency?

A culturally competent organization recognizes, respects and responds to and celebrates cultural differences, offering full equitable access to services for all people from all cultures.

Cultural competency goes beyond cultural awareness. It denotes an individual's ability to effectively interact with and among others whose values, behaviors and environments are different from your own.

Culture refers to the totality of socially transmitted behavior patterns, arts, values and beliefs, institutions and all other human work and thought. In this context, the term competent means one is capable, qualified, adept and effective in interacting with others.

Culture plays a role not only in communicating and receiving information, but also in shaping the thinking process, behavior and existence of individuals and groups.

A culturally competent organization encompasses all aspects of teaching and learning and recognizes, respects and responds to and celebrates cultural differences. This offers full equitable access to services for all people from all cultures.

Being culturally responsive recognizes the importance of including participants' cultural references in all aspects of treatment.

Age Appropriate Care Through the Life Span

This agency requires that any providers who have participant contact be competent in age appropriate characteristics and needs. This agency requires that all individuals with participant contact receive education and training related to the characteristics and needs of the age groups with which they come into contact. Although the following information may include age groups with for which you do not provide care, it is important to understand an overview of the needs across the life span.

Age Groups: A Definition

Although it is not always clear when one age group ends and another begins, the following is a generalized definition of the age groups.

Infant ..... Birth to one year

Toddler ..... One to three years

Preschool ..... Three to five years

School Age ..... Five to twelve years

Adolescent ..... Twelve to eighteen years

Young Adult ..... Eighteen to forty-four years

Middle Age Adult ..... Forty five to sixty five years

Older Adult ..... Over sixty five

Although all characteristics of an age group do not apply to all individuals, they are meant to be guidelines that should be considered when providing care to people of differing ages.

Developmental Needs

The developmental psychologist Erik Erikson probably most notably writes about developmental needs across the life span. He has identified eight stages with corresponding tasks that must be met and resolved in order for individuals to progress through the life span in a fulfilling manner. Health care providers must consider the developmental challenges facing their persons served and adjust their care accordingly.

by Steve Didham, MSW, and Rick Csiernik, PhD

Erikson's Stages

Age Group	Task	Lack of Resolution Leads to...
• **infant**	development of trust	mistrust and failure to thrive
• **toddler**	autonomy, self-control, will power	shame,doubt, low frustration tolerance
• **preschool**	initiative, confidence, purpose, & direction	guilt & fear of punishment
• **school age**	industry,self-confidence, & competency	inferiority & fears about meeting expectations
• **adolescent**	identify formation, devotion, fidelity sense of self	isolation & poor self-concept
• **young adult**	intimacy, affiliation, & love	isolation & avoidance of relationships
• **middle age**	gererativity, production & concern for others	stagnation & lack of concern for others
• **older adult**	ego integrity, wisdom—views life with satisfaction	despair—life is meaningless

As detailed in the book "Culturally Proficient Instruction: A Guide for People Who Teach," cultural proficiency is a continuum with six steps. They are:

1. Cultural destructiveness:

The elimination of another cultural group or the suppression of the culture's practices.

2. Cultural incapacity:

Treatment of members of nondominant groups based on stereotypes and with the belief that the dominant group is inherently superior.

3. Cultural blindness:

Failure to see or to acknowledge that differences between groups often make a difference to the groups and to the individuals who are members of those groups.

4. Cultural precompetence:

Behaviors or practices that seek to acknowledge cultural differences in healthy ways but that are not quite effective.

5. Cultural competence:

Effective interactions with individuals and groups of people from different ethnic and social cultures; use of the essential elements as the standards for individual behavior and organizational practice.

6. Cultural proficiency:

Practices that reflect knowing how to learn and teach about different groups; having the capacity to teach and to learn about differences in ways that acknowledge and honor all people and the groups they represent.

IF THE WORLD WERE A VILLAGE OF 100 PEOPLE

If this world were shrunk to the size of a village of 100 people, what would it look like?

- 59 would be Asian
- 14 would be American (North, Central and South)
- 14 would be African
- 12 would be European
- 1 would be from the South Pacific
- 50 would be women, 50 would be men
- 30 would be children, 70 would be adults.
- 70 would be nonwhite, 30 would be white
- 90 would be heterosexual, 10 would be homosexual
- 33 would be Christians
- 21 would be Muslim
- 15 would be Hindus
- 6 would be Buddhists
- 5 would be Animists
- 6 would believe in other religions
- 14 would be without any religion or atheist.
- 15 would speak Chinese, Mandarin
- 7 English
- 6 Hindi
- 6 Spanish
- 5 Russian
- 4 Arabic
- 3 Bengali
- 3 Portuguese
- The other would speak Indonesian, Japanese, German, French, or some other language.

In such a village with so many sorts of folks, it would be very important to learn to understand people different from yourself and to accept others as they are. Of the 100 people in this village:

- 20 are undernourished
- 1 is dying of starvation, while 15 are overweight.
- Of the wealth in this village, 6 people own 59% (all of them from the United States), 74 people own 39%, and 20 people share the remaining 2%.
- Of the energy of this village, 20 people consume 80%, and 80 people share the remaining 20%.
- 20 have no clean, safe water to drink.
- 56 have access to sanitation
- 15 adults are illiterate.
- 1 has an university degree.
- 7 have computers.
- In one year, 1 person in the village will die, but in the same year, 2 babies will be born, so that at the year's end the number of villagers will be 101.

- If you do not live in fear of death by bombardment, armed attack, landmines, or of rape or kidnapping by armed groups, then you are more fortunate than 20, who do.

- If you can speak and act according to your faith and your conscience without harassment, imprisonment, torture or death, then you are more fortunate than 48, who can not.

- If you have money in the bank, money in your wallet and spare change somewhere around the house, then you are among the richest 8.

- If you can read this message, that means you are probably lucky!

The statistics were derived from Donella Meadows "State of the Village Report" first published in 1990

The concept of diversity encompasses acceptance and respect.

It means understanding that each individual is unique, and recognizing our individual differences. These can be along the dimensions of race, ethnicity, gender, sexual orientation, socioeconomic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies.

It is the exploration of these differences in a safe, positive, and nurturing environment.

It is about understanding each other and moving beyond simple tolerance to embracing and celebrating the rich dimensions of diversity contained within each individual.

Below is just a small sampling of diversity facts:

Did You Know That ...

- Nearly 11 percent of the white population doesn't have health insurance versus 19.1 percent for Blacks, 30.7 percent for Latinos, 17.6 percent for Asians and 31.7 percent of American Indians and Alaska Natives. (Source: U.S. Census Bureau)

Disability

- Over a 12-year period—from 1995 to 2007—the purchasing power of people with disabilities increased by 26 percent, the equivalent of $45 billion. (Source: U.S. Census Bureau)
- In August 2009, the unemployment rate of people with a disability was 16.9 percent, compared with 9.3 percent for people with no ADA-defined disability. (Source: Department of Labor/Bureau of Labor Statistics)

Latinos

- From 1990 to 2013, Latino purchasing power is projected to grow by 560 percent, while white purchasing power during the same period is only projected to grow by 211 percent. (Source: Selig Center for Economic Growth)
- Between 2005 and 2016, college enrollment for U.S. Latinos is expected to increase by 45 percent, compared with 17 percent for the general population. (Source: U.S. Census Bureau)

Or That ...

Women

- Approximately 2.4 percent of Fortune 500 CEOs are women, up from 0.6 percent in 2000. (Source: Fortune)
- Twenty percent of the highest-paid employees at Fortune 500 companies are women. (Source: Catalyst)

Veterans

- Six million veterans have disabilities, including loss of hearing and hypertension. Source: U.S. Census Bureau)
- Since the Iraq/Afghanistan wars, 9,100 veterans have been diagnosed with traumatic brain injuries (Source: U.S. Pentagon)

And That ...

LGBTs

- About 78 percent of LGBT people and their friends and relatives would switch brands to companies that are known as being LGBT-friendly. (Witeck-Combs/Harris Interactive)
- All of The DiversityInc Top 50 Companies for Diversity have LGBT employee-resource groups versus 30 percent five years ago. (DiversityIncBestPractices.com)

Blacks

- From 1990 to 2007, the nation's Black population increased by 27 percent, compared with 15 percent for the white population and 21 percent for the total population. (Sources: American Community Survey, U.S. Census Bureau)
- In 2007, the Black share of total buying power was 8.4 percent, up from 7.4 percent in 1990. This was expected to rise to 8.7 percent by 2012, which accounts for nine cents out of every dollar spent nationwide. (Source: Selig Center for Economic Growth)

6 Professional Conduct

It is the policy and practice of this company to maintain a respectful work and therapeutic environment. This company will maintain an environment free from discrimination, violence, harassment and offensive behavior. We will not tolerate such behavior by or toward any employee, program participant or officer. Any employee, program participant or officer of this organization who engages in such behavior is subject to consequences.

Discriminatory behavior includes inappropriate remarks about or conduct related to an employee, contractor or participant's race, color, creed, religion, national origin, disability, sex, marital status, age, sexual orientation, or status with regard to public assistance.

Violent behavior includes the use of physical force, harassment, intimidation, or abuse of power or authority when the impact is used to control by causing pain, fear or hurt. Violent behavior also includes verbal abuse and/or acts, words, comments, or conditions that would lead a person to reasonably believe a violent act could occur.

Harassment includes words or conduct that is severe or pervasive, and that a reasonable person would find abusive.

Offensive behavior includes words or conduct that a reasonable person would find reprehensible, although the conduct is neither severe nor pervasive.

Behavior prohibited by this organization also includes requests to engage in illegal, or unethical conduct, or retaliation for making a complaint.

One specific kind of discriminatory and offensive behavior is sexual harassment. Sexual harassment, which can consist of a wide range of unwanted and unwelcome sexually-directed behavior, is defined as unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature when:

1. Submitting to the conduct is made either explicitly or implicitly a term or condition of an individual's employment or of obtaining services
2. Submitting to or rejecting the conduct is used as the basis for an employment decision affecting an individual's employment or the delivery of services
3. Such conduct has the purpose or results of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, or offensive work or service environment

Behavior prohibited by policy can include unwelcome sexual remarks or compliments, sexual jokes, sexual innuendo or propositions, sexually-suggestive facial expressions, kissing, touching, and sexual contact.

Any person who feels he or she is being subjected to discriminatory, violent, or offensive behavior of any kind may feel free to object to the behavior and shall report the behavior to their supervisor or to the Human Resources Director. In the case of violent behavior, the incident needs to be reported immediately after the incident.

Any supervisor who receives a discriminatory, violent or offensive behavior complaint or who has reason to believe that such behavior is occurring shall report these concerns to their Department or Office Director or to the Human Resources Director.

All complaints of discriminatory, violent, or offensive behavior will be investigated promptly, fairly, and completely. The facts shall determine the response to each complaint. Each situation will be handled as discreetly as possible. Resolution of complaints can include, but not necessarily be limited to, an apology, transfer, direction to stop the offensive behavior, counseling or training, verbal or written warning,

suspension with or without pay, or termination. In the event that offensive behavior recurs, it should immediately be reported to the appropriate Department or Office Director or to the Human Resources Director.

Employees should understand that this applies to each and every employee and official of this organization. We will not tolerate retaliation or intimidation directed toward anyone who makes a complaint.

Notes