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ABSTRACT

This guidebook is designed to help community colleges develop programs to train direct care personnel for new community-based residential facilities for developmentally disabled people. Such programs are expected to be increasingly necessary since high priority has been recently given to implementing new forms of care for the developmentally disabled. The first and second chapters of this publication define the population of developmentally disabled persons and the types of personnel which are currently relied upon to provide service and care to such individuals. The third chapter reviews specific questions which the community college must answer before it implements a program for the training of direct care personnel. The fourth chapter addresses, at a conceptual level, the development of a direct care personnel training program in terms of program objectives, scope and content. The fifth and sixth chapters examine several model programs currently in operation, suggesting that while academic training is important, direct experience is also extremely valuable. The final chapter includes general recommendations relating to development of such programs at the community college level. A bibliography is included. (JDS)

Community Colleges and the Developmentally Disabled

Training Models for Direct Care Personnel

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Foreword

Increasingly public agencies and private groups concerned with care for the nation's developmentally disabled people have emphasized the need for communities to organize themselves to care for those with developmental disabilities. This emphasis has been translated into legislation at the federal and state levels. In 1971, the President pledged his administration to the expansion of support for mental retardation programs within the federal government, and urged all Americans to join in a commitment to the goals of reducing the occurrence of mental retardation, and of returning at least one third of the more than 200,000 developmentally disabled persons then in public institutions to useful lives in the community.

The latter goal carries with it the responsibility for the development of manpower resources for work with developmentally disabled people in various community settings; a limited number of community and junior colleges have begun to play a role in the development of those resources through the creation of training programs for care-personnel. The primary objective of our project was to broaden this involvement. Working in cooperation with the American Association of Community and Junior Colleges, staff at the Center in Mental Retardation, California State University at Los Angeles, conducted a survey and held conferences to determine manpower needs, patterns in manpower development, and existing involvement by community colleges in manpower training in this field. The project completed, it remains our belief that community and junior colleges should be encouraged to develop training programs in this area, and it is to that end that this guideline report was written.

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Contents

This volume is a report from The Community Colleges and the Developmentally Disabled Project, David Bilovsky, Ph.D. and Jane E. Matson, Ed.D. co-directors. The project was funded by the Division of Developmental Disabilities, Office of Human Development, Department of Health, Education, and Welfare, Grant #56-P-71093/9-01. Publication of this report is a joint venture of the Center in Mental Retardation, California State University, Los Angeles, and the American Association of Community and Junior Colleges, Washington, D.C.

Introduction

This is a guidebook designed to help community colleges develop programs to train direct care personnel for new community-based residential facilities for developmentally disabled people. Such programs will be increasingly needed because the society has recently given a high priority to new forms of care for these people and has granted them new legal status.

Both these developments are represented in the provisions of the Developmentally Disabled Assistance and the Bill of Rights Act (P.L. 94-103), a comprehensive act to support and fund programs for the developmentally disabled on a national level. This law defines a developmentally disabled person as

> "a person who has a disability attributed to mental retardation, cerebral palsy, epilepsy, or other neurological handicapping conditions found closely related to mental retardation or to conditions which require treatment similar to that required by mentally retarded individuals."

It has become a stated national policy that whenever and wherever possible those individuals who are developmentally disabled shall be cared for within the community. As a result of such national policies and similar state policies, developmentally disabled individuals are being "de-institutionalized," or moved from large custodial hospitals to smaller community settings. For this process to meet its objectives, however, the numbers of community facilities must now be increased greatly, and their quality raised. A range of alternative placements in varying kinds of community facilities or homes must be available. Carefully planned programs and training must be available for these individuals so that they can cope with the greater freedom and richness of the community environment. None of these requirements can be met unless many more trained direct-care personnel are available.

It is the thesis of this report that community colleges are best equipped to train many of these direct-care workers, and it is the author's hope that community colleges will seriously consider setting up programs to train them. Chapters 1, 2, 3, and 4 of this report will provide information related to the basic question, "Shall we institute such a program?" Chapters 5, 6, and 7 are a guide to structuring the program itself, once a decision in favor of it has been made.

Community Colleges and Those Who Need Care

Community colleges recently celebrated their 75th anniversary; the major portion of their existence has been spent in coping with rapid growth and expansion. It is significant to note that only within the last few years has the term *community* become an integral part of the identity of many of them. The field of community services has focused the attention of the institutions on programs primarily designed to serve needs not being adequately met by other community organizations.

In the spirit of this milieu, this report is presented. It describes an opportunity for community colleges to move still further into a leadership role in community-based, performance-oriented service.

The community colleges are little aware of the developmentally disabled; the developmentally disabled are little aware of the community colleges. The University Affiliated Facilities presently existing in 21 institutions of higher learning was set up in part to develop "interdisciplinary training programs for personnel needed to render specialized services for persons with developmental disabilities" (Public Law 94-103). Although these facilities are authorized to do so, the training of direct-care personnel in the sub-professional level by them is minimal. The individual who is developmentally disabled appears to be served by either a person who has no training or by one who has an advanced degree. There appear to be very few jobs available for those between those two levels.

Edmund J. Gleazer, Jr., president of the American Association of Community and Junior Colleges, refers to a community-based and performance-oriented approach for the community colleges. He states that a college is community-based when its "educational programs are based on a determination of local educational needs, instructional activity is designed to serve those needs, and there is maximum utilization of community resources in the delivery of those programs. Performance-oriented means to be characterized by clear and simple learning objectives which can easily be evaluated and measured as to the degree of attainment or accomplishment."[1]

This report is directed to the person in the community college responsible for the identification of community needs and the design of programs and the implementation of these programs to meet these needs.

Figure 1

Mental Retardation Versus Other Conditions

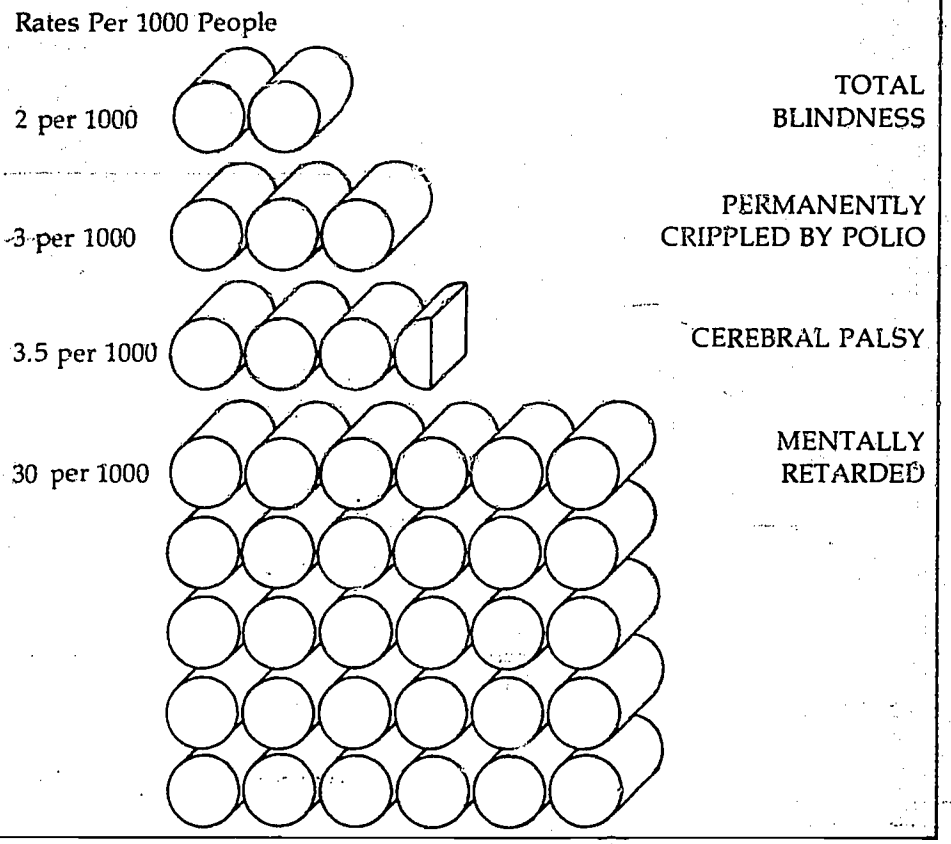
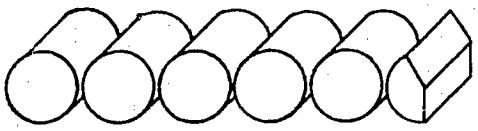
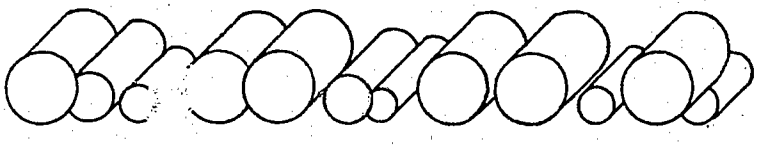


Figure 2

The Developmentally Disabled and their Advocates



5.4 MILLION PEOPLE ARE MENTALLY RETARDED



THEY AND THEIR FAMILIES ADD UP TO 15 TO 20 MILLION PEOPLE OR ABOUT 10% OF THE POPULATION

The Quiet Minority

Until very recently, many developmentally disabled individuals have been sequestered in large institutions or kept quietly at home by families who have not wanted to advertise their involvement with a severely handicapped person. Consequently, the developmentally disabled population has been less visible to the general public than the population, let us say, of blind individuals. Yet the developmentally disabled population is in fact a much larger one, as figure 1 makes clear.

Disagreement on the exact prevalence of retardation is partially a reflection of the various definitions of the upper limits of mental retardation as determined by I.Q. Illustrative of this, 2.3 per cent of the general population taking the Stanford-Binet could be expected to fall below an I.Q. of 70. If an I.Q. of 75 is used as the upper limits for identifying those classified as retarded, the prevalence estimate would be about twice as high! Empirical data reveals that at the lower end of the normal curve, increments greater than what should be statistically expected occur. We believe it is reasonable to use an I.Q. of 69 as the boundary for the purposes of roughly estimating the size of the retarded population; studies on this basis have found a prevalence rate of about 3 per cent. The President's Panel on Mental Retardation,[2] (now the President's Committee on Mental Retardation) has accepted this rate as the most valid as well as consistent estimate. We believe it is safe to say that at some time in their lives, 3 per cent of the population would be in need of specialized services because of their retardation.

The estimate of the number of individuals with cerebral palsy and epilepsy who will require the same type of services as the retarded is more difficult to come by. However, the prevalence figure currently being used for cerebral palsy is 1.5 per 1,000 population, of whom an estimated 75 per cent will require the same type of services as the retarded. For the individual who has epilepsy, a prevalence rate of 2 per cent of the population is used, of whom an estimated 20 per cent require the same type of services as the retarded.

By themselves, then, the developmentally disabled who require significant aid are a large minority group but the group of those closely related to a disabled person is larger yet. Figure 2 gives an impression of the size of this larger minority concerned with the mentally retarded alone. If the other disabling conditions are added, it can fairly be said that one out of every eight or nine persons in the nation has some close family interest in a retarded or otherwise developmentally disabled person.

A large segment of this relatively large minority is becoming increasingly active in humanizing society's view of the developmentally disabled and working to change views of how they should live and the care they should receive. A few years ago society's program for the mentally retarded and other developmentally disabled consisted almost exclusively of institutional placement with the major

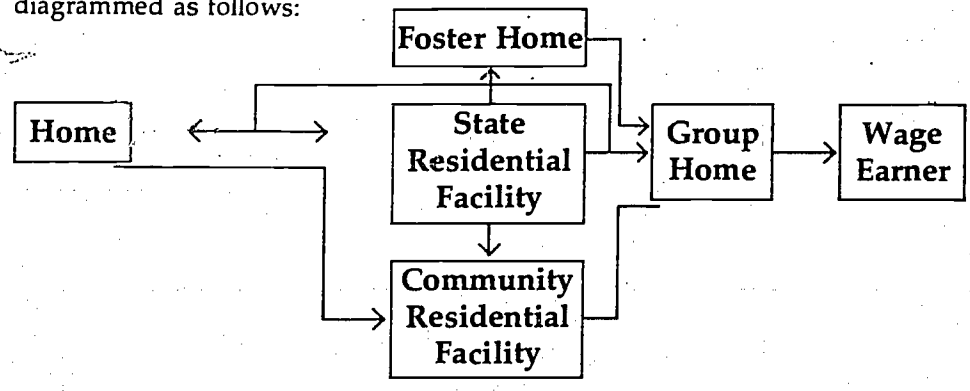
purpose being custodial care. The life-process of the disabled individual could have been diagrammed thusly:

The changing views, those now coming to predominate, are in considerable contrast to that model of only 20 years ago. Some of the values underlying it can be seen in the Declaration of General and Special Rights of the Mentally Retarded, and A Bill of Rights for the Handicapped reproduced herein. Similar bills of rights have been developed by such groups as UNESCO, the Epilepsy Foundation, and the National Society for Autistic Children. It is apparent from these bills of rights that many groups are asking society for certain rights for the developmentally disabled as a matter of equity—rights which are essentially incompatible with isolated institutional care of a custodial nature.

Recent court decisions have begun to give these claimed rights status in the law. The U.S. District Court, Minnesota, (*Welsch v. Likens*) has ruled that the retarded and other developmentally disabled have a right to be placed in "the least restrictive" setting. The Minnesota case stated that there is a constitutional right to care and treatment under the due process clause of the Constitution. Also, there is a constitutional right to the "least restrictive alternative" and thus the state has an affirmative duty to develop and provide appropriate community services.

Organization for Community Care

As a consequence of these developments, a new model for the life and care of the disabled has developed. Although it is still evolving, it can be generally diagrammed as follows:



A number of forces are moving this model toward increased acceptance and actualization. The President's Committee on Mental Retardation has developed guidelines for national action, and has strongly stressed the need for communities to organize themselves to care for the retarded within the community itself. A number of states have legislated or are in the process of legislating new models and standards for care. Legislation on the federal level has translated the work of the President's Committee into regulations which require states to develop community plans for services to disabled individuals and their families.

Public Law 94-103, Section III (excerpted):

Congress makes the following findings respecting the rights of persons with developmental disabilities . . .

(2) The treatment, services, and habilitation for a person with developmental disabilities should be designed to maximize the developmental potential of the person and should be provided in the setting that is least restrictive of the person's personal liberty.

(3) The Federal Government and the States both have an obligation to assure that public funds are not provided to any institutional or other residential program for persons with developmental disabilities that—

(A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons. . . .

Role of the Community Residence

The community-based residential facility is a key part of all of the new models for service to the developmentally disabled. It is housing other than the individual's natural home, yet might be relatively close to it and definitely within a community. The community residence makes available to its residents a home environment and also contact with the mainstream of community services. The staff of the community residence offers and structures experience which stimulate the development of the residents; the very existence of the community residence and program is based on the idea that mental retardation and other developmental disabilities are dynamic conditions permitting growth and are responsive to developmental approaches. (This view is, of course, also manifested in the Bills of Rights previously mentioned). Since retarded and other developmentally disabled people vary in their degree of handicap and other needs (as all people vary), it is clear that there must be a wide range of available community facilities and services. The National Association for Retarded Citizens emphasizes that a community's human service delivery system must be so comprehensive and of such a scope that "no mentally retarded person has to leave his community in search of needed residential or rehabilita-

tive services." The National Association for Retarded Citizens has conceptualized the elements of a comprehensive community service system which would meet this criterion as follows:[3]

Temporary Assistance Services involve a residence which provides temporary and crisis assistance to the retarded. There is an increasing need to relieve parents on a short-term basis. Such homes may also serve as transition care before long-term residential placement may allow for a family vacation, and provide for family crisis or emergency placements for dependent individuals who have no other place to live while more permanent plans are being made.

Life-Start Program Facilities are intended to serve primarily those individuals who are so neurologically or orthopedically handicapped that special medical and developmental programming is essential. They differ from regular comprehensive nursing care programs in that primary emphasis is placed upon developmental programming rather than upon mere maintenance of life services.

The goal of life-start programs will be to habilitate each individual to a sufficient degree to permit placement in more normalized programs. This is achieved through the provision of intensive stimulation and intervention.

Child and Adolescent Development Facilities provide programs for children and adolescents who have developed beyond the needs of life start. The residents living in these facilities will be participating in community, educational and prevocational training programs; daytime programming in such residential settings may be minimal. However, the caretakers in these facilities, as advocates, must be aware of how they plug their residents into the mainstream of existing community service systems. Evening and weekend in-house programs would typically include areas such as:

1. Self-help skills
2. Concept development
3. Social skills
4. Personal hygiene
5. Money management
6. Food preparation
7. Laundry maintenance
8. Planned group activities

These developmental programs are designed to meet the needs of those mentally retarded persons who lack the behavior skills which will permit them to move into relative independent living.

Vocational Development Facilities are for those who are enrolled in a vocational or pre-vocational training program in the community. These facilities are designed to be intensive training settings for those individuals who will be able to live independently or with minimal supervision upon completion of the training program.

The program in vocational development facilities is integrated with the vocational training program. The teaching of skills such as cooking, housekeeping, budgeting, social relations, use of leisure time, etc. as well as experience in group interaction, group activities, etc. is of prime importance in these facilities.

As in child and adolescent facilities emphasis should be placed upon the use of generic, community, recreational and service resources. The emphasis upon family living will be decreased and greater emphasis placed upon group and independent living, teaching the residents to rely more upon their peers and their own decision-making and problem solving ability.

Sheltered Living Homes serve individuals over the age of 18 who require continuing assistance and supervision on a daily basis. These homes are intended primarily for moderately and severely retarded adults whose current stage of development precludes independent living.

The goal of sheltered living is to provide a setting in which these individuals may enjoy a more normalized life in the community as opposed to long-term placement in an institution.

The program in sheltered living homes will focus on the development in self-held and self-care skills in order to increase the social competency of each person.

The Apartment Living Training Facility typically consists of a cluster of three or four apartments for residents and one apartment housing staff teachers. The staff works with each individual or couple on such skills as cooking, meal planning, cleaning, budgeting, relations with the landlord, use of community services resources, and use of recreational resources.

The trainees in this type of program will be taught where to go for emergency help and how to solve many of the more intricate problems associated with independent living.

Apartment living represents the final stage in continuum from dependence to independence and from segregation to integration, provides the mentally retarded individual with the greatest opportunity for self-sufficiency and independence of all the residential service programs.

Independent living represents a goal toward which all training programs are aimed, although it is recognized that some mentally retarded individuals may never be able to achieve this level of independency and self-sufficiency.

Residences for the Elderly . . . The aged mentally retarded citizen frequently develops special needs with advancing age and requires a greater degree of supervision than may have been required in the younger years. For many persons this will mean initially moving from an independent apartment to more structured living arrangements in a sheltered home or a residential nursing home. For others health problems will indicate the need for intermediate or comprehensive nursing care. (Residential Services and Facilities

Committee, *The Right to Choose*, National Association for Retarded Citizens, Arlington, Texas 1973).

The State of Pennsylvania, in defining the scope of residential services needed, has developed a Community Living Arrangements Program which suggests its commitment to deinstitutionalization and the prevention of institutionalization (the Eastern Nebraska Community Office of Mental Retardation has a somewhat similar model.) The Community Living Arrangements Program forms a comprehensive, progressive continuum which makes available to the mentally retarded person an opportunity for an existence as close as possible to the patterns and norms of the mainstream of society, and makes it possible for every mentally retarded person to achieve his or her fullest potential and to become as independent and economically self-sufficient as possible. The Community Living Arrangements Program "strives to make possible not just the re-entry of a retarded person into the societal mainstream as well," according to its developers. Following is an outline of the continuum envisioned in this program.

1. **Developmental Maximation Unit.** This service shall have a strong medical emphasis and operate on the medical model. The primary objective of this unit is to plan developmental programs directed toward moving each individual into a more residentially and educationally oriented setting as quickly as possible.

2. **Infant Nursery.** Program emphasizes nurturent development of infants and young children up to the age of about four, and attempts to equip them with self-help functions such as walking, feeding, some communication, and some toilet training

3. **Intensive Behavior Shaping.** For individuals who are severely and profoundly retarded and/or have very special problems. This service emphasizes shaping and maintenance of basic habits and is most often a temporary one.

4. **Structured Correctional.** This residential service shall be for those persons displaying difficult to manage and consistently anti-social, uncontrolled, or self-destructive behavior.

5. **Child Development.** Serves those in an age range of about four to 18 with the goal of providing family typical inter-relationships between older and younger individuals.

6. **Adult Long-Term Sheltered.** Sheltered living and training for those individuals who are not capable of finding employment in competitive industry and will be retained in a vocational services center or day-activity center for a prolonged period of time.

7. **Adult Short-Term Training/Young Adult Development.** This evaluation and training oriented service is for young adults, age 18 and over, who are involved in an active vocational training program or in some form of employment.

8. **Adult Minimal Supervision.** This residential service could be run by a program-oriented landlord in a rooming or boarding house, or by other personnel making supervision visits to unstaffed apartments or houses.

9. **Family Relief.** This service is intended to assist families in specific crisis and give stress relief by providing non-residential supervision for part of a day or evening.

Standards for Developmental Care

New models for community life and care have been followed by new standards and regulations intended to guarantee a high level of quality and quality control in dispersed facilities. The Accreditation Council for Facilities for the Mentally Retarded of the Joint Commission on Accreditation of Hospitals has compiled Standards for Community Agencies Serving Persons with Mental Retardation and other Developmental Disabilities (hereinafter referred to as the JCAH Standards)[4] and the Developmental Disabilities Act of 1975 has translated some of these into law.

Many states have established similar rules. Minnesota's Department of Public Welfare Rule 34, (Standards for the Operation of Residential Facilities and Services for Persons who are Mentally Retarded) states, for example, that the staff must formulate an individualized program and treatment plan for each resident, that this plan must specify objectives for behavioral and physical development and must include programs of education, self-care skills, economic skills, language development, number and time concepts, domestic occupations, vocational skills, and maladapted behavior and emotional disturbances. It is specified that this is to be done through developmentally oriented day activity, educational, recreational, religious, sheltered workshop, social work, vocational training and health services.

Pennsylvania's standards are contained in Regulation 9600, "Community Living Arrangements for the Mentally Retarded;" among other things, this Regulation states that individual community facilities shall develop structured training . . .

which will vary with each residence in accordance with its specific purpose as determined by the type of persons it serves. In all residences, children and adults, there shall be emphasis on richness and variety of experiences, especially those that involve community contact and contact with non-retarded persons. These residences shall serve not only as houses that provide accommodations for sleeping and eating; but as homes where the residents receive emotional support, training in everyday living activities, engage in some recreation, and learn how to use community facilities . . . residences shall serve as a basis from which to go forth for community interaction, in schools, in churches, in recreation facilities, in medical facilities, etc. Weekly plans should be developed to ensure that residents will develop life styles and needs consistent with those of citizens in the community.[5]

Massachusetts, in standards developed by the Department of Mental Health, places a very strong emphasis on the development of an Individual Service Plan in the state's community residences for the retarded. The Department defines the Individual Service Plan (ISP) as a written plan "of intervention and action that developed and modified at quarterly intervals and which specifies individual goals and objectives and identifies a continuum of developmental services." An ISP must be developed for each person receiving residential services, and must include programs in the areas of sensory motor development, social development and cognitive development.

Since such standards conform with general national policy, it can be expected that many other states will soon follow suit with very detailed descriptions of and standards for developmental programs for the severely handicapped, primarily oriented to the context of dispersed community residence and service facilities.

Summary

The developmentally disabled have, until recently, been a nearly invisible minority in the population and have been viewed as needing primarily custodial care institutions. At present a full-scale revolution in beliefs and values related to the developmentally disabled is underway. The disabled are seen as capable of growth and as being entitled to the fullest possible life, in maximum feasible contact with the mainstream of society. A change in life and care models has ensued and a body of laws and standards defining and regulating such models is in the process of evolution. A key to all new models is small community residential facilities, which are a setting for needed care given without isolating the developmentally disabled individual from the surrounding mainstream society. Professionals, parents, and the courts all are demanding this new model of care, and consequently it is to be expected that a large proportion of those 250,000 individuals now residing in large state-operated institutions will eventually join the almost equal number now already moved to or living in community-scale facilities.

[1]Gleazer, Edmund J. Jr. *New Programs for New People*, paper presented at the First Community College President's Forum, Educational Testing Service. Princeton, New Jersey. July 27, 1976.

[2]President's Panel on Mental Retardation, *A Proposed Program for National Action to Combat Mental Retardation*. The Presidents Panel on Mental Retardation, Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. October, 1962.

[3]Residential Services and Facilities Committee, *The Right to Choose: Achieving Residential Alternatives in the Community*. (The Association, Arlington, Texas, 1973).

[4]Accreditation Council for Facilities for the Mentally Retarded. *Standards for Residential Facilities for the Mentally Retarded*. Joint Commission on Accreditation of Hospitals, Chicago, Illinois, 1973. (645 North Michigan Ave. Chicago, Illinois, 60611).

[5] Bureau of Community Residential Programs, Office of Mental Retardation, Department of Public Welfare, Commonwealth of Pennsylvania, *9600 Series Regulations—Community Living Arrangements for the Mentally Retarded*. (Harrisburg, Pa., various dates.)

Declaration of general and special rights of the mentally retarded

Declaration of general and special rights of the mentally retarded

Whereas the universal declaration of human rights, adopted by the United Nations, proclaims that all of the human family, without distinction of any kind, have equal and inalienable rights of human dignity and freedom;

Whereas the declaration of the rights of the child, adopted by the United Nations, proclaims the rights of the physically, mentally or socially handicapped child to special treatment, education and care required by his particular condition.

Now Therefore

The International League of Societies for the Mentally Handicapped expresses the general and special rights of the mentally retarded as follows:

ARTICLE I
The mentally retarded person has the same basic rights as other citizens of the same country and same age.

ARTICLE II
The mentally retarded person has a right to proper medical care and physical restoration and to such education, training, habilitation and guidance as will enable him to develop his ability and potential to the fullest possible extent, no matter how severe his degree of disability. No mentally handicapped person should be deprived of such services by reason of the costs involved.

ARTICLE III
The mentally retarded person has a right to economic security and to a decent standard of living. He has a right to productive work or to other meaningful occupation.

ARTICLE IV
The mentally retarded person has a right to live with his own family or with fosterparents; to participate in all aspects of community life, and to be provided with appropriate leisure time activities. If care in an institution becomes necessary it should be in surroundings and under circumstances as close to normal living as possible.

ARTICLE V
The mentally retarded person has a right to a qualified guardian when this is required to protect his personal wellbeing and interest. No person rendering direct services to the mentally retarded should also serve as his guardian.

ARTICLE VI
The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If accused, he has a right to a fair trial with full recognition being given to his degree of responsibility.

ARTICLE VII
Some mentally retarded persons may be unable, due to the severity of their handicap, to exercise for themselves all of their rights in a meaningful way. For others, modification of some or all of these rights is appropriate. The procedure used for modification or denial of rights must contain proper legal safeguards against every form of abuse, must be based on an evaluation of the social capability of the mentally retarded person by qualified experts and must be subject to periodic reviews and to the right of appeal to higher authorities.

ABOVE ALL
THE MENTALLY RETARDED PERSON
HAS THE RIGHT TO RESPECT

A Bill of Rights for the Handicapped

"A Bill of Rights for the Handicapped" was presented at the United Cerebral Palsy Association's Annual Conference in Washington, D.C. on May 3, 1973. Hundreds of delegates representing the 300 United Cerebral Palsy affiliates throughout the country signed the Bill indicating their support and commitment to furthering these basic rights. The Bill was approved by the membership on May 4, 1973.

United Cerebral Palsy Associations, Inc.
66 East 34th Street • New York, N.Y. 10016

A Bill of Rights for the Handicapped

PREAMBLE

We hold these Truths to be self-evident that all Men are created equal, that they are endowed by their Creator with certain unalienable Rights, and that among these are Life, Liberty and the Pursuit of Happiness.

The rights of the individual begin with the inherent right to be born with the capacity to grow and develop fully and to have the birthright insured by services which protect the embryonic environment and the entry of the individual into the world.

Those who are denied this birthright or who are handicapped by other causes have the right to be assured the means of achieving maximum growth and development and to enjoy the dignity, respect and opportunities accorded all men by the freedoms and privileges enumerated in the Constitution of the United States.

For the handicapped who cannot obtain the rights of first-class citizenship for themselves, society must provide, preserve and protect the means whereby these rights are assured from earliest infancy throughout life. These means form a particular "Bill of Rights for the Handicapped."

The handicapped individual has the right to:

I PREVENTION OF DISABILITY insofar as possible through early detection of abnormalities in infancy, immediate and continuing family guidance, and comprehensive habilitative services until maximum potential is achieved.

II HEALTH SERVICES AND MEDICAL CARE for the protection of his general well-being and such additional special services as are required because of his handicap.

III EDUCATION to the fullest extent to which he is intellectually capable, provided through the regular channels of American education.

IV TRAINING for vocational and avocational pursuits as dictated by his talents and capabilities.

V WORK at any occupation for which he has the qualifications and preparation.

VI AN INCOME sufficient to maintain a lifestyle comparable to his non-handicapped peers.

VII LIVE HOW AND WHERE HE CHOOSES and to enjoy residential accommodations which meet his needs if he cannot function in conventional housing.

VIII BARRIER FREE PUBLIC FACILITIES which include buildings, mass or subsidized alternative transportation services and social, recreational and entertainment facilities.

IX FUNCTION INDEPENDENTLY in any way in which he is able to act on his own and to obtain the assistance he may need to assure mobility, communication and daily living activities.

X PETITION social institutions and the courts to gain such opportunities as may be enjoyed by others but denied the handicapped because of oversight, public apathy or discrimination.

UNITED CEREBRAL PALSY ASSOCIATIONS, INC.

The Direct-Care Staff

A Primary Need

The key to the new form of aid to the developmentally disabled just discussed is the direct-care staff, for the development of residents in any facility is more dependent upon this staff than upon any other factor. This staff group is "the interpreter of and agent for the intentions of society and wields a truly amazing amount of power and control over the mentally retarded individual" (Wolfensberger). It is this staff which has the primary responsibility of one-to-one contact, as distinguished from responsibility for planning, staff coordination, and keeping house management records. The importance of direct-care personnel is emphasized in a study by Thormalen[1] of a California institution. He found that not only did direct-care aides fail to train children in the area of self-sufficiency (their assigned task) but actually succeeded in retarding the children's development by making them more dependent.

In a fully developmental model of assistance to the handicapped, of course, the role of the direct-care staff is even more critical, because what takes place in interaction between this staff and the retarded resident is vastly more complicated than the interaction in a purely custodial model of care. Basic needs are still met but they are merely the beginning in the developmental model. We have reviewed some of the different specifications in state plans for the processes expected to occur in a developmental program, and the wide range of interactions required of a direct-care worker in such a program can easily be inferred. While a direct-care worker may not be responsible for the basic formulation of objectives and a multitude of prescribed activities for an individual (as mandated in the Massachusetts ISP model, for instance), he or she will still be devoting more time than any other worker to carrying them out with a given individual. Massachusetts recognizes that the success or failure of any community residence is dependent upon its personnel, and has established the

following standards to be met by any person seeking a position in a community residence program:

1. Demonstrated ability to provide emotional support and training in the daily living activities required by the mentally retarded individual.
2. A demonstrated ability to work with people.
3. Awareness and understanding of the individual needs of the mentally retarded.
4. Respect for the dignity of the mentally retarded individual and a belief in his or her capacity for self-determination and growth.
5. Willingness to adhere to and protect human rights of the mentally retarded as set forth in the Declaration of Human and Individual Rights.
6. An understanding of "Normalization" and the willingness to adhere to and to apply the principles as set forth by this philosophy."

The courts have begun to go even further. Soon there may be a widespread legal requirement for personnel who not only have the admirable human qualities and beliefs required by Massachusetts but training in addition. The case of *Wyatt v. Hardin*, brought before the Federal District Court in Alabama by private citizens, legal rights groups, and the United States Department of Justice established the principle that every individual has a right to treatment which must include an individualized treatment program, a humane physical and psychological environment and an adequate and qualified staff and programs, all provided in the least restrictive manner possible. Other cases involving the same principle have been filed in at least 17 other states and are at this time in various phases of adjudication. The principle was upheld in a recent unanimous Supreme Court decision (*O'Connor v. Donaldson*).

Finally, in setting standards for the accreditation of community residential facilities, the Accreditation Council has stated that it is its

> "continued belief that the most basic requirement for accreditation of a residential facility for the mentally retarded is the preservation of an active habilitation program . . . to receive accreditation, a facility must provide habilitation programming for all residents within a normalized environment that respects their rights and dignity. . . .
>
> The fundamental requirements for active programming include an interdisciplinary team process for identifying the specific needs of the resident. . . .
>
> The interdisciplinary team process *must include the participation of the direct-care staff persons who must be responsible for the resident's day-to-day care and program, and not just their supervisors.* At any given time the team must include all those persons whose participation is relevant to meeting the needs of the resident, so that the decisions result in a totally integrated habilitation program plan for the resident, rather than in fragmented isolated or independent efforts.
>
> The essential requirements for a normalized environment include a physical environment that is as home-like as possible, and in which residents can be divided into small groups, for which *specific direct-care staff are responsible*, so that there can be individualized attention to the developmental needs of residents, rather than merely large-group or mass care routines."

Lack of Training

However, personnel skills of the level mandated in state program descriptions and standards gradually being set by the courts are presently not equalled by practice in the average community. It has been estimated that fully 90 per cent of all care given to the retarded and other developmentally disabled is given by those who have no training or certification to perform the types of tasks called for in the state plans. The very personnel who now carry the day-to-day responsibility for face-to-face care and training of the retarded are receiving the least amount of pay and are not even on the bottom rung of a career ladder leading to higher competence, pay, or responsibility. Tender loving care is an important asset in their work, but meeting the *developmental* needs of mentally retarded and other severely disabled people calls for the possession of a body of knowledge and skill. Recognizing the discrepancy between what is now demanded of many direct-care workers and their ability to meet those demands, many states have developed in-service training programs. A few of them (the program created by the Extension Division of the University of North Carolina is a case in point) are well thought out and comprehensive. In-service programs do not provide the *ultimate* answer to the problem of generating skilled manpower. Klaber (In: Sarason, S.B. and Dori S.J. Chapter 9, *Psychological Problems in Mental Deficiency*, 4th ed. Harper & Row, 1959) has examined such programs and concludes that they can go only a limited way in modifying existing behavior.[2]

A New Occupation—New Forms of Training

Many people are presently able and ready to provide traditional custodial care to individuals who are mentally retarded or have allied disabilities. An unskilled, untrained couple may establish a relatively humane residential care facility which essentially provides custodial care, and this facility may still be licensed by the state and receive clients. The need for even basically humane care is still extreme in many areas. But there is a constant turnover of such unskilled personnel and facilities. As standards for service quality continue to rise, and parents continue to demand more adequate forms of treatment, this group of workers will be in less and less demand; people trained and equipped to meet society's more extensive demands for higher qualities of care will be in increasing demand. A manpower shortage of trained workers can be expected to be both considerable and widely recognized by the early 1980's—just about the time that community college programs planned to meet the demand to begin to produce graduates.

During this period, another process can also be expected to occur, the establishment of direct-care service as a discreet occupation to those who are develop-

mentally disabled. Presently, where it can be determined that certain services are mandated by society, occupations are being created and given definition by a planned training and licensing process. This has occurred with the occupation of vocational nurse, for example. The Office of Child Development of the Department of Health, Education, and Welfare is currently setting up training and credential requirements for personnel to work with young children—the occupational title will be that of child development associate. Psychiatric technicians have a role originally planned and defined in much the same way, and the occupation of paralegal associate is emerging along similar lines. Such intentionally created occupational roles are promising tools for meeting social needs; particularly when they are planned and defined cooperatively by training institutions, professional groups and other agencies involved in the specific need area. We see the beginnings of that process presently in the area of developmental disabilities; the indications are that training programs are already being instituted in some educational institutions (see Chapter 7) and there is a move toward the credentialing and licensing of direct-care personnel. Some states now mandate licensing or certification for supervisory personnel, but few have at this point completed and put into full operation such structures for direct-care personnel. Further indications that definite occupational roles and titles will be increasingly recognized in this field are that conferences on care for the substantially handicapped reiterate the need, year after year, and more and more State Directors of Developmental Disabilities express a strong interest in working with community colleges and other institutions to create manpower training programs. Manpower concerns in the field were summarized at a joint conference sponsored by the National Institute of Child Health and Human Development,[3] The President's Committee on Mental Retardation and the Canadian Association for the Mentally Retarded, in 1969—although this was eight years ago, the summary remains pertinent:

1. The shortage of qualified staff requires a more careful assessment of the functions and competencies specifically required for effective work with the retarded.
2. The institutions of higher education, such as community colleges and universities, should play a far more active role in the development of career training programs for workers in the developmental handicap areas.
3. The present approach to the service and manpower needs of the retarded makes it very difficult to increase the quality and quantity of trained personnel in this field.
4. The large residential institutions are no longer functional and extensive staff retraining is a requisite if more functional and relevant educational programs are to be developed.
5. Public and private funds should be utilized to create more productive and humane methods of community-based treatment for the retarded.
6. Most of the retarded (about 85 per cent of the institutionalized retarded) do not require medical treatment, but rather education and social training to insure the maximum development of their learning potential.
7. An effective rehabilitation program for the retarded requires the presence of a highly skilled educationally oriented basic-care staff.

A Turning Point

We believe there is a strong probability that by 1980 there will be a firmly established legal mandate, strong parent demand, and official sanction and recognition from governmental agencies responsible for the licensing of care facilities, for the "highly skilled educationally oriented basic-care staff" deemed critical by the Banff conference and by professionals in the developmental disabilities field. The community college can play an important role in this development because it is one which will be best achieved by several simultaneous and mutually supporting efforts, and one of these efforts can only be made by educators and educational institutions. National and state governmental agencies will not act in a vacuum to give the new occupation recognized status; they *will* act if they see educational institutions making concrete plans for training programs. The new occupation will have nationwide standing, will become part of a career ladder, and trainees will have transferable skills if educational institutions and other groups can coordinate their plans to a common model or pattern (and there appears to be little reason that this cannot be done). The entire effort will receive added impetus if educational institutions coordinate their plans with those local and national parent-groups and other interest groups in the developmental disabilities area who will be creating the demand for trained workers.

In short, we are asking community colleges not to respond to an already established manpower demand, but to help create one by working in alliance with other interested groups to bring about an extremely needed shift in manpower resources for the developmentally disabled. We will explore additional aspects of such a decision in the following chapter.

Summary

Sophisticated models have recently been evolved for humane and growth-oriented services to the developmentally disabled, primarily involving de-institutionalization and contact with a direct-care staff operating within an educational and developmental framework. In many cases standards and guidelines for "good services" and for adequately skilled personnel have been created. But we have not, as yet, solidified a demand and developed systems for training that essential direct-care staff. Presently the community relies upon untrained people most of whom are still only equipped to deliver custodial care, but this is becoming an increasingly intolerable state of affairs and is under increasing pressure for change.

A number of mutually supporting developments will bring about the desired change. Educational institutions will play an essential role, interacting with national and state agencies concerned with care for the developmentally disabled, with interest groups, and with credentialing and standard-setting authorities to create and define a new needed occupation.

[1]Thormalen, Paul, "A Study of on-the-ward Training of Trainable Mentally Retarded Children in a State Institution," *California Mental Health Research Monograph #4.* California State Department of Health, (Sacramento, California, 1965.)

[2]Klaber, M. Michael (Chapter IX). In, Sarason, S. B. and Doris J., *Psychological Problems in Mental Deficiency, 4th ed.* Harper and Row, New York, 1969.

[3]Cohen, Julius S., ed., *Manpower and Mental Retardation, an Exploration of the Issues; Proceedings of the Banff International Conference.* President's Committee on Mental Retardation, Washington, D.C., 1969. (Washington, D.C. 20201)

A College Decision

Across the United States there are more than 1200 community-based two-year colleges which constitute potential resources for improving service to the developmentally disabled. Whether this potential should be actualized in the case of a particular community college is a decision involving a number of factors. Whereas preceeding chapters have outlined the general need for trained personnel and the belief that some community colleges should respond, this chapter treats some of the specific questions a junior or community college should deal with before making a commitment to a specific program.

Responsibilities to the Community

The community college can be said to have some responsibility to seriously consider the possibility of instituting training and related programs. The development of community colleges has been based on the premise that they are responsive community agencies willing and ready to provide services to all citizens, limited only by resources available. Community colleges have already assumed the societal task of preparing professionals and technicians in a variety of fields, and the number and variety of curricula related to manpower training are steadily increasing. Frequently, community colleges primarily receive local financial support, maintain the lowest possible costs and the most open access policies feasible, and in general strive for maximum accessibility.

In a recent article in the Community and Junior College Journal (December-January 1974), Edmund J. Gleazer, Jr. urges that this function be extended. Traditionally, he suggests, community colleges have played an essentially passive role, waiting for community demand for post-secondary education and

then responding to that demand. Some businesses, Gleazer suggests, take a more active position. They create value-satisfying goods and services, researching a need or potential market, operating from a consumer-oriented, not a product-oriented viewpoint. What would happen, Gleazer asks, if the community colleges were to operate more in this manner? Were colleges to actively seek out needs in their communities, they might well find new opportunities for service.[1]

It would certainly appear that an increased effort by a college to improve service to the developmentally disabled in a community or region would fall squarely within the bounds of Gleazer's proposal. The developmentally disabled are a significant part of the community, and their needs are considerable even though they may be a quieter minority than some others. The family of a developmentally disabled person in a college district is paying its share of the college's support, yet the disabled family member usually cannot make use of the college's regular program in the standard way. One of the most pressing needs of these families is for skilled care and aid to the disabled family member; if a college actively pursues a program which conceivably will meet these families' needs, it is likely to gain intense and long-term support from them.

Responsibility Toward the Students

Interwoven with its responsibility to the general community is, of course, the college's obligation to its students, who may or may not remain members of that community. A college cannot assume that its community's needs are mirrored exactly in the general society in which the graduates must find employment; the community the college services directly may have a greater or lesser demand for a particular occupation than the state and region surrounding the college. Clearly defined occupational education, as opposed to general liberal arts or science education, should and must have occupational outlets, and each community college considering any occupational program must address itself to such questions as these proposed by Donald T. Rippey, former president of El Centro College in Dallas, Texas:[2]

1. Approximately how many persons trained in the proposed program will be employed annually?
2. What training experiences and opportunities are already available?
3. What is the pay differential between trained and untrained people in this occupational area now, and what will it be?
4. What are projected employment needs for the next 1-5 years?
5. And, lastly, how much assistance can the community college expect from business and industry.

In the case of training for direct-care work with the developmentally disabled, as we have seen, such questions may not have as definite answers in the

short run as they would if applied to a proposed program in electronics technology, but sources in the developmental disability community and local social agencies will be able to provide some perspective.

Building a Decision Cooperatively

A cursory analysis of occupational needs based on Dr. Rippey's questions may not, as suggested in the earlier chapters, yield a very bright picture of the short-run opportunities for graduates trained to give high-level care to developmentally disabled persons. This is not to say, however, that the need outlined in the first three chapters is not significant, or that the prospects do not look better for the future. It has been argued that they do. More important is that the investigation continue beyond cursory answers to those questions, and beyond the first investigative stages, even though they may not have yielded encouraging results.

This is because care for, training of, and interest in developmentally disabled people involves a complex network of interested groups. The public service agencies may come most immediately to mind for they and public-care institutions, such as state hospitals, are most familiar to the general public. Parent groups, organized and unorganized, do not generally make themselves as visible, but they have an acute concern for the development of good social service delivery systems, and as special interest groups go, they are highly energetic, active, and extremely committed.

These parent groups are organized into formal parent associations, identified with the retarded, epileptic, cerebral palsied, or autistic segments of the population of handicapped people. Usually local parent groups are affiliated with national groups. The Developmental Disabilities Act requires every state to have a Developmental Disabilities Council (whose responsibility, in part, is related to insuring responsiveness to system users and parents, to long-range planning, and the administration of national developmental disabilities funds). Also involved in the care network are the professional workers who serve developmentally disabled people directly (physicians, public health nurses, special educators, and so forth.) And there are all the people associated with community care facilities themselves, the staffs of sheltered workshops, activity centers, and residences. Each region has its own distinct pattern, but usually includes parents, planning body, professionals, and deliverers of direct-service who form the nucleus of the developmental disabilities power structure.

It should also be noted that because of federal funding, increasing awareness, and the increasing dynamism in the field, parent and other interest groups are becoming larger, more highly organized and articulate, rather than the reverse. At stake for them are the increasingly richer possibilities for their disabled family members. It is safe to say that in most states the network connections between such groups and state and local social service agencies is

becoming stronger and leading to more creative solutions for the problems of the disabled.

The existence of this complex network of agencies and interest groups creates quite a different arena for decision-making in this occupational area by a college than would be created by, let us say, the growth of a new chemical industry in the college's service area. Without clear answers to questions about occupational demand, potential assistance to the college for a program will neither be immediately evident nor particularly stable over time. Adequate and satisfying answers will probably come only after a period of interaction with a broad range of interest groups and individuals. Images of possible programs or other involvement on the part of the college will be pieced together, revised, and reassembled again. As the developmental disability power and service structure becomes aware of a college's interest, the network of groups and agencies may shift programs and priorities to create a role for the college, a role which could not have been easily foreseen at the early planning stages.

In other words, the potentials for a community college involvement with the developmentally disabled may build even as the feasibility of such involvement is being considered. The act of beginning the discussion is likely to be "futures creative," leading toward an outcome that will be heavily shaped by the process itself.

The critical elements in such a process, we propose, are time and patience, because a complex network of service providers, agencies, and parent groups cannot respond as quickly as an industry with a clearly articulated decision-making structure and a clearly defined manpower need.

Decision and Initial Planning

If a college administration is willing to commit a planning team to careful researching of the possibilities for a program, where does such a team begin and what does it consider? The following questions and related suggestions are a basic guide. In pursuing almost all of them the assistance of a broadly based advisory committee will be essential. While advisory committees are customarily used in the development of new curricula in community colleges, it is especially important that in this instance, the committee include broad representation from potential employers, government and community agencies involved in administering programs for the developmentally disabled, parent groups, and even potential students. This advisory committee will be the college's primary means of gaining contact with the broader network of interest groups described above, as well as a direct resource.

1. *What program or programs, service or services are needed?*

   The major emphasis of this report is the establishment of programs to train direct-care workers to a one- or two-year certificate level, but in the initial planning phases a broader view should be taken, and the best possible informa-

tion on many aspects of community and regional need should be assembled.

a) What is the *present* need of local families, community residences, state and private institutions, programs in special education, and so on, for college-trained direct-care workers?

b) What are projected five and ten-year needs of the same entities, given a continuation of present program trends?

c) Would demand for trained personnel change if interested groups could be assured of the availability of such personnel? If so, how, and when?

d) What are needs for direct-service delivery within the community or surrounding area? What possibilities might there be for the college to undertake or participate in some service-delivery, involving students, staff and community people in a cooperative effort with a service agency or institution? Such a cooperative effort would provide a built-in practicum for students.

The investigation of needs logically will be done first, and it is likely that during this early open-ended phase many of the college's initial contacts within the developmental disabilities service and power structure will be made (see box). It is during this phase that potential members for the advisory committee can be identified and invited to participate in the ensuing discussions.

Community Contact Points

Parent Organizations

Local Chapters of:
- National Association for Retarded Citizens
- United Cerebral Palsy Association, Inc.
- National Epilepsy League
- National Society for Autistic Children, Etc.

Professionals working directly with individuals who are developmentally disabled

- Physicians
- Social Workers
- Special Educators
- Psychologists
- Public Health Nurses

Community Care Facilities

- Workshops
- Activity Centers
- Residential Facilities

Planning Bodies and State Agencies

- Developmental Disabilities Council
- State Department of Rehabilitation
- State Department of Health, Mental Hygiene

2. *What students may be interested?*

In general, our society is moving toward more interest and employment in social service occupations, and the odds are that it may also become more humanistically oriented in the future. It is likely, as a result, that in most areas some student interest in a developmental disabilities training program can be assumed. Nonetheless, particular economic situations, competing interests, or other factors could limit the pool of potential students. And potential student interest is also limited by a lack of general knowledge about the developmentally disabled. The research team might well enlist the aid of advisory committees in field presentations about the developmentally disabled and potential occupational roles in local high schools. Perhaps initial interest immediately following such presentations will be misleading; follow-up visits would be more likely to isolate potential students whose interest had persisted.

3. *What level or levels of program might be offered?*

Eventually, we believe that most direct-care workers should complete a full two-year A.A. or A.S. degree program, and probably this should be the college's long-range goal unless a particular local situation contraindicates. A strong program in a nearby institution might be such an indication. But one-year certificate programs are a possibility, as are options added to an already existing curriculum—a human services option in a psychology program, for instance. This is an expeditious and often fruitful course of action. Short-term training sessions to upgrade the skills of those already employed in the field locally are, as suggested earlier, less likely to upgrade skills effectively, and are less likely to tie into a national certification pattern and career-ladder design, but they may be of some help in meeting an immediate local need.

There are undoubtedly other program forms which could be a particular college's response to a particular need. It is conceivable that simpler programs could be planned as exploratory efforts—a weekend in-service program could bring together college, institutional personnel, interest-group representatives, and potential students.

4. *What resources are available for a program?*

A broad view, again, should be taken while exploring this question. Thoughts may turn immediately to budgets and to existing programs and personnel in the college, and these may eventually be important aspects of a new program. But the network of agencies and groups discussed above may contain sources of funding and expertise, or know of such sources, and can probably help the college gain access to them. Parent groups may provide volunteer consultation, part-time resource people for an instructional program, or other resources. State agencies may have development funds, or have access to federal funding; such agencies may also make personnel available to contribute to a program.

In the long run, financial responsibility for the program should become part of the college's budget for reasons of security and continuity. However, in this shifting field some form of relatively long-term supplemental funding from other sources is not inconceivable.

5. *What procedure will be appropriate for program design?*

The curriculum or training program will be more effective in the long run if the planners initially ignore apparently relevant courses offered by the college. It is more in the ultimate graduates' interests to carefully outline the competencies they ought to have at the completion of the program, with an eye both toward basic skills for direct-care employment, and potential for further academic work.

After the planning team has outlined desired competencies and a general content plan, courses and units can be mapped. It is at this point, we suggest, that the relationship of the new program to already existing ones be considered. It may be that some existing programs in a number of fields or departments can be utilized, or departments may be willing to modify some courses to make them dovetail with the new program's requirements. However, the description of the new program will now be specific enough to resist the inevitable "pulling" from established courses and interests in the college.

6. *What procedures will be established to keep the new program tuned to changing requirements and standards in the field?*

It can be assumed that a full assessment of the local community and the involvement of a broadly based advisory committee will tune the program quite closely to present- and short-run-future needs. But it is also important to insure that the training provided remains flexible, generic, and portable. Graduates should be prepared to serve people with various disabilities in a variety of community and institutional settings, in varying regions of the country. The skills and knowledge taught must also fit into emerging career-ladder patterns in the field.

To meet these requirements, at least some members of the advisory committee should have the respc. sibility of reporting on evolving standards in the home state and surrounding ones, and on federal standards and trends toward national certification or personnel accreditation in the field. Those planning committee members in touch with educational pre-requisites in the surrounding geographic area should periodically review the program's compatibility with B.A. degree programs.

7. *How will experiential education be included in the program?*

A highly important element of any direct-care worker's training is appropriate practical experience; this part of the program leads most directly to employability and allows contact with the institutions and employers in the field. Advisory committee members representing public institutions and private-care institutions will be important resources in lining up or working to create practicum positions—the specific role of practicum sections in some program models will be discussed in the next chapter.

8. *How will the program be evaluated?*

Advance planning for evaluation frequently sharpens the purpose and planning for an entire educational endeavor; we suggest that the mode and extent of evaluation for a planned curriculum be established early in the planning process. Criteria for evaluation agreed upon by the advisory com-

mittee, the college staff and ultimately the college's governing board prior to the start of the program will avoid misunderstandings and misconceptions about the nature and purpose of the program. Ample evaluation planning and careful program assessment will also prove useful when the budget for the program must be extended, or if program expansion becomes a possibility.

Summary

A training program for direct-care workers to serve the developmentally disabled cannot be adopted or rejected as quickly or on as clear-cut bases as for many other programs, e.g. a program to train computer programmers. Occupational definition in the field is not yet firm, and the opportunities for trained workers are not easily verifiable in many geographical locations. In addition, a large community of people and many agencies are interested in the problems of the developmentally disabled, and are themselves constantly interested in new possibilities for their children and clients. A college seriously considering a new program and assessing demand for projected graduates should make extensive contacts in this network of interest groups; this will take time and an open-minded approach. It is essential for representatives of parts of this network to join the college's advisory panel for the new program.

After initial needs are assessed, the potential resources—financial, and human, including students—for a program may be explored. More detailed planning steps will follow, including procedures to keep the program tuned to developing standards in the field to potential career-ladders, and agreements on the proper form of evaluation for the program.

[1] Gleazer, Edmund J. Jr., "After the Boom, What Now for the Community Colleges?", in, *Community and Junior College Journal*, December-January 1974. (American Association of Community and Junior Colleges, One Dupont Circle, N.W., Washington, D.C. 20036)

[2] Rippey, Donald T., "Defining Objectives for a Technical-Occupational Program to Train Career Counseling Technicians." Paper presented to Seminar on Career Counseling Technicians, New Orleans, LA 1973, as reported in *Career Counselor-Technician* Southern Regional Educational Board, Atlanta, GA., 1974, (Atlanta 30313)

Developing a Program-Objectives, Scope, Content

A community college planning team developing a program to train direct-care workers must keep both the immediate and long-range needs of students in mind. Students need a strong emphasis on marketable skills and practical experience with at least one group of developmentally disabled people. Their training must be broad enough, however, to be applicable to a range of community settings and varying types of disabilities, and contain enough academic material to permit later continuation in a B.A. program, a likely component of career-ladders in this field. Such a program is likely to meet national credentialing standards as they emerge, as well.

The planning team also should consider themselves advocates for the graduate's future clients, for those clients are the program's ultimate consumers, and they and their families must eventually be satisfied with the graduates-in-action if the college's program is to have a solid future and meet its social objectives. In this role, the planning team needs to consider the client's basic needs—for respect as a fully human individual, for life enrichment, and for assistance with development, at whatever the level of handicap. These needs will be served if the skills and knowledge of the staff are educationally and developmentally oriented, and if staff attitudes are positive toward the people served.

Standards for Essential Competencies

The scope of a program may be approached by examining the skills needed in the type of care being provided; at present these are most comprehensively indicated in emerging programming standards. We have already made reference to the Joint Commission Standards, and at this point a closer examination of them is in order. They outline program areas quite specifically, and many states are using the Standards as the basis of their own program requirements.

The Joint Commission has suggested that a complete set of standards must cover five major areas:

1. Provision of active habilitation programming to each resident.
2. Provision of services within a normalized and normalizing environment.
3. Assurance of the rights of residents and their families.
4. Effective administrative practices.
5. Maintenance of a safe and sanitary environment.

It is clear that the first and second areas are those in which extensive training of direct-care staff plays a critical role. Staff people on the direct-care level must know requirements in the other areas, of course, but maintenance of these standards is usually either a major responsibility of people in higher-level positions, or a function of the overall style and operation of the facility. In contrast, the areas of habilitation programming and the provision of a normalizing environment are very much a responsibility of the direct-care worker, in everyday interactions with clients.

The Joint Commission, wishing to further emphasize the importance of the programming segment, adopted the following addenda to their standards in 1975:

> *"in order to receive accreditation, a facility must provide active habilitation programming for all residents within a normalized environment that respects their rights and dignity. It is not sufficient for a facility to be providing active programming, even exemplary programming, for some residents, while providing only essential custodial care for others.*
>
> *The fundamental requirements for active programming include an interdisciplinary team process for identifying the specific needs of the resident; establishing priorities for meeting those needs, if it is not possible to work on meeting all of them at once; determining programs for meeting the priority objectives, and assigning responsibility for them; reviewing on a regular basis the resident's progress toward the objectives; and modifying the objectives and/or the programs in the light of the resident's progress. The interdisciplinary team process must include the participation of the direct-care staff persons who must be responsible for the resident's day-to-day care and program, and not just their supervisors. At any given time the team must also include all those persons whose participation is relevant to meeting the needs of the resident. The interdisciplinary team process and activity must be documented, so that the team's shared considerations and decisions result in a totally integrated habilitation program plan for the resident, rather than in fragmented, isolated or independent efforts. The essential requirements for a normalized environment include a physical environment that is as home-like as possible, and in which residents can be divided into small groups, for which specific direct-care staff are responsible, so that there can be individualized attention to the developmental needs of residents, rather than merely large group or mass care routines."*

Congress has given additional teeth to this view of the priorities within a facility's program by stipulating in Public Law 92-223 that no Medicaid funds could be used to pay for the care of any retarded person living in an intermediate care facility unless that person was receiving "active treatment." The Regulations governing this law define active treatment as ". . . an aggressive and organized effort to fulfill each resident's fullest functional capacities. It requires an environ-

ment approximating, as closely as possible, the patterns and conditions of life in mainstream society. It has as its goal the development of those skills, habits, and attitudes essential to adapting in contemporary society. It means equipping each resident who is able, to return to community life."

Individualized Program Development

The major emphasis in the *Standards* and in many state plans revolves around the development and implementation of an individualized program plan for every resident by a team of care-workers. Each individual prior to his placement in a community residential facility has had a medical examination, a psychological examination and an assessment of social functioning and adaptive behavior. As a rule, information is available regarding the educational achievement, social history, and previous vocational experiences of each resident. On the basis of data such as this, the individualized program for each resident is begun. Such a program specifies goals and objectives, prescribes the needed interventions and sets up an accountability procedure leading into the development of new goals and objectives. The following plan is from the Accreditation Council for Facilities for the Mentally Retarded, Joint Commission on Accreditation of Hospitals, 875 North Michigan Avenue, Chicago, Ill. 60611, 1971.

The Individual Program Plan

Definition:
The individual program plan is a written plan of intervention and action that is developed, and modified at frequent intervals, with the participation of all concerned. It specifies objectives and goals and identifies a continuum of development, outlining projected progressive steps and the developmental consequences of services.

Principles:
An individual program plan should be developed for each person accepted for service, regardless of chronological age or developmental level. The plan should be based on individual assessment data and on other data that assist in understanding the client's situation, and it should be developed by the relevant staff of the agency (facility) serving the client, with the participation of the client and his family. A plan developed prior to the onset of services by the agency should be reviewed and updated, so as to meet the current needs of the client. Long and short-term objectives should be stated separately and within a time frame, and they must be expressed in behavioral terms that

provide measurable indices of progress, and that enable the effectiveness of interventions to be evaluated. Modes of intervention for the achievement of the stated objectives must be specified, and agencies capable of delivering the needed services should be identified. The individual program plan must be modified as goals and objectives are, or are not, attained. Review and appropriate revision of the plan must be a continuous and self-correcting process. The plan must help all concerned to coordinate their efforts and activities, so as to maximize services to the client.

In essence, this procedure represents the application to the developmentally disabled of an educative model dealing with human growth and learning now common in many areas. The model unifies many approaches in areas of psychology, education, and human services; it is based in learning psychology. It follows that a program emphasizing this model will not be highly restrictive for a student, but will tend to give him or her not only specific skills and knowledge in the developmental disabilities area, but also a broadly applicable "language" related to many human-service and human-development areas.

An examination of sections of the *Standards* will show how this general educative model is related to program and personnel skills needed in community facilities. One section, for example, relates to sensorimotor development.

Definition

Motor development means the *development of those behaviors* that primarily *involve muscular, neuromuscular, or physical skills,* and that involve varying degrees of physical dexterity. Sensory development includes the development of *perceptual skills.* Because sensory and motor development are intimately related, and activities in these areas are inseparable, attention to these two aspects of bodily activity is combined in the concept of sensorimotor development.

Standards

The individual program plan contains *objectives* relating to sensorimotor development, including, but not necessarily limited to, the development of:

Balance and posture
Perceptual-motor skills
Locomotor skills
Manipulative skills
Body image

The progress of the client toward these objectives is *evaluated* and *recorded* at least quarterly.

Specific programs are directed to the sensorimotor development of non-ambulatory individuals.

Individually prescribed sensorimotor development activities are performed by each person regularly.

Sensorimotor development programs *proceed from simple to complex activities, in logical sequence.*

Activity programs are designed to increase individual skills, strength, and endurance.

Activities are *modified in accordance with the client's progress toward* his *sensorimotor development objectives.*

The agency provides direct services or obtains consulting services from professionally qualified persons to assist the family in sensorimotor training.

The agency *demonstrates functional integration of sensorimotor activities* and therapeutic interventions *in the educational, social, recreational, developmental, or vocational programs,* that it provides.

We have underscored a number of the key phrases and terms, which imply specific skills and elements of knowledge a direct-care worker would need in order to achieve these standards within the context of a community facility's program. It is clear that the worker would need a basic acquaintance with sensorimotor function and development, would have to know the meaning of the terms used in the Standards and others on a similar level, and be aware, at least on a general level, of how sensorimotor development relates to the overall development of an individual. This knowledge should not be on only a theoretical level, but on an applied level sufficient for the worker to observe and record particular characteristic behaviors for report to another staff person or a consulting specialist. The worker would probably need an elementary knowledge of diagnostic procedures and tests in this area, and a beginning knowledge of intervention techniques.

It can be seen that while the standard introductory psychology course would contain some of this material, it probably would not go deeply enough into the area of sensorimotor development to give the student knowledge implied by these standards.

A sub-section of this part of the Standards relates to communicative development, as an extension of sensorimotor development.

Standards:

The individual program plan contains *objectives* relating to communicative development.

The progress of the client *toward these objectives* is *recorded* at least quarterly.

The agency provides appropriate training in the areas of *sensory stimulation*, awareness, *appropriate gestures, receptive skills, speaking, writing, reading, listening,* and *expression*.

Specialized services are provided or procured by the agency in order to correct structural or habit deficits that interfere with the client's communicative development.

The agency provides for each client *specific opportunities* for the *use of functional communication skills in activities* of *daily living*.

The agency provides instruction concerning the availability and utilization of all forms of communication media, such as radio, television, telephone, and such specialized equipment as may be required.

The content areas implied by this sub-section might involve speech therapy and other specialized subject matters within education, and basic concepts in communication courses, although probably not the bulk of material usually covered in such courses. The worker needs to be able to identify specific communicative behaviors, and the sequence in which they are likely to develop, well enough so that the next-to-last standard above can be met and clients can be provided opportunities to use these communicative skills in daily living situations.

In working with clients in both of the areas described by this section of the Standards, it can be seen that the direct-care worker needs to be oriented to and able to use the communication mode of objectives terminology. Training in behavioral observation and recording, record keeping, objective writing and sequencing is implied, and in fact this should be a major focus, emphasized in a number of courses and experiences. This is important in direct-care work because it focuses the worker's attention on the client in an educative, performance-oriented way; it is important for the worker's communication with supervisory personnel, and also is a basic skill for many areas in which a worker might later specialize.

Social Development

The same basic focus on objectives-setting, sequencing, and recording, the planning and implementing of prescribed activities within an objectives context, and evaluation against a set of objectives is found in another important section of the Standards, that describing criteria in the area of social development (again key terms have been underscored).

Definition:

Social development refers to the formation and growth of those *self-help* and *interpersonal skills* that enable a person to establish and *main-*

tain appropriate roles and *maintain fulfilling relationships* within his environment.

Standards:

The individual program plan contains *objectives relating to social development.*

The *progress* of the client *relative to these objectives* is *recorded* at least quarterly.

The agency's programs provide for the development of culturally normative behavior by its clients.

The agency provides opportunity for social development *appropriate to the client's chronological age.*

The agency provides activities that promote the development of *socially adaptive relationships with the opposite sex.*

The agency provides a sequential family life education program based upon the *client's developmental level* and consistent with cultural norms.

Activities are provided for individual social interaction outside the training programs.

The agency provides programs to assist the client with clothing selection and grooming *appropriate to various social situations,* such as work, school, church, and leisure time activities.

As a part of the social development program, the agency provides special training relating to safety in all activities of daily living.

The agency designs a program for use by the family to encourage independent functioning through the acquisition of self-help and interpersonal skills.

The agency counsels with the client and his family concerning *interpersonal conflicts,* or conflicts arising from isolated or disorganized families.

If the agency refers its clients to another agency for counseling, it provides follow-up to ensure resolution of the conflict.

An additional content area now becomes significant, that involving human relationships, communication, sexual relationships, and appropriate social behavior and interactions. It might be supposed that this knowledge is more "common sense" than knowledge in the sensorimotor area, but such is not necessarily the case; one worker's background may contain quite different "common sense" data from another's. So some part of the curriculum needs to address the questions of functional and dysfunctional elements in human relationships, sexual relationships, and values about appropriate social behavior. Again enough grounding is needed so the worker can communicate with a supervisory worker, or a consultant visiting the facility periodically. Each content area can be seen as a

possibility for future professional specialization for the worker, and the curriculum might well contain at least some introduction to opportunities for further specialization in each content area. The worker should have some knowledge of psychological terminology as it relates to social development and behavior, have some acquaintance with testing devices or programs designed to measure social skills and maturity, and have at least an introduction to group techniques and group process. Practice in leading group activities should be coordinated with content in this area.

Affective Development

Competencies in the area of affective development can be drawn from another section of the Standards; individual emotions, the concept of self-image and the effects of varying interactions on both are the major focus.

Definition:

Affective development pertains to the *development of feelings and emotions*. It includes the *development of behaviors* that relate to, arise from, or influence *interests, attitudes, emotions,* and *values.*

Standards:

The individual program plan contains *objectives* relating to affective development.

The *progress* of the client toward these objectives is *recorded* at least quarterly.

The agency develops with the client and his family a plan for *developing the expression* of *appropriate emotional behaviors.*

The staff provides a warm, *accepting* environment that is conducive to the development of positive feelings.

Opportunities are provided for the expression of appropriate feelings by the client.

The agency provides for the development and enhancement of the client's *self-concept* through activities that promote awareness of self and the *experience of success* and security.

A variety of experiences are provided to develop the client's interest in and appreciation of the esthetic components of his environment.

Clients displaying *maladaptive behavior* have *specified training objectives* that lead to more adaptive behavior.

Records are maintained of *significant maladaptive behavior*, and of actions taken by parents and staff as a consequence of such behavior.

When necessary, specialized therapeutic techniques to develop constructive adaptive behaviors are provided or procured by the agency *for the client and his family*.

Again, these standards imply skills and orientation for approaching the client from a developmental perspective—assessment, planning, objective setting, prescriptive teaching and activities, and reassessment. The content is likely to be approached by both teaching staff and the direct-care student in a more intuitive and empathic way than is appropriate to the other content areas—the perceptions, knowledges and skills to be gained here are likely to be of the nature of those involved in very sensitive and compassionate parenting. Individual students may need to analyze their own behaviors which express criticism, acceptance, and/or nurturance.

It is likely that content in this area will be organized from both a developmental perspective (as in a child-development course) and a therapeutic approach (an introduction of perspectives on family functioning and family therapy, for instance). One college surveyed broadens the content to include the disabled individual's family, providing a course in "Introduction to Parent Therapy."

Cognitive Development

The Standards section for cognitive development implies necessary academic content more directly; key words are again underlined to direct the reader's attention to some key knowledges and competencies.

Definition:

Cognitive development refers to the development of those processes by which sensory input is transformed, stored, recovered, and used. It includes the development of the *processes and abilities* involved in *perceiving*, recognizing, *remembering*, conceiving, *judging, reasoning, thinking*, and knowing. As applied to cognitive development, learning emphasizes the *acquisition of intellectual outcomes*, such as *knowledge, comprehension, application, analysis, awareness, synthesis*, and *evaluation*.

Standards:

The individual program plan contains *objectives relating to cognitive development*.

Objectives are *written in behavioral terms*.

The *progress* of the client *relative to these objectives* is *recorded* at least quarterly.

Progress is recorded in behavioral terms.

The agency helps the parents to *recognize* and *implement their roles* in fostering the cognitive development of the child.

The agency *provides initial activities* in the development of cognitive skills as the most basic developmental level, including sensory stimulation.

Specialized services are provided to remediate or compensate for specific barriers to learning.

Opportunities are provided for the client to select alternatives leading to independent action.

The agency provides opportunities for the client to evaluate the consequences of his decisions.

The content suggested is now quite specifically psychological, and it involves a heavy emphasis on neurological aspects of the learning process such as sensation, perception, symbolization and conceptualization, and principles of remediation applicable to deficit areas. Tolls of analysis and treatment in this area would also be studied, and students would be expected to show competency in interpreting diagnostic profiles and preparing individualized remedial programs in specific learning-deficit areas.

If the Standards as well as other current programs specified in various states are looked at closely, the implication is very strong that a worker needs a solid grounding in the psychological and educational strategies of a developmental approach to individuals. A program giving this grounding, specific application of the general concepts to the disabled population, and practice in applying the principles consistently to real clients, will meet the objectives stated at the beginning of this chapter: an education in immediately useable skills, an orientation to a national approach in services for the disabled, and a broader orientation which connects with other human service and developmental fields. These elements contain the basis for further movement up a logically constructed career ladder, or progression to a baccalaureate level if desired.

Summary

Examination of a comprehensive set of program standards suggests that direct-care workers need solid grounding in a developmental and educative approach to individuals, including the central notions of assessment, against an expected sequence of development, objective-setting, prescriptive intervention

(teaching, structuring of activities, and so on), and evaluation and reassessment. This should therefore be an important focus or an underlying thread in any program. Knowledge about the several areas of individual development constitute another major emphasis. The need for marketable skills upon graduation, as well as the more general need for relating theory to specific practice and problems of the disabled, require an application focus to the curriculum as well.

This chapter has shown that a performance-oriented as well as competency-based curriculum can be developed from program standards in general and the Joint Commission Standards in particular. Utilization of such standards will help assure that the curriculum for the training of direct-care personnel is community-based as well as performance-oriented.

Program Issues and Program Models

General Considerations

Any planning group designing a program to train direct-care workers must wrestle with a number of issues and problems as they go forward, problems and issues related to the basic intent of the program and the competencies and opportunities it is to give its graduates. Fortunately it is not necessary for a college's planning team to re-discover all the dilemmas independently. A number of groups have developed philosophies and approaches to program design, and have often developed model programs as well. It is the purpose of this chapter to review some of these efforts, and highlight some of the program-design issues in this field in the process.

Most planning groups probably first run into the dilemma of employability training versus an academic emphasis which implies continued education (in a four-year institution, typically). It is our impression (and others seem to share the view) that meeting both objectives in a typical A.A. degree program structure is difficult, assuming that the entry requirements for the four-year institution's junior year are typical and not subject to modification upon the request of community college planners. Employability training and employment-producing contact with care facilities in the student's geographical area imply considerable time devoted to field experience, practicums, etc., and a program demanding a large expenditure of student time and energy in that direction cannot easily accommodate a full academic preparation. Another consideration is whether the program is to have a generic emphasis in academic and practicum components, or a specialist emphasis. To some degree this choice must depend on the definition of the labor market in the area, but it also depends on the preference of potential employers, including the public service network in the area, and the planners' own views as to whether generic programs provide specific enough skills by the end of a two-year program. Nor is this an either/or choice—a mix of generic and specialized elements can be included.

There are possible variations in the time-structuring of a curriculum. Most American proposals have been conceived within the traditional boundaries of courses and seminars meeting weekly, and involve varying proportions of classwork and practicum experience within the week and the semester. The Canadian and Danish models, also reviewed, have longer periods devoted alternately and more or less wholly to academic work and practicum experience, in a "work/study" pattern. This pattern at least presents the opportunity for more diverse practicum experiences, since the student can re-locate for the longer practicum and academic periods; whether it has educational advantages seems not to have yet been discussed by program planners.

There are substantial variations in the apparent competencies toward which different program models are directed, in turn derived from the overall service pattern and manpower utilization scheme graduates will enter. Some programs equip the graduate with substantial para-medical skills, while others de-emphasize this side of care for the disabled, focusing more on social skills and programming skills. More or less attention may be devoted to administrative subjects and skills.

A systematic approach to competencies desired underlies the most consciously constructed models, with the competencies specified derived in turn from a manpower model or manpower philosophy for the service system as a whole. Darrel J. Mase of the University of Florida has proposed one such overall philosophy, working from the viewpoint that the labor market has been generally lopsided in the health and education professions.[1] People with bachelor's, master's, and doctorate degrees, Mase suggests, have often been performing tasks which do not require the advanced knowledge, skills, and capability—there is a consequent waste of *mindpower*. Efficient utilization of the mindpower held by these relatively highly trained people would be better achieved if they spent more time supervising those with less training, in the process passing on skills and knowledge and increasing the aggregate mindpower available in the field.

Mase has suggested a numerical rating of the knowledge, skill, and capacity for independent action appropriate to work at four different personnel levels in the health and education fields; his scheme appears to be a good basis for a logical hierarchy of manpower utilization, and also a good initial guide to the planning of a career-ladder system. His proposed rankings are as follows:

Level of Education	Knowledge	Skill	Capacity for Independent Action
I—Doctorate	4+	4+	4+
II—Bachelor's and Master's Degree	4+	4+	2+
III—Two-year College Associate Degree	2+	4+	1+
IV—On-the-job, Vocational, and Technical Training	1+	4+	0

The Mase conceptualization might be extended to specific competency lists for each area at each level of training, a strategy which would lend specificity to the

meaning of the "1" knowledge level for the lowest level, for example. In fact, several groups have worked in this general direction, specifying competencies related to particular levels of training. Combining such an approach with the Mase schema, we propose, will eventually be a productive way to compare and describe programs as they evolve.

An Application of Multi-level Competencies—The National Mental Retardation Manpower Model, Canada*[2]

Canada's National Institute on Mental Retardation has been working since 1969 on a national manpower model for mental retardation workers. The model is based on a broad concept of developmental handicaps. The model assumes (we judge properly) "that there are many common areas of knowledge and skill involved in working with individuals with developmental handicaps." The major areas within the field are, according to the Canadian analysis:

Behavior Disorders	Multiple Handicap Interactions
Mental Retardation	Social Maladjustment
Learning Disorders	Specific limitations due to deafness and blindness

The Canadian model is basically a non-medical one, since the Institute judges that the non-ambulatory mentally retarded or "chronically mentally retarded" comprise at most 20 per cent of the institutionalized mentally retarded population. This group, the Institute feels, needs a sufficiently different treatment to require another model.

The Canadian Institute's model proposes four levels of training appropriate to paid direct-care and supervisory workers. (The Institute suggests that other alternative approaches are needed for volunteers.) It seems likely to the Institute that the levels will require length and types of training as follows:

Level	Location of Training	Length of Training
I	Community College	One Year
II	Community College	Two-Years
III	University	Three to Four Years
IV	University Graduate School	Four-plus Years

It is the Institute's intention that these levels become formalized with national credentialling, and that the hierarchy give not only a guide to manpower utilization but also provide a new career system within the developmentally handi-

*For detailed Information write G. Allan Roeher, director, National Institute on Mental Retardation, York University Campus, Toronto.

capped field. That is, an important part of the hierarchy and training programs proposed is that workers have clear routes and opportunities for moving up the ladder, as well as having their status within the system clearly defined.

The Institute is focusing on mental retardation workers specifically, and is assuming a residential or quasi-institutional setting for its work. Consequently it has been able to phrase job responsibilities and desired competencies quite specifically. Both types of descriptions for Level I and Level II workers follow in abbreviated form. The reader can try applying the Mase scheme to them.

Functions of Level I Workers

Provide stimulating environment . . .

Organize the daily life of the individual . . .

Utilize the total milieu of the facility to gain the active involvement of the individual . . .

Utilize the total milieu of the community . . .

Serve as a behavioral model . . .

Provide basic daily care and social training . . .

Assist with the residential household activities and works in developing a home-like environment . . .

Work effectively under the supervision of a Diploma Level II or III staff member in designing and implementing a daily program.

Functions of Level II Workers

Create an environment in which the individual may develop to the limit . . .

Assist the individual in developing more appropriate behavior . . .

Provide an educational and training program . . .

Prevent dehumanizing aspects from developing . . .

Serve as an advocate . . .

Develop daily and weekly educational programs . . .

Provide remedial and preventive health care . . .

Assist parents in coping more effectively with . . . handicapped family members . . .

Utilize group process as a remotivational force . . .

Provide occupational-vocational assessment and training . . .

Competencies for Level I Workers

Provide required physical and personal care

Utilize knowledge of first aid and administer necessary drugs under supervision

Develop and maintain a home-like environment

Motivate the individual to engage in (the full range of) activities

Relate . . . with empathy and sensitivity

Competencies for Level II Workers

Relate academic and social learning tasks to daily institutional activities

Reinforce appropriate behaviors and demonstrate behavioral management skills

Develop independent self-generating behaviors for his or her group

Write and maintain weekly objective reports

Relate to and involve parents

Devise solutions for frequent daily problems.

Comparing the job responsibilities and competencies projected for these two personnel levels reveals differences which seem generally to parallel the Mase rankings in the areas of knowledge, skill, and capacity for independent action. It is fairly clear that the Level I worker is expected essentially to operate day by day, under supervision, and deal with the present and obvious needs of clients. Enough theoretical knowledge is needed to cooperate with and understand in broad terms the directions of supervising colleagues, and comprehend the general direction and purpose of programs and activities. The Level II worker is expected to perceive and shape larger systems or entities within the facility, and is expected to take a longer-range view of the individual handicapped person, his or her potential directions of development, and appropriate interventions.

At present, the Canadian Institute feels that much Level I training will take place within the context of a facility for the mentally retarded, with the academic dimensions of the curriculum provided at a nearby educational institution. However, the Institute's hope for the future is that community colleges or other educational institutions will become "home base" for trainees seeking the Level I diploma.

The total time involved in the Canadian Level I program is eleven months, half to be devoted to academic work and half to supervised practicum experience in several different facilities. It appears that the academic and practicum periods will be two or three months in length each; the program might consist of one academic period of three months and another of two months, with practicum segments of similar lengths. However, the placement in any one practicum setting is not expected to exceed one month. The material proposed to be covered in the academic segments is as follows:

Curriculum Areas—Level I

Human Development	Social Care and Daily Programming
Learning	Recreation and Leisure: Applied Activities
Behavioral Management	Health Maintenance and Basic Pharmacology
Human Relations	Home Craft

The educational sequence for a Level II diploma is proposed to take twice as much time as for the Level I, 22 months (a schedule covering two full years with a month vacation each year). As with the Level I program, this time is divided equally between academic work and practicum experience. Academic and prac-

ticum segments are either two or three months long each, in a "work study" pattern, but each different practicum experience is typically one month in duration.

Work in the academic segments falls into three divisions: theoretical courses, technical courses, and applied activities.

Theoretical Courses—Level II

- Human Development
- The Handicapped Individual
- Group Theory and Methods
- Psychopathology
- Physiology and Maintenance of Physical Health
- Pedagogy of Leisure and Recreation
- Learning Theory
- Social Psychology
- Educational Theory and Method
- Sociology of Handicapped Behavior
- Group Process and Remotivation of the Handicapped Individual

Technical Courses—Level II

- Observation and Report Writing
- Rehabilitation Strategies
- Basic Care and the Development of a "home-like" Milieu
- Teaching Strategies for the Handicapped
- Daily Programming and Behavioral Management
- First Aid

Applied Activity Subjects—Level II

Handcrafts: Painting, Modeling, Drawing, Music and Dance, Gymnastics, Calisthenics, Games and Recreation, Development of Instructional Materials

At present the Institute has solved the problem of how a graduate will move from Level II training into further academic training, principally by specifying that selected, promising Level II students may be encouraged to go directly on to Level III work. The transition and entry into a four-year educational institution might well be eased by the fact that the Canadian Level II program does have somewhat more academic content than might a comparable four-semester U.S. community college program. The Institute's document does not so far specify how an individual student might move from Level I to Level II; it seems likely that as Level I as well as Level II training takes place in a college setting, more attention will be given to facilitating this transition.

The Michigan Institute Model: Pre-Service and In-Service Programs with an Emphasis on Employability[3]

Two support-personnel training models of interest to community college planners were developed in the course of a conference conducted by the Institute for the Study of Mental Retardation (at the University of Michigan), and co-sponsored and supported by the United Cerebral Palsy Association of Michigan, in 1970. The proceedings of the entire conference have been published, as "Guidelines for the Preparation of Support Personnel."

Unlike the Canadian Institute's planners, the Michigan conferees did not attempt to specify competencies expected of graduates, but the emphasis on competence in general and its relation to employability was nonetheless underscored. The Michigan conference conceptualized a range of possible training programs aimed at increasing the competence of all workers in the field, as follows:

1. Two-year training programs leading to an A.A. Degree
   a. Pre-service
   b. Post-service (full-time in-service)
2. In-Service
   a. Training provided for entry-level people
   b. On-the-job updating of skills and the lateral movement of employee
   c. In-service training for promotion—vertical movement

Our primary interest is in the two-year training programs leading to the A.A. Degree; the Michigan conferees saw a need for two such programs. Pre-service students, it was felt, needed a core of academic and special subjects, with a broad enough scope in both academic work and field [illegible] allow full exploration of the field and the career options within it. A person presently working in the field, on the other hand, already should have that orientation, and needs more assistance in tying his or her everyday experience to theoretical understandings. This line of thinking led the Michigan people to two quite differently organized programs, albeit leading to the same degree.

The pre-service program involves, in the first year:

> Core subjects, at 8 class hours per week and 8 units per semester: Communications skills, Social and Psychological Foundations, Human Development/ Interpersonal Training, Health Sciences, and Physical Education.

In both semesters, there is a combined seminar-practice course. Introduction to Helping Services. This is assigned 5 semester credits, and takes at least 10 actual hours per week.

> The seminar section treats technical language and terminology, ethics, work habits, acceptance of supervision, and applications of concepts in the parallel academic courses. The practice involves observation and hands-on assistance

in a variety of settings in the community, including facilities for the mentally retarded and other developmentally disabled, but also a wide range of other social service facilities and programs.

The second year of this first, pre-service A.A. program is heavily devoted to a career field-course each semester, both such courses taken in one of three areas of specialization chosen by the student. (The options are Health and Related Services, Social and Vocational Rehabilitation, and Education). In the Health and Rehabilitation options, there is a minimum of core academic work, some specialized academic work in the field, and the practicum and its associated seminar, which alone are expected to take between 25 and 30 hours per week of the student's time. (The Education option has somewhat more course work and a less extensive practicum).

It is clear from the emphasis given the practicum segment and the shift toward an extensive practicum commitment in the second year that the Michigan conferees did not expect very many, if any, A.A. degree candidates in the pre-service category to go directly on to more advanced training. Instead, the emphasis is strongly upon specialized practice in a section of the field, and presumably on the contacts gained through such practice which may lead directly to employment.

The A.A. degree program for the experienced worker (somewhat mislabeled in the Michigan publication as an "in-service" program), also is a full-time two-year schedule (four semesters). However, each of the semesters is organized similarly, around a half-time commitment to academic work, and a half-time commitment to a practice/skills/work experience assignment. The student is to engage in a wide range of practicum experiences, and there would seem to be little opportunity for these to be combined with the students former work role, hence the inappropriateness of the "in-service" label. The following courses make up the academic program through the four semesters:

Growth and Development of the Individual (2 semesters)
Social Aspects of Handicapping Conditions
Medical and Neurological Aspects of Handicapping Conditions
Psychological Aspects of Handicapping Conditions
Community Resources and Services for the Handicapped Person
Planning for Services and Programs
Seminar on the Interdisciplinary Approach to Services

Each of the four practice/skills/work experience assignment also has a specific focus, and placement or placements in a facility or other program coordinated to that focus:

First semester. Placement in nursery school programs or institutional and educational settings with young physically handicapped children. The focus is on diagnostic procedures and techniques applicable to this group; supervised experience in helping children with basic skills, language experience is provided.

Second semester. Placement in community-based activities programs, occupational thereapy programs in institutions. The focus is on assisting the handi-

capped person in activities of daily living, home management skills, and in sex education.

Third semester. Similar placements as in semester two, and the focus continues to be on helping the handicapped person with regular activities of daily living. There is a particular focus this semester on arts and crafts, and recreation and leisure-time activities.

Fourth semester. Placement in sheltered workshops, halfway houses and residential centers. The focus is now less on helping the handicapped individual with particular learning tasks, and more on working within organizational structures. Management skills, principles of administration and methods of evaluating community service, report writing and case recording are some of the key subjects. There is some emphasis on principles of vocational training and occupational education.

The Michigan planners did not compare their two A.A. degree program models, but some interesting implications come from such a comparison. The trend in the first (the pre-service program) is toward specialization, aimed at producing employment at the end of the second year, while the tendency of the second (the "in-service" or more properly post-service program) is away from specialization, and toward equipping the worker with a broad view of the field and perhaps generating an interest in supervisory-level work. The implicit suggestion is that a proper career ladder in this field may involve a basic orientation and extensive skills training at first, followed by several years of work experience in the field, followed by a return to school for a course which integrates the previous experience, deepens theoretical perspectives, and moves the individual toward broader responsibilities for the human management of services. In that sense, the second Michigan program might almost be made an extension of the first, with some intensification of the course content suggested. The Canadian Institute also implicitly suggests the essential nature of prolonged work experience as part of at least one career ladder in the field, by the proposed requirement that a practicum supervisor must have had at least two years field experience.

The Southern Regional Education Board Model— Toward Competencies for Generalists[4]

The Southern Regional Education Board has been a major force in developing programs in the South to train middle-level mental health workers. Its work has not been specifically directed to training workers in the field of mental retardation, and intentionally so, because the Board's study-project team has taken the position that middle-level workers should be generalists in training and in fact. The Board's team began their work by surveying the major professions in the mental health fields, and, while acknowledging that each profession made unique contributions and had some distinguishing characteristics, it was concluded that each

also had much in common with the others, and that this common core should be emphasized heavily in early training. The decision on a generalist approach also was based upon the view that middle-level workers are often intermediaries between clients and more highly specialized workers, and need to be able to see the needs of the client from a broad perspective.

The Board's approach is also of interest because, in contrast to the Canadian Institute's effort, an attempt was made to specify competencies that apply across-the-board, in a wide range of mental health and developmental health areas. This is also in contrast to the Michigan Institute's approach to at least the pre-service program, where specialization directed to employability is the major emphasis.

According to the Board, an effective generalist in the mental health field has these characteristics:

1. The generalist works in conjunction with other professionals, with a limited number of clients or families to provide "across-the-board" services as needed by the client and the family.
2. The generalist is able to work in a variety of agencies and organizations that provide mental health services.
3. The generalist is able to work cooperatively with all the existing professions in the field rather than having direct affiliation with any one of the existing professions.
4. The generalist is familiar with a number of therapeutic services and technicians rather than specializing in one or two areas.
5. The generalist is a "beginning professional" who is expected to continue to learn and grow.

In order to define the training appropriate to the creation of such a generalist, the project group at SREB developed the notion of a "core of competence" in the mental health field (and at the intermediate, A.A. degree level). Working committees made up largely of college directors of mental-health worker programs already in existence polled their experience and expertise, attended closely to a study of the work being performed by 30 recent graduate-workers, and checked specific competencies for mental health workers developed previously by SREB in a roles and functions study symposium, as well as reviewing a composite list of objectives of individual college programs in the South. The core of competence is divided into three basic categories: Knowledge, Skill, and Attitudes; within each category are the sub-divisions "Essential," "Highly Desirable," and "Optional." Proficiency levels are then specified within each of these sub-divisions in turn. The whole schema might be outlined as follows:

Knowledge (Skills, Attitudes)

Essential Knowledge areas

1. Personality theory and function (Area 2, 3, 4, etc.)
   Proficiency level a.—some knowledge (detailed)
   Proficiency level b.—basic knowledge (detailed)
   Proficiency level c.—considerable knowledge (detailed)
   Proficiency level d.—extensive knowledge (detailed)

Desirable Knowledge areas

5. The social welfare field (area 6, 7, 9, etc.)
   Proficiency levels . . .

Optional Knowledge areas

9. History of HEW programs (etc.)
   Proficiency levels . . .

The SREB group proposes this schema as a way of approaching the problem of outlining competencies, not as a rigid system, but the group does believe that a consistent core of competencies in this field is rapidly becoming essential for community college planners, and for mental health agencies to use as a basis for writing job descriptions. Space precludes listing the competencies at each level proposed by the SREB committees, but a listing of some of the topic areas is indicative:

Knowledge: Essential

Personality theory and function, abnormal psychology, theories of intervention, methods of intervention, chemotherapeutic agents, job roles in the field, mental health and mental retardation organizations.

Knowledge: Highly Desirable

Social welfare field, community resources for human services, sociology, data gathering techniques and evaluation procedures in mental health, other cultures and value systems, contemporary events . . . related to mental health, physiology of human development and function.

Skills: Essential

Interviewing, observing and recording, interpersonal skills, group skills, skills for changing behavior and enhancing emotional growth, instructional skills, consultation, community process skills.

Skills: Highly Desirable

Administrative skills, management skills

Skills: Purely Optional

Administering psychological tests, statistics and research and evaluation methods, remotivation for adults, special therapies, special tests.

Attitudes: Essential

Awareness of one's own limitations and willingness to seek assistance, conviction that the mental health of clients can be improved, acceptance of serving clients through organizations, agencies, etc., openness to change in organizations and services, commitment to continuing self-development, respect for the dignity of the individual and his or her person, privacy, decisions, and opinions, willingness to exercise personal responsibility and initiative, (etc.)

Attitudes: Desirable

Respect and tolerance for "different" individual and cultural lifestyles, concern for contemporary events relevant to mental health, a conviction in favor of collaborative team effort in serving, awareness of various value positions, awareness of personal value system regarding race and racism, awareness of own and society's attitudes and values regarding poverty, dependency, awareness of own and society's values regarding physical and mental disability.

Having begun with this broad approach, the SREB project group did not feel it was appropriate to specify detailed time allotments and courses in a model program—instead, they surveyed current practice in community colleges in the South, in programs directed toward the A.A. Degree.

In general, they found that colleges in the South commit about:

25% of the student's time to general education courses not related to the mental health area,

25% of the student's time and credits to required courses deemed part of a "mental health core" (psychology, for instance),

30% to required (and relatively specialized) mental health courses *not* considered part of the general education core of the college, and,

10% to specialized electives in the mental health field of interest to the student.

(An additional 10% is allocated to free electives).

In this breakdown, practice experiences, field work, etc. are counted as part of the course distribution; the SREB group does not outline specific plans for this part of the curriculum. However, a survey of the amount of student time devoted to different types of educational experiences shows that in general, as the student progresses from the first to the fourth semester, there is a shift away from didactic/academic experiences, toward experiential/fieldwork experience. Overall, the student's time commitment in actual hours appears to be divided nearly equally between academic work and practicum-fieldwork experience. This is an overall balance quite similar to the Canadian and Michigan models.

It is difficult to judge, working from the general presentation of the SREB conclusions, just how generic or how immediate-employment related a program developed from this "core of competence" might be; in fact, one of the Board's objectives is to encourage varied programs which nonetheless all produce certain basic results. However, it can at least be said that a program designed on a generalist basis is likely to include more generic and less specialized courses, may permit the two-year graduate easier entree to a four-year institution, and leaves more specific training to on-the-job stages in the graduate's career.

The Council on Social Work Education Model— An Orientation to Continued Education[5]

The Council on Social Work Education, in cooperation with the American Association of Community and Junior Colleges, has proposed a program model for the training of community services technicians, with the intent of preparing students for employment in social services in the community, but also wherever possible permitting the student to continue onto higher education. In keeping

with this goal, the curriculum is extremely generic, and in general it appears that courses customarily found in a community college have been rearranged into a two-year community service technician package.

The student's time commitment and course credits in this model are:

General Education Core: 50% of the total program, somewhat over thirty credits, in:

Orientation, Freshman Composition, Biology or a science elective, Health and Physical Education (2 semesters), English Literature, American Government, General Psychology, Sociology, Economics, Humanities (2 semesters) and Public Speaking.

Supportive Social Science Core: 25% of the total program, between 16 and 18 credits, in:

Social Problems, Social Welfare as an Institution, and electives from courses such as the Family, Abnormal Psychology, the Culture of Poverty, Racism, (and so on).

Social Service Technical Core: 23% of the total program, between 14 and 16 credits, in:

Field experience (2 semesters), interviewing skills, group leadership skills, social change skills.

It is plain from this emphasis on coursework that further education is envisioned as a likely possibility for many students, either immediately or in the short-range future. In order to provide some potential for employment as an assistant in welfare agencies, municipal recreation programs, and others, there is some emphasis on social management skills and, of course, the general implicit emphasis on human and social dynamics and concepts.

The Denmark Training Model[6]

It is general knowledge in the developmental disabilities field that the Scandinavian countries have highly advanced programs for the handicapped, although this is not so well known outside the field. Direct care workers and others associated with the care of the handicapped are relatively well paid and have respected positions in the society.

In Denmark the care assistant is the worker with long-term contact with a number of handicapped clients, and the worker with overall responsibility for their development and well-being. The Danish government has developed a post-secondary curriculum and school specifically for training such personnel. The focus is on knowledge and skills involved in the care of both the aged and handicapped. The overall philosophy is that the trainee become equipped to provide "the social, pedagogical and practical support which may counteract, cure, or relieve the consequences of physical and/or mental retardation," and also

"to ensure the greatest possible support and contribute to the best possible well-being of the patient."

The course takes somewhat over three years, resulting in at least the potential for a higher level of training than is likely to be provided by a two-year A.A. degree program in the United States. A person entering the program must be at least 18 years of age, and must have had at least nine years schooling. A characteristic of the Danish program less often found in the United States is that practicum and academic sections of the program are not combined within the same study period—that is, there is a study segment, a work segment (perhaps involving the student's relocation for a period of some months), another study period, and so on. The usual Danish progression is as follows:

The Danish Program—38 Months Typical

Practical training—3 or 4 mos.	Theoretical training—5 mos.	Practical training—12 mos.
Theoretical training—5 or 6 mos.	Practical training—12 mos.	

The two 20-week theoretical training periods in the Danish sequence are structured on the basis of a 29 class-hour academic week, (an imposing schedule by United States standards). Subjects classified as "Pedagocial-Psychological" make up about a third of that total, with Psychology and Child Development given primary emphasis. The courses are structured to aid the trainees in understanding their handicapped countrymen, and aiding them in taking part in the daily life of institutions or in the community. Four hours with a sociological focus are devoted to giving the trainees a broad basic knowledge of social legislation and the structure of Danish relief programs, and, coordinately, a view of society from the handicapped person's point of view (in a course "Handicaps and the Handicapped Person" which helps widen the trainees knowledge of the physical and psychological consequences of a handicap). A five-hour "applied subjects" segment focuses primarily on specific techniques in daily living skills training, and secondarily on institutional administration.

The category "Social Medicine" contains another group of courses which prepare the student to assist the medical staff in daily treatment and training. Basic courses in anatomy/physiology and psychiatry are supplemented by applied ones in drugs and medication, physical therapy and working techniques, and occupational therapy and ergonomy.

Finally, another four-hour segment is devoted to training in leisure-time activities appropriate to the disabled—music, singing and rhythmic activities, and physical activities and games.

The extensive practical training segments of the Danish program are designed to provide both job practice and informative practice. In job practice periods, students form part of a normal duty team and participate in all practical and pedagogical work with disabled clients. This is done under expert instruction, but

with the students acting on a par with the regular staff. A variety of job practice assignments gives trainees a good idea of the entire care service, and allows them to explore their own capabilities in different types of care work.

In periods of informative practice the students do primarily in-depth observation of treatment and team-work practices in the field. The student is expected to participate in the routine to some extent, but most of the time is spent in getting a broadened experience and first-hand knowledge of a wide variety of methods and treatments.

In both types of practice periods, some clinical demonstrations and theoretical teaching is included, related to the work of the particular institution and that with individual clients. Both types of practice periods take place in the complete range of existing facilities of the Danish Regional Centers. Every type of ward is included, as are kindergartens, day-care centers, and workshops.

Summary

A number of dilemmas exist in planning programs designed to train direct-care workers in the developmental disabilities field. It is difficult to determine how much emphasis should be devoted to general courses, or to practicum segments which show the student a broad range of social programs, and how much should be devoted to highly specialized academic work and practicum experience. Choices are possible in the timing of academic and practicum segments. There are a variety of possible structures for practicum work itself, acknowledged to be a critical part of every program.

A number of approaches to these dilemmas have been reviewed. None, unfortunately, is directly comparable to any other because working groups have gone at the planning task in quite different ways. However, there does seem to be consensus that multiple levels of skill need to be arranged in a comprehensive manpower design, that competencies can be specified for training at different levels, that a major commitment needs to be made in any training program to a practicum, supervised by experienced and well-educated individuals—and that heavy commitment to practicum segments stressing applied skills makes immediate movement into further academic work problematical for the student, at the least. However, that "problem" may merely indicate that direct experience is so highly valuable in this field that career ladders ought not involve long academic training without interludes of field experience. Such is the implied verdict of the structure of the Canadian and Danish plans, and to a certain extent of the Michigan Institute's plan.

[1] Mase, Darrel J., "Problems in Training Program Development," in *Manpower and Mental Retardation, an Exploration of the Issues, Proceedings of The Banff International Conference*. President's Committee on Mental Retardation, Washington, D.C. 1969. (P.C., M.R., Washington, D.C. 20201).

[2] National Institute on Mental Retardation (Canada), *A National Mental Retardation Manpower Model*

(*Progress report on project 563-9-6, Welfare Grants Division*, Department of National Health and Welfare). National Institute on Mental Retardation, Toronto, Canada, 1972. (Kinsmen NIMR Building, York University Campus, Toronto, Canada).

[3] Institute for the Study of Mental Retardation, the University of Michigan, *Guidelines for the Preparation of Support Personnel (Proceedings of a Conference*, June 11, November 9th and 10th, 1970). (The University, Ann Arbor, Michigan, 1971.)

[4] McPheeters, Harold L. and King, James B. *Plans for Teaching Mental Health Workers; Community College Curriculum Objectives*. Southern Regional Education Board, Atlanta, Georgia, 1971. (130 Sixth St. N.W., Atlanta, GA. 30313).

[5] Council on Social Work Education, *The Community Services Technician—Guide for Associate Degree Programs in the Community and Social Services*. The Council, New York, 1970. (345 E. 46th St., New York 10017).

[6] Personnel Training School, (Denmark), *FLASH on the Danish National Service for the Mentally Retarded, Numbers 1 and 2*. The Personnel Training School, Copenhagen, 1974 and 1976.

Programs in Operation

A number of programs in operation in various sections of the United States are summarized briefly in this chapter. Many are directed specifically to training workers for the mental retardation field, but two have a somewhat broader focus. The reader will want to note the extent and organization of practicum segments of these curricula, and also make his or her own judgments as to their career-ladder implications, although, of course, such judgments are not very reliable unless made in the context of a knowledge of the overall manpower-utilization pattern in that particular section of the country where he or she is located. Many or all of the programs have doubtless evolved since the summaries the author used were made available to the Center in Mental Retardation, and readers wishing up-to-date information on any particular program should contact the college involved.

Mental Retardation Technician Program: Fort Steilacoom Community College, (Tacoma, Washington Box 99186)

Fort Steilacoom established two programs for training institutional, group home, and workshop staff in 1969, in cooperation with Rainier School. We outlined the A.A. Degree program, designed to be preparation "for middle management in an institution, group home, or other facility for the handicapped." The first year of this A.A. Degree program is also the basic program for the lower-level certificate. Although field experience is separately listed as a course only in the second year, it must be assumed that some of the courses listed for the first year have sessions operated in conjunction with Rainier School which provide some practicum experience.

The First Year Courses

Required

Art	110	Art Activities	3 credits
Educ	113	Introduction to Children's Literature	3

Eng	52	Written Communications (Prereq: Eng. 51, text, or equivalent)	3
MM	193	Basic Supervisory Certification	3
MR	53	Introduction to Mental Retardation	2
MR	163	Methods of Observation and Evaluation I	3
MR	164	Methods of Teaching the M/R	3
Mus	205	Music for Children	3
PEP	91	Health—Personal and Community	3
PEP	206	P.E. Activity—Elementary Level	2
PEP	272	Industrial First Aid	2
PEP	276	Advanced Industrial First Aid	1
PEP	278	Safety for the Handicapped	1
Psych	71	Elementary Psychology	3
Psych	163	Behavior Modification I	3

Suggested Electives

Eng	50	Early Language Development	3 credits
Eng	51	English Workshop	3
Eng	53	Oral Communications	3
MR	90/91	Sign Language, Beg./Adv.	2
Zool	51	Human Structure and Function	3

The Second Year Courses

Required

MM	194	Supervisory Development	3 credits
MR	173	Methods of Observation and Evaluation II	5
MR	201	Field Experience Community Involvement Community Placement Education—Teacher's Aide Foster Parent Placement Occupational Training Physical Therapy Recreation	5 credits
Psych	115	Human Relations—Group Processess	3
Psych	164	Behavior Modification II	5
Psych	165	Behavior Modification III	5
Soc	120	Family Relationships	3

Suggested Electives

Hum	101/2/3	Humanities or Any Humanities Course	5 credits
MR	190	Task Analysis and Program Design	5
MR	202/203	Field Experience	5
Psych	201	Psychology of Adjustment	5
Soc Sci		Any Social Science Course	5
Soc	219	Child and Community	5

Many of the courses listed are generic in focus, according to the course descriptions provided by Fort Steilacoom Community College, but a few are more oriented to children and/or the retarded than their titles would indicate. For instance ART 110, Art Activities, is a study of art experiences for children, and could well involve practice sessions at the school. ENG 52, Written Communication, emphasizes the writing of reports. MR 163, Methods of Observation and Evaluation I, focuses on behavior modification with emphasis on program development and management for those with learning disabilities.

Child Development Technician Program, St. Mary's Junior College (2600 South 6th Street, Minneapolis, Minnesota 55406)

The St. Mary's program was designed to prepare personnel to assist professionals in the field of mental retardation, specifically in daytime activity centers, work activity programs, workshop programs, special programs within residential settings, and special education classrooms. Graduates complete a minimum of 90 quarter-credits in six quarters; approximately half in general education courses, and half in courses required within the Child Development Technican Program.

Practicum in the St. Mary's program is structured as part of one major program-required course each quarter. Just how much time is committed to the different practicum experiences by students is unclear.

The First Year Courses

		Credits
First Quarter:		
CDT 115	Fundamentals of Retardation I (Lecture 3 credits, practicum 2 credits)	5
BIO 11	Human Anatomy and Physiology	3
PSY 11	General Psychology	3
COMM 11	Communication in Society	3
	Medical Terminology	1
Second Quarter:		
CDT 125	Fundamentals of Retardation II (Lecture 3 credits, practicum 2 credits)	5
BIO 12	Human Anatomy and Physiology	3
PSY 21	Human Growth and Development	3
COMM 14	Oral and Written Communication	3
THEO 11	Contemporary World Religions	3
Third Quarter:		
CDT 136	Education of the Mentally Retarded (Lecture 3 credits, practicum 3 credits)	6

SOC 11	Man in Society I	3
	Humanities Area (Literature)	3
PSY 22	Psychology of Learning	3

The Second Year Courses

First Quarter:		Credits
CDT 216	Perceptual Disabilities (Lecture 3 credits, practicum 3 credits)	6
	Second SOC Course (Choice)	3
	Humanities Area (Art)	3
	Elective	3
Second Quarter:		
CDT 226	Introduction to Exceptionality (Lecture 3 credits, practicum 3 credits)	6
PSY 23	Psychology of Adjustment	3
Phil 22	Ethical Problems in the Health Fields	3
	Elective	3
Third Quarter:		
CDT 237	The Retarded Adolescent and Adult (Lecture 3 credits, practicum 4 credits)	7
	Humanities Area (history)	3
	Elective	3

The progression of involvements in practicum experiences appears to be well planned in the St. Mary's program. The first quarter is spent in the St. Michael Learning Center in an orientation program partly devoted to an introduction to the field and partly devoted to work with young retarded children. Experience in the second quarter is focused on program development and developmental observation of retarded children, followed in the third quarter by the student acting as assistant to a classroom teacher, and participating in all aspects of the classroom curriculum. This pattern is continued in the second year, with two quarters of placement in special education classrooms, and one in a facility for adolescent or adult retarded people.

The Mental Retardation Aide Program, Manchester Community College, (Manchester, Connecticut 06040).

This program involves little practicum experience in the first year, and a total of six credits assigned to practicum in the second year, making a smaller commitment to practicum training overall than some of the other programs examined, and considerably less than the models reviewed. However, the half-credit/semester mental retardation seminars provide an interesting approach to the

orientation phase of this type of curriculum, and a mental retardation clinical experience is also specified. This carries three credits, and is an intensive three-week on-site in-service session. It may be taken in either year, but Manchester Community College suggests that the Freshman year is a preferable time for this experience.

The First Year Courses

First Semester:		Credits
ENG 111	Introductory Composition (report writing)	3
BIO 151	Survey of Human Anatomy and Physiology	3
PSY 111	General Psychology I	3
	Elective (Liberal Arts & Sciences)	3
	Elective (Social Science)	3
	Mental Retardation Seminar I	½
Second Semester:		
ENG 112	Advanced Composition	3
	Elective (Math or Physical Science)	3
PSY	Characteristics of the Retarded	3
	Elective (Liberal Arts & Sciences)	3
	Elective (Social Science)	3
	Mental Retardation Seminar II	½

The Second Year Courses

First Semester:		Credits
PSY	Behavior Modification	3
Pub Serv 211	Social Service Methods I	3
	Mental Retardation Field Experience I	3
ENG 120	Introduction to Literature	3
	Elective (Free)	3
Second Semester:		
Pub Serv 212	Social Science Methods I	3
	Mental Retardation Field Experience II	3
Pol Sci 111		3
	Elective (Free)	6

The Developmental Disabilities Curriculum, Chabot College, (Hayward, California 94545)

Chabot College's curriculum, like that of St. Mary's in Minnesota, is organized on the quarter system. Exactly half of the required 9 units for the A.A. Degree in

Developmental Disabilities are required courses in the major, while half are in the general education segment of the college's offerings. In the terms of the models reviewed, a somewhat low time commitment appears to be made to practicum experience.

Freshman Year	Units A	W	S	Sophomore Year	Units A	W	S
DEVELOPMENTAL DISABILITIES 50 (Introduction to Child with Developmental Disabilities)	3			DEVELOPMENTAL DISABILITIES 63A-63B (Methods in Working with the Developmentally Disabled)	3	3	
DEVELOPMENTAL DISABILITIES 51 (Introduction to Learning Disabilities)			3	DEVELOPMENTAL DISABILITIES 67 (Developmentally Disabled Adult and the Community)			3
EARLY CHILDHOOD DEVELOPMENT 50 (Introduction to Early Childhood)	3			DEVELOPMENTAL DISABILITIES 95 (Work Experience)			1-2
EARLY CHILDHOOD DEVELOPMENT 61 (Literature for the Young Child)			3	DEVELOPMENTAL DISABILITIES 96 (Work Experience Seminar)			1
EARLY CHILDHOOD DEVELOPMENT 62 (Child, Family and Community)		3		EARLY CHILDHOOD DEVELOPMENT 64 (Play and Play Materials)	3		
HUMAN GROWTH AND DEVELOPMENT 70 (Prenatal to Early Childhood)		4		EARLY CHILDHOOD DEVELOPMENT 65 (Introduction to Administration of Early Childhood Program)			3
HEALTH 5 (Standard First Aid and Personal Safety)			1	EARLY CHILDHOOD DEVELOPMENT 90 (Supervised Experience)		3	
NUTRITION 11 (Nutrition for Human Development)			3	Physical Education 1	½	½	½
Physical Education 1	½	½	½	American Institutions (7 units)			
English Composition-Speech (7 units)				Humanities (4 units)			
Natural Sciences (4 units)				Social Sciences (4 units)			
Health Education (3 units)				*Electives (6½ units)			
*Electives (6½ units)							45 units
			45 units				

COURSES IN THE MAJOR MUST BE TAKEN IN SEQUENCE

*Electives to be selected from the following courses: Early Childhood Development 63A-63B (Early Childhood Curriculum), Recreation 65 (Recreation for the Physically Handicapped), Recreation 66 (Recreation for the Mentally Handicapped), Physical Education 1 (Physical Education for the Handicapped), Psychology 33 (Personal and Social Adjustment), Human Services 5C (Behavior Modification), Human Services 5B (Individual and Group Use of Transactional Analysis), Speech 28 (Normal Language Development).

The graduation requirement for mathematics must also be met. Chabot College A.A. Degree (total units required—90).

A one-year program might be offered, particularly for students in other degree programs other than paraprofessionals and professionals, that would concentrate on developmental disabilities and early childhood education courses only. The following is a list of suggested courses for the quarter system in a one-year program.

DEVELOPMENTAL DISABILITIES

	UNITS
Developmental Disabilities 50 (Introduction to the Child with Developmental Disabilities)	3
Developmental Disabilities 51 (Introduction to Learning Disabilities)	3
Developmental Disabilities 63A-63B (Methods in Working with the Developmentally Disabled)	6
Developmental Disabilities 67 (Developmentally Disabled Adult and the Community)	3
Developmental Disabilities 95 (Work Experience)	1-2
Developmental Disabilities 96 (Work Experience Seminar)	1
Early Childhood Development 50 (Introduction to Early Childhood)	3
Early Childhood Development 62 (Child, Family and Community)	3
Human Growth and Development 70	4
Nutrition 11 (Nutrition for Human Development)	3
Total units required— (Certificate of Achievement)	34

The Associate in the Science of Human Services Program, St. Petersburg Junior College, (St. Petersburg, Florida, 33733)

The St. Petersburg program gives a broader core of academic work than some of the other programs reviewed, but provides for student specialization in the areas of mental retardation, mental health, or social services, primarily through the

opportunity for students to specialize in practicum work. Freshmen spend nearly one full working day per week in agency assignments, while sophomores spend two days per week, each semester's practicum assignment running 15 weeks. Particularly if a student has not made a clear and well-justified choice of specialization, the staff makes an effort to provide assignment to a different agency each semester.

First Year Courses

First Semester:		Credits
EH 130 or 140	Communication I (or composition)	3
Human Serv. 101	Introduction to Social and Intellectual Exceptionalities	1
Human Serv. 110	Field Experience in Human Services (lab.)	2
PSY 132	General Psychology	3
SY 226	Introductory Sociology	3
Human Serv. 102	Introduction to Human Services	2
PE 258	Body Mechanics	1
Second Semester:		
EH 131 or 141	Communication I (or composition)	3
Human Serv. 103	Roles and Functions of the Human Service Worker	1
Human Serv. 104	Treatment and Management Procedures in Human Services	2
Human Serv. 111	Field Experience in Human Services (lab.)	2
PSY 210	Child Development	3
SY 227	Social Problems	3
BS 160	Biological Sciences	3

Second Year Courses

First Semester:		
HH 297	Standard First Aid	2
PSY 211	Adolescent Development	3
SD 146	Fundamentals of Speech	3
Human Serv. 202	Family, Community, and Institutional Dynamics	3
Human Serv. 210	Field Experience in Human Services (lab.)	4
Elective		3
Second Semester:		
GT 152	American Government I	3
PSY 240	Personality Development	3
PE	Physical Education	1

80

Human Serv. 204	Advanced Study of Treatment and Management Proced ures in Human Services	3
Human Serv. 211	Field Experience in Human Services (lab.)	4
Elective		3

The Mental Health Technician Program, Miami-Dade Community College North (Miami, Florida 33156)

This program, as well as the St. Petersburg program, are examples of the Southern Regional Education Board approach to intermediate mental health worker training, discussed in the previous chapter. Graduates of the program are qualified to function under supervision in social agencies, mental health programs, agencies for child care or senior citizens, as well as in facilities for the mentally retarded or other developmentally disabled. A major commitment to a practicum or "externship" is made in the second year, with nine credits each of two terms given for that experience, and two credits each term for the associated seminar.

First Year Courses

Fall Term:		Credits
ORI 101	Orientation	1
MEH 160	Introduction to Mental Disabilities	3
MEH 161	Survey of Community Resources	3
SOP 210	Human Relations	3
APC 160	Expository Writing	3
HEN 210	First Aid	2
Winter Term:		
MEH 162	Materials and Activities	3
NEH 180	Orientation in Comm Mental Health	3
PSY 241	Human Growth and Development	3
PRN 120	Body Structures and Function	3
SSS 101	Social Science	3
Spring Term:		
MEH 170	Recreation for Special Groups	3
PSY 212	Dynamics of Behavior	3

Second Year Courses

Fall Term:		
MEH 288	Seminar I	2

MEH 298	Externship I	9
PSY 211	Introduction to Psychology	3
SSS 102	Social Sciences	3
SOC 201	Introduction to Sociology	3
Spring Term:		
MEH 289	Seminar II	2
MEH 299	Externship I	9
SOC 220	Marriage and the Family	3
APC 161	Technical Report Writing	3
	Elective	3

The University of North Carolina Developmental Disabilities Training Institute: A leader in in-service short-term training

It has been suggested that in-service programs are probably not the best long-term answer to adequate training of direct-care workers; nonetheless, they will continue to have a role to play in a manpower training and retraining system for some time to come, and it is quite possible that such programs will have greater effectiveness as they are further developed. One highly developed in-service staff training program is that offered through the North Carolina Institute. Since its inception in 1963, the Institute has conducted more than 200 short-term training programs for over 6,000 trainees. Each program is typically two to four and one-half days in length. Topics which community colleges might consider modifying for their own uses, perhaps in an in-service "event" aimed at building bridges between students and care-workers in the area, have included the following:

Mental Retardation—Nature and Management
Working with Parents and Siblings of Developmentally Disabled Persons
The Role of Developmental Disability Councils in the Development of a Comprehensive Array of Services to Developmentally Disabled Persons
Administration of Preschool Programs for Developmentally Disabled Children
Teaching Preschool Age Developmentally Disabled Children
Administration of Activity Centers Serving Developmentally Disabled Adults
Teaching Developmentally Disabled Persons in Activity Centers
Administration of Sheltered Workshops Serving Developmentally Disabled Persons
Vocational Evaluation of Developmentally Disabled Persons
Vocational Adjustment Services for Developmentally Disabled Adults
Application of Behavior Modification in Developmental Disabilities
Implementing the Normalization Principle in Developmental Disabilities
Community Residential Programs for Developmentally Disabled Persons
Employment Placement of Developmentally Disabled Persons

Coordination of Community and Institutional Programs Serving Developmentally Disabled Persons
The Use of Counseling the Developmentally Disabled Persons
The Delinquent Developmentally Disabled Person
Serving Developmentally Disabled Youth in Cooperative Programs Between Special Education and Vocational Rehabilitation
Vocational Rehabilitation of Developmentally Disabled Persons
Institutional Services to Developmentally Disabled Persons
On the Design and Implementation of In-Service Training Programs for Persons Working with Developmentally Disabled Individuals
Rehabilitation of Adolescent and Adult Developmentally Disabled Persons

The Community Care Television Project, Instructional TV Consortium of the California State University and Colleges, California State College, Sonoma (Rohnert Park, California 94928)

Developed in cooperation with the Department of Health, State of California, this Project involved an in-service, locally-accessible training design with 26 half-hour TV programs and supporting study materials. The first part of the program included 16 half-hours, the second 10. Among topics covered in detail are self-help skills and their teaching, safety and hazard orientation to home-environment settings, behavior problems, including a focus on approaching behavior change through the setting of objectives, and reinforcement techniques for new behaviors, sexuality and the mentally retarded, planning recreation and leisure activities for the disabled, pre-transition training, and aspects of team planning.

The Macomb-Oakland Residential Center In-Service Program, (Fraser, Michigan 48026)

This series of programs is unusual in that it was initiated by a State of Michigan residential facility, and is planned and offered in cooperation with the Oakland Community College. The program also involves the cooperation of the state hospital system, and resource people for it are often drawn from the state system. Topics treated so far are: orientation to mental retardation, fire and safety considerations in facilities, problems in maintaining a healthy environment, elements to be considered in programming, relations with families of the disabled, methods of influencing behavior, and perspectives on administrative responsibility. Sexuality of the handicapped and vocational training considerations have also been treated.

Summary

Programs in current operation in the field are quite diverse, providing varying amounts of academic background, field experience, and specialization. Presumably much of the diversity represents accommodation to local needs and the particular interests of students, and probably also accommodation to the structure of service agencies and the availability of work experience assignments in the service structure. Some of the apparent diversity is probably due to varying amounts of detail provided for this report. It should be emphasized that all programs of this nature should be dynamic, evolving in response to change in service structures and the general needs of the community. Once in contact with those agencies and advocacy groups for the developmentally disabled, in fact it will be difficult for the college to hold to an unchanging program design. Whatever the name of the program, and its structure at a given time, the response of the community will be the most valid measure of its appropriateness.

Summary and Recommendations

The staff of the Center in Mental Retardation, in the course of its research, has developed a number of convictions about how direct-care workers for the developmentally disabled should be trained in the years to come, and how community colleges may best participate in that effort. Many of these convictions are apparent in a number of sections of the manuscript, but it seems worthwhile to summarize some of them topically in this final chapter.

Need for Programs in General

Many community colleges will be serving their areas well by making an effort to become involved in the developmental disabilities field. The developmentally disabled and their families are a needful minority. Service to and care for the developmentally disabled in our nation can stand considerable improvement and attention.

It is generally accepted that occupations related to the delivery of human services (as part of a movement toward services in general) will expand in the late 1970's and 1980's, and beyond. Despite this, and the general need we have summarized, not every college should undertake a training program in the delivery of human services, or in direct-care training. Each college must develop its own local needs assessment mechanism, to see in part where its community stands in terms of a developing need for trained workers. Although there is a national shortage of *trained* manpower, some communities will not yet have reached the stage of demanding trained manpower for facilities for the developmentally disabled.

Involvement with Local Organizations

Assessing the level of demand for newly and more adequately trained workers will almost certainly lead the college's planners to local groups serving the developmentally disabled and advocating for them. We believe that a strong and prolonged involvement with such groups will give the college data about current needs, and, these groups may be able to increase the demand for trained manpower, and generally integrate the proposed training program into the broader network of developmental disabilities services and groups.

Through Local Organizations to National Organizations

National advocacy organizations, in particular, will be working for nationwide standardization of service and personnel requirements, through accreditation mechanisms, and credentialling programs, as well as other means. The college should remain conscious that the long-term interests of its graduates are well-served by contact with such groups, through their local and state chapters.

Basic Program Model

By far the largest number of those individuals who are developmentally disabled do not require continuous medical or nursing care. They do require habilitation education and social skill training. Medical and nursing skills are only a minor part in training for the developmental approach.

For this model, an appropriate training program should place stress on educative social and vocational training. Training should be directed at enhancing the service deliverer s ability to understand the living problems encountered by the developmentally disabled as he moves through the community. The teaching of self-help and community living skills to the developmentally disabled should have the highest priority.

Generic Versus Specialist Programs

There are many generic components to the knowledges and skills necessary in working with the developmentally disabled. Some of the developmental disability areas which appear to have common skill needs are mental retardation, multiple handicaps, behavior disorders, and learning disabilities. Deafness, blindness, and more general social maladjustment are types of handicaps which require some similar skills to those appropriate to working with the developmentally disabled.

However, it may be asking too much to expect a program to be so generalized that its graduates supposedly might move into community recreation programs or welfare agencies as readily as into a facility for retarded children. The *developmental* aspect of mental retardation, or those disabilities resembling mental retardation, is a critical one for students to explore and master; specific perspectives and techniques are appropriate. A curriculum designed to cover an area of social or helping services that is too broad is not likely to ground students in necessary skills. If specialization is to be combined with a broad generic program, it may be achieved by a major commitment to practicum experiences.

Experiential Parts of the Program

It is our feeling that carefully supervised experiences should constitute at least 50 per cent of the program, with the remaining 50 per cent devoted to academic and skill training. Supervision should be provided by a trained person who has had experience in the direct daily care of the developmentally disabled. The supervisor should be responsible for no more than 15 trainees. The supervisor should be able to integrate theory with practice and should be on the staff of the community college. The practicum experience should rotate from agency to agency among the various developmental disabilities during the first year. However, during the second year the student should specialize in one or two of the disability areas.

In-Service Training

The training of staff within existing community facilities is of prime importance, although, as we have suggested, research indicates that structuring a truly effec-

tive in-service program is a major challenge. It is possible that a community college can use a series of in-service sessions, perhaps combined with public workshops, to begin and deepen involvement with the developmental disabilities service and advocacy groups in the area, as well as with staff and management of care facilities, such involvement leading eventually to the establishment of a full pre-service program. Certainly college involvement with successful in-service programs creates a sound basis for moving toward the full-scale program.

Career Ladder Considerations

It is hoped that many of the trainees in these programs will choose to operate effectively as direct-care personnel, with one or two years of community college training. However, the opportunity to continue in further training should be established in some way. We have identified this a major problem in the design of programs which must at the same time focus on directly applicable skills. Solving this problem will eventually involve bringing institutions likely to give higher-level training, and local and state agencies, together to create a full manpower training, utilization, and career systems model. With its conceptionalization of four definable manpower-training levels, the model proposed by the Canadian Institute is a basis for further thinking along these lines. Certainly the college alone will not be able to create a career-system model, but should be involved with other entities in working toward one. Such a model will not only be in the long-run interests of graduates, but in the interests of rational and humane service to the disabled as well.

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