

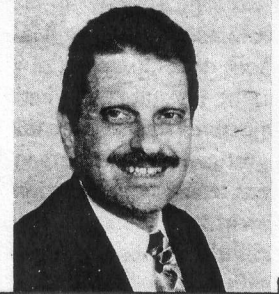
“LIVING IN NEW KINDS OF SITUATIONS”

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TRAINING FOR TODAY

It's All In How You Say It

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HISTORICAL INFLUENCES ON TRAINING: THE DEVELOPMENTAL MODEL

Training programs today are an ever-changing process guided by two major influences. One, to assure staff skills are responsive to the needs of persons receiving services, and two, that the training is reflective of and consistent with current professionally-acceptable standards for services.

As discussed in the preceding article, the evolution of clinical services to individuals with mental retardation has had a direct and significant impact upon the structure and content of staff training TODAY. The transition in services from the Custodial/Medical Model to the Developmental Model served as a harbinger of major changes in staff training.

Developmental Model

The Developmental Model was a refutation of the past, a rejection of the old stereotypes of persons with mental retardation. The Developmental Model had its greatest impact on service delivery in the mid-'60s. Trainers

applying the Developmental Model looked at services for people with mental retardation with the expectation that skills and competencies could be learned.

This expectation for learning and growth resulted in a desire to hold the professionals who designed and delivered the service accountable for that growth. Though not pursued with vigor, there certainly was lip service that special educators, social workers, psychologists, etc., be held accountable. As trainers, we began to focus on the skills professionals needed to fulfill this new obligation.

We focused, then, on measurable outcomes for people with mental retardation. Staff practicing within this Model were guided by the use of “logical structures;” that is, a large number of commercially produced systems were marketed that organized the sequence of developmental growth by developmental domain. These documents were generally referenced as

Developmental Data Documents.

Developmental Data Documents detailed a supposedly logical sequence of growth and development that we, as service providers, attempted to “move people through.”

These Developmental Data Documents differed widely with respect to the developmental domains identified and the order and/or content of skills in each domain. Examples of widely-used documents included the Adaptive Behavioral Scales, the Missouri Minnesota Behavioral Scales, and the Patient Assessment Chart. Each document was structured around a series of developmental domains. Commonly-used domains included a gross motor domain, a cognitive domain, and an affective domain. Each domain delineated those developmental skills and competencies nominatively demonstrated by individuals at various stages of development.

Individuals served were then

evaluated by determining their level of performance in relationship to the developmental sequence; thus, a determination could be made as to where the individual was performing in each respective domain. Identifying what the individual should learn next was merely a matter of moving toward the next developmental skills in the sequence.

For example, if an individual was able to roll over from side to side, as behaviorally stated in the Gross Motor Domain, it "logically" followed that the individual should next be taught to hold his or her head erect without assistance.

Trainers and staff pursued those "next logical steps" in the various domains with a great deal of vigor. Those developmental objectives were taught, unrelated to whether the objectives had any meaning or significance to the person served. Staff were teaching people things (skills) not by virtue of their importance to the individual or how it would improve the quality of the individual's life; but rather, the next developmental step was taught because it followed in a particular developmental sequence.

When so-called plateaus were reached (these plateaus seemed more frequent than not) with a particular developmental objective in a given domain, it frequently resulted in the individual being *fixed* at that point in the domain, not able or allowed to move forward.

The Developmental Model was predicated on the concept of a "readiness model," dictating, for example, that if we wanted someone to ride a bicycle, staff might conclude: "He's not ready yet because he is not able to ambulate." This conclusion was drawn because ambulation, according to the Developmental Data Document, was a prerequisite for riding a bicycle. Thus individuals were precluded from learning new skills that they possibly could learn. This denial was based on a predetermination that they were "not ready" because they had not "demonstrated mastery" of what was supposedly a prerequisite skill.

This model, not unlike the Medical/Custodial Model, was influenced by the design of the organization in which the

services were delivered. The Developmental Data Document lent itself to a departmentalized organizational design (intradisciplinary). In effect, the developmental skills in the gross motor domain were frequently relegated to the Recreational Services Department (activity therapy), whereas the skills to be learned in the cognitive domain were under the aegis of the Special Education Department (education therapy).

As professionals, we eventually recognized that The Developmental Model was not meeting the real needs of those served. The change from this model to the next was likely influenced by the inevitable change of the organizational structures in which services were delivered (or vice versa). As service delivery systems became more interdisciplinary, the demise of The Developmental Model seemed inevitable, though these changes may have been more correlative than casual.

As trainers influenced by this model, we trained staff to carry out the model; that is, we designed our training to instruct staff how to teach the developmental objectives incorporated in each domain. Staff training emphasized the how-to of writing operationally (empirically stated) objectives and the task analyzing of skills to be taught in each domain.

Trainers of staff and the staff delivering services moved away from the Developmental Service Model to what has become known as the Habilitation Model.