

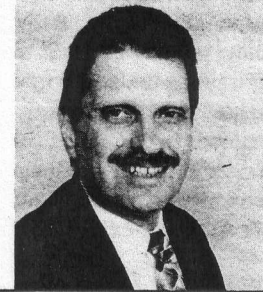
“LIVING IN NEW KINDS OF SITUATIONS”

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

TRAINING FOR TODAY

Inclusion: Beyond Habilitation

By Thomas E. Pomeranz, Ed.D.



Service models to persons with mental retardation and other disabilities have evolved as a result of professional, social and economic considerations. In previous articles, the Custodial/Medical and Developmental models were reviewed. The “Habilitation Model” is based upon teaching competency to the individual. The “Inclusionary Model” focuses on developing meaningful relationships with others, from which independence evolves.

Habilitation Model

The Habilitation Model is a readiness model and begs the question, “What is (are) the major barrier(s) or impediment(s) in a person’s life?” This model, when implemented, was celebrated in the early ’80s. We now realize its shortcomings.

This model, too, can serve to prevent people with disabilities from moving toward a less restrictive alternative or environment, bearing in mind that the less restrictive alternative or environment is not a place, but those conditions within one’s physical environment that restrict one’s freedom of movement and/or opportunities to adapt to the environment.

The Habilitation Model recognizes that there are many things that a person with a disability might not know (not unlike all persons) and many things that the individual is capable of learning. This model, as generally interpreted, does not set out to teach individuals skills because the individual does not possess them, but rather the model is focused to teach those skills which are relevant to that person’s life.

The underlying message is simple -- teach those things that allow people with disabilities to move to a less restrictive environment; by enhancing one’s competence, the individual will more effectively adapt to the environment in which he or she resides or works. It is my opinion that this model has been furthered by the advent of ICF/MR regulations, as interpreted by many service providers and surveyors.

The Habilitation Model necessitates an identification of those adaptive behaviors whose absence impedes the individual’s ability to manage and control his/her environment. The process of habilitation works toward assisting the individual in

gaining competence to achieve greater independence (interdependence).

The Habilitation Model may be exemplified by the person unable to turn the wheels of his or her wheelchair. The inability of that person to be mobile, as demonstrated by a failure to move his wheelchair from place to place, results in a major barrier impeding the individual’s ability to adapt to his environment. Under the Habilitation Model, service providers would likely focus their training effort on teaching the individual those skills required to turn the wheels of his chair.

Not unlike the Developmental Model, the Habilitation Model is based on the concept of readiness. Consequently, entry criteria were established for the varied levels of residential options, and the individual was precluded from moving to the next level until he/she demonstrated the required entry competency. The Habilitation Model seemed to be inextricably intertwined with the concept of a residential continuum. Thus “needs” were identified in individuals which were to be addressed through the habilitation process. If the habilitation process was

not successful, the individual was prevented from moving to the next level in the continuum; i.e., institution to group home, group home to apartment, etc.

The Habilitation Model proclaims, "We will teach you those skills and competencies that we have established as a requirement for you to move into residential options that are less restrictive and more integrative (WE WILL DO TO YOU). However, we cannot allow you to move forward into a more integrative, less restrictive environment until you have learned the required competencies -- you must be ready."

The Habilitation Model is a "Do To" approach to services. That is, we will correct you, fix you, manage you, so you can move on. The Habilitation Model substantially influenced the content of the training provided to staff. Specifically, staff training under this model was heavily weighted toward providing staff with techniques to decrease challenging behavior and instructional procedures to teach toileting, dressing, mobility, and other ADL self-help "type" skills.

We realize now that all three models (Custodial/Medical, Developmental and Habilitation) are lacking. Most importantly, as professionals, many of us never asked the questions, "Why do we want people to grow, develop, and become more independent? How will that independence alter the quality of their lives?"

The early 1980s saw the emergence of community-integrated residential services to provide individuals with greater opportunity for community participation. It is the expectation of this model that habilitation will result from meaningful and appropriate participation in social, work, recreational, and religious activities. It can be said of the "Inclusionary Model" that habilitation is not a goal, it is a result!

Inclusionary Model (The Trilogy)

The Inclusionary Model has three distinct components: community integration; opportunities for the individual's participation; and the formation of meaningful relationships leading to inclusion. How can we, as trainers, support the growth of this model in our organizations TODAY? We have learned that the least restrictive setting for an individual is not determined by the skills or competencies possessed by the individual, but rather by the extent and

nature of support needed by the individual to live and work meaningfully and safely.

It is self-evident that the process of participating in community functions can result in an individual's growth and competence. Habilitation is achieved by extending to individuals the experiences of community participation in a structured, meaningful way.

What makes this model so particularly delightful is that the individual is afforded opportunity to learn in the environment in which the skill should be exercised. The model can best be described as "do with." In that people with mental retardation frequently have difficulty generalizing learned behaviors from one environment to another, this model avoids the pitfalls of generalization. It provides the individual with a wealth of cues and prompts to support the skills or behavior to be learned.

The antithesis of integration is found in institutional practice, where individuals reside in environments that are all-inclusive systems. That is, social, educational, vocational, medical and religious needs are all addressed in the same physical environment with the same individuals participating.

Institutional practice dictates, for example, that a chapel be built on campus so that all those in residence can attend. The process of integration, however, celebrates the fact that people attend the church of their choice in local community settings. They are, in this way, partially integrated into their community.

Physical integration, in and of itself, has limited value. Initially, we, as professional service providers, were excited by the opportunity for people to experience integration. Over time, however, we began to recognize the true intent behind integration. That intent was not going to be realized unless we strongly advocated for the individual to have opportunities for meaningful participation with others in the integrated setting.

Though church attendance may be meaningful for the individual, it is limiting unless the individual has an opportunity to participate, for participation demands and results so much more. The Inclusionary Model requires that we assess what supports may be required to allow the individual to participate in such activities as being in the bell choir, handing out church

bulletins, or collecting the offerings. The essence of the Model is the recognition that any individual, regardless of the extent of his or her disability, is capable of participating in these activities when the appropriate supports are provided.

From a staff training perspective, we must provide our staff with the tools to identify the types of support required by the individual and the skills to provide the supports when and where appropriate. This is a serious challenge in TODAY's training environment where resources are scarce.

Participation, not unlike integration is not the pinnacle of the process, for it is hoped that inclusion will flow from participation.

Inclusion is best defined by the word "relationships." That, my colleagues, is what all this integration is about -- the realization that the quality of one's life is found in the meaning of the relationships he or she has developed.

As in the case of the individual participating in weekly church services, perhaps by being in the bell choir, inclusion is achieved when the woman sitting next to the man in the bell choir calls the home in which he lives, speaks to him or a staff member, and extends an invitation for lunch at her home next Sunday after the church service.

Ah-hah! We've just achieved inclusion! A relationship is formed!

In that whole process, individuals are extended an opportunity to grow, develop and become more independent. It takes training, on our behalf, training that must be extended to our staff, to know how to effectively utilize participative opportunities.

Conclusion: We have now established the entire base for the remainder of our columns -- Philosophy, Policy, and Practice.