

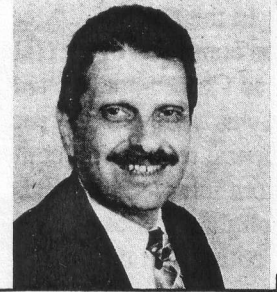
## "LIVING IN NEW KINDS OF SITUATIONS"

A PUBLICATION OF THE NATIONAL ASSOCIATION OF PRIVATE RESIDENTIAL RESOURCES  
(Serving People With Mental Retardation and Other Developmental Disabilities)

### TRAINING FOR TODAY

*It's All In How You Say It*

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#### HISTORICAL INFLUENCES ON TRAINING: THE CUSTODIAL/MEDICAL MODEL

The first article presented in TRAINING FOR TODAY focused on our language, emphasizing the importance of People First Language in training and daily usage. The second (a two-part article) established a philosophy that should serve to guide us as trainers by sensitizing staff to the characteristics or qualities that can cause a residence to become an institution.

This article, and the two to follow, provide trainers a historical perspective on the evolution of training models used over the past 25 years. The first model, the Custodial/Medical Model, will be discussed in this article. The Developmental Model, Habilitation Model and Inclusionary Model will be analyzed in two future articles. These articles set the tone for many of the proceeding articles, and may serve as our foundation for structuring successful TRAINING

#### FOR TODAY.

Let me begin by discussing a comprehensive historical perspective on training for and services delivered to people with mental retardation and developmental disabilities.

Over the past 25 years, we as trainers have seen and experienced several significant changes in the method and means by which habilitation services are delivered to people with mental retardation and developmental disabilities. It would not be an exaggeration to state that these changes in service delivery were of epic proportions.

Over the last quarter century, those changes in service delivery can be identified as four distinct models. These models have arisen out of corresponding changes in our professional philosophy. And be certain that the model for service

delivery that we espouse as trainers TODAY will be followed by an untold number of subsequent and logically evolving models.

In reviewing the models of service in which I practiced and trained staff over the last 25 years, I felt some remorse, if not shame. Apologies are not warranted, however. The methods we used and the living environments we designed in each of the four models were what we thought best at the time, as are the services and the environments in which we deliver services TODAY.

Awareness and non-defensiveness are the key to improve training; an awareness from where TODAY's training has emanated and a clear vision of where it will most likely lead. Let us not apologize for our part in supporting models that we now view as archaic and insensitive-let us move on.

The point to be made is that if we do not know where we were and we do not know where we are, we are likely to end up somewhere we do not wish to be. Given our role as trainers, we will be leading staff in tomorrow's direction; we must be confident that it is the right direction, whatever that may be.

Let us now explore the four models of service delivery briefly alluded to above and discuss their respective impact on staff training TODAY and tomorrow.

### The Custodial/Medical Model:

In the Custodial/Medical Model, the condition of mental retardation was viewed and treated as a disease. It was believed that people with mental retardation could not benefit from intervention, and thus their "plight" was permanent. There was a confusion, if you will, between the cause of the individuals' condition; e.g., damage to brain cells and the resulting behavioral manifestation; i.e., major impairment in adaptive behavior. In that the focus was on the pathology (damage to the brain), which, in fact, had a substantial degree of permanence, it was concluded that the individual's adaptive behavior was correspondingly unalterable.

Services had the pretense of meeting essential needs--food, shelter, and protection from harm. In truth, it was only a pretense. Unfortunately, the years in which the Medical Model existed, most people were not free from harm.

The conditions in which they lived were generally deplorable. The belief sustained by the Custodial/Medical Model, that persons with mental retardation could not grow and develop, became a self-fulfilling prophecy. Thus, we, as trainers, did not prepare the staff to deliver habilitative services.

Under the Custodial/Medical

Model, we used a language reflective of that paradigm. People were labeled as "patients" who were "admitted" to state schools and "hospitals" and placed on "wards." "Therapists" recommended "treatment" carried out by "direct care" staff, documented in "ward charts" and maintained by "medical record technicians." The service was structured "to do for."

People did not benefit or grow more independent under the Custodial/Medical Model. The model ascribed to "admission as treatment rather than admission for treatment." The staff training of that period reflected this Model, training, primarily limited to infection control procedures, responding to seizures and preventing decubitus. The parameters of staff training seldom extended beyond training staff to be caretakers.

It was only after significant legal intervention through the courts that the conditions under which these people lived began to change and improve. Thus, a new model emerged and influenced our staff training--The Developmental Model.