PRINCIPLES OF HABILITATION

Introduction

Welcome!
This introduction is intended as a guide to get you started on the journey to completing Principles of Habilitation, either as a DODD approved 30-hour seminar or as a 2-hour course for college credit.

Because this is a correspondence course, the seminar is designed to rely on you to self-direct your own learning. In a typical face-to-face learning environment, most of our time would be spent on the instructor sharing information with you ("lecturing"), small group activities, and discussion on the various topics, in which you would respond to questions about the topics as well as listen to other participants’ responses. Because this is a correspondence course, you will be asked to read the information in this Manual, review various web sites, watch a number of videos, and to respond to questions by writing rather than talking.

Course Materials
The syllabus and assigned reading materials for this course are included as part of this Manual. Links to additional assigned reading materials and to assigned videos are also included in this Manual. All written assignments that you are required to submit to NOWAC are included in the Workbook that accompanies this Manual.
You may submit these items electronically to NOWAC via email to michelle@nowac.com, or hard copies via snail mail to NOWAC, Michelle Vogelsong, 1804 Elmwood Dr., Defiance, OH 43512.

Questions?
We have tried to make this course as simple to follow and navigate as possible, but we recognize that it may not be as self-explanatory as we hoped. If at any time you are confused or have questions about any of the assignments, please do not hesitate to contact NOWAC via an email to Deb@nowac.com.

What’s Next?
Your next step is to review the course syllabus (below). Please read the first two pages of the syllabus closely and scan the Assignments on the remaining pages.

Ready to Begin!
After looking over the syllabus, you are ready to get started with the assignments in Section I.

We hope this is an enjoyable and positive learning experience that will enhance your work with people with developmental disabilities!
PRINCIPLES OF HABILITATION PROGRAMMING

SYLLABUS

Instructor: Brenda Oyer  
Email Address: Deb@nowac.com  
Phone: 419-782-4006

Course Organization and Objectives
The course is divided into four sections.

1. Habilitation Overview
   - **Objective 1A:** Define habilitation.
   - **Objective 1B:** Distinguish habilitation programming from sheltered work productivity objectives.

   - **Objective 2A:** Distinguish vision/desired outcome from goals and objectives.
   - **Objective 2B:** Reconcile the concept of self-determination with assessment and evaluation.

3. Developing an Individual Plan
   - **Objective 3:** Write a statement of desired outcome or vision, a goal, and two or more objectives from a case study.

4. Training Methods
   - **Objective 4:** Demonstrate an example of task analysis, assigning support intensity types to each step.

The time it will take to complete each section is indicated under “Assignments” below. Please complete the assignments in the order listed.

Assignments and Time Frames
The assignments for this course are divided into 4 sections. The assignments for each section are listed below. Please note that each section has a designated amount of “total time” for completing its assignments. The amount of time you spend on each specific assignment is very flexible. However, it is very important that the total time you spend on each section matches the “total time” required for that section. You will notice that the “total time” required for all 4 sections adds up to 30 hours. Our goal is that you devote 30 hours of time to this course—not less, but also not more than that. To ensure that you meet this goal, **it is very important that you review the Time Management Tips below. Please note that you are allowed up to 10 minutes of “break” time per hour that you spend on this course.**

Activities and Reflections Exercises (Ungraded)
As indicated in the Assignments section (below), each section includes one or more “Activities” and a “Reflections Exercise.” The purpose of the Activities and Reflections Exercises is for you to relate the material to your job and thereby make the material meaningful to your daily work with people with developmental disabilities. Although the Activities and Reflections Exercises are not graded, you must complete them in order to receive credit for completing the course.
Tests
The course includes four tests—one for each section. The tests are located in the course Workbook.

Time Tally Sheets
You will need to complete a Time Tally Sheet after completing the assignments for each section, to submit with the written assignments related to that section. Time Tally Sheets can be found in the Workbook accompanying the course Manual.

Final Paper
Students taking this course for college credit are required to write a 3-5 page double-spaced paper following completion of all other assignments. The paper should be typed using Times New Roman 12-point font, with 1-inch top, bottom, and side margins. Please refer to the following scoring rubric.

Final Paper Scoring Rubric

<table>
<thead>
<tr>
<th>Scoring Criteria</th>
<th>Points</th>
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<tbody>
<tr>
<td>The paper included a description of an individual served, including diagnosis, and vision statements for living, working, and playing/participating in the community.</td>
<td>20</td>
</tr>
<tr>
<td>The paper included a description of the individual’s strengths and needs (including health and safety issues) as relevant to the attainment of his/her vision for living, working and playing/participating in the community.</td>
<td>20</td>
</tr>
<tr>
<td>The paper identified resources for assisting the individual with attaining his/her vision for living, working and playing/participating in the community. Such resources may include paid supports, natural supports, and generic services/community resources.</td>
<td>20</td>
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<tr>
<td>The paper included a description of the individual’s planning team (protecting anonymity), and an analysis of the extent to which the individual’s planning process was consistent with the concepts of self-determination, informed choice, and free choice of provider.</td>
<td>30</td>
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<tr>
<td>The paper was written with appropriate grammar, spelling, and punctuation.</td>
<td>10</td>
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Total Points 100

Submitting Assignments
After completing the written assignments listed for each section (found in the Workbook accompanying this Manual), please submit them to us either electronically via email, or hard copies via snail mail.

Grading (Applies only to those taking the course for college credit)
Grades will be based upon completion of all assignment in the course Workbook, and on scores on the Post-tests and final paper. A total of 250 points is possible, based on the following assignments:

<table>
<thead>
<tr>
<th>Test/Section #</th>
<th>Possible Points</th>
<th>Test/Section #</th>
<th>Possible Points</th>
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<tbody>
<tr>
<td>1</td>
<td>20</td>
<td>3</td>
<td>60</td>
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<tr>
<td>2</td>
<td>30</td>
<td>4</td>
<td>40</td>
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Final Paper: 100 possible points
Grades will be assigned as follows:

- **A** = 90-100% (225-250 points)
- **B** = 80-89% (200-224 points)
- **C** = 70-79% (175-199 points)
- **D** = 60-69% (150-174 points)
- **F** = Below 60% (149 points or less)

No grade will be assigned until all non-graded assignments in the course Workbook (i.e., Activities and Reflections Exercises) have been completed and submitted.

**Assignments**

<table>
<thead>
<tr>
<th>Preliminary Activity</th>
<th>Total Time: 30 minutes</th>
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<tbody>
<tr>
<td><strong>Topics</strong></td>
<td></td>
</tr>
<tr>
<td>Course Introduction/Review syllabus</td>
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<table>
<thead>
<tr>
<th>Section 1: Habilitation Overview</th>
<th>Total Time: 3 hours, 30 minutes</th>
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<tbody>
<tr>
<td><strong>Topics</strong></td>
<td></td>
</tr>
<tr>
<td>Definition of habilitation</td>
<td></td>
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<tr>
<td>History of habilitation programming in Ohio</td>
<td></td>
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<tr>
<td>Challenges in the modern day habilitation environment</td>
<td></td>
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<td>Day habilitation as a Medicaid HCBS waiver service</td>
<td></td>
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<tr>
<td>Distinguishing habilitation programming from sheltered work productivity objectives</td>
<td></td>
</tr>
<tr>
<td>Down time; boredom</td>
<td></td>
</tr>
<tr>
<td>Creativity; community membership</td>
<td></td>
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<tr>
<td>Providers</td>
<td></td>
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<tr>
<td>Connection between Adult Day Services and community/supported employment</td>
<td></td>
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<tr>
<td>Ohio Administrative Code 5123:2-9-16 (HCBS Waivers – Supported Employment)</td>
<td></td>
</tr>
<tr>
<td>Ohio’s statutes, rules, policies and waiver assurances regarding day habilitation</td>
<td></td>
</tr>
<tr>
<td>Ohio Administrative Code 5123:2-9-17 (HCBS Waivers – Adult Day Support and Vocational Habilitation)</td>
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<tr>
<td>Conditions for provision of day habilitation as a waiver service</td>
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<tr>
<td>Coordinating day habilitation with therapies, a behavior support plan, and other services</td>
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**Assessment**

- Complete Post-Test 1*
- Complete Activity 1A and either 1B or 1C*
- Complete Section 1 Reflections Exercise*

* Found in the accompanying course Workbook
Section 2: Habilitation in the Context of Individual Planning  
**Total Time: 10 hours**

**Topics**
- General Guiding Philosophies
- Single Coordinated Planning
- Developing a vision of an individual’s optimal self-determination and empowerment
- Health and safety issues
- Understanding informed decision-making and informed choice
- Free choice of provider and informed choice
- Assessment and evaluation
- Utilizing natural supports, generic services, and community resources

**Assessment**
- Complete Post-Test 2*
- Complete Activity 2A, 2B, and 2C*
- Complete Section 2 Reflections Exercise*

Section 3: Developing an Individual Plan  
**Total Time: 12 hours**

**Topics**
- Identifying vision/desired outcomes with the circle of support
- Writing individualized statements of desired outcomes, goals, objectives, strategies, resources, measures, and progress notes
- Goal domains: living, working, playing/participating, learning, etc.
- Objective domains (as appropriate to the individual): self-care; communication; socialization; safety; perceptual motor skills; functional arithmetic (i.e., numerals, money, measurement, time); behavior support; vocational skills; community experience; using adaptive technology; daily living skills

**Assessment**
- Complete Post-Test 3*
- Complete Activity 3A and 3B*
- Complete Section 3 Reflections Exercise*

Section 4: Training Methods  
**Total Time: 4 hours**

**Topics**
- Systematic methodologies
  - Task analysis
  - Levels of prompting/intensity in supporting task outcomes
  - Forward and backward chaining
  - Reinforcement
  - “Try Another Way”
- Partial participation

**Assessment**
- Complete Post-Test 4*
- Complete Activity 4
- Complete Reflections Exercise 4*

* Found in the accompanying course Workbook
TIME MANAGEMENT TIPS

For the assignments in each Section, follow the steps below to ensure you spend the designated amount of time for each section. Use the Time Tally Sheet in the course workbook to record the time you spend on each assignment.

First: Complete the Post-Test for that section, using the materials from the manual to help you answer the questions. After finishing the Post-Test, record the amount of time you spent on the Post-Test, including the time you spent reviewing materials to help you answer the questions.

Second: Complete the Activity(ies) assigned for that section (listed in the course workbook). Do your best to stay within the amount of time given for the Activities. Then record the amount of time you spent on the Activity(ies) for that section.*

Third: Add the time you spent on the Post-Test and the time you spent on the Activities.

Fourth: Spend whatever time you have left for that section answering one or more questions on the Reflections Exercise for that section (found in the course workbook). This should include any additional time you spend reviewing materials, videos, etc. from the manual.

*If the Activities take more time to complete than the designated time, please contact NOWAC, so we can help you determine how to complete the section without significantly going over the total time designated for that section.

Example: The total time designated for Section 2 is 10 hours.
1. Time spent completing the Section 2 Post-Test (including reviewing the materials from the manual): 3.5 hours
2. Time spent completing the Activities for Section 2: 4.5 hours
3. Total time spent on the Post-Test and Activities: 3.5+4.5=8 hours
4. Spend the remaining 2 hours for that section answering one or more of the Reflections Exercise questions (including reviewing the materials, videos, etc. from the manual).

The total time required for the course is 30 hours.
Section 1: Habilitation Overview

NOTE: Total time designated for this section is 3 hours and 30 minutes.

Assignments for Section 1, located in the course Workbook:
- Section 1 Post-Test
- Activity 1A (required); Activity 1B or 1C
- Section 1 Reflections Exercise

Definition of Habilitation (http://medical-dictionary.thefreedictionary.com/habilitation)
“the process of supplying a person with the means to develop maximum independence in activities of daily living through training or treatment”

Habilitation, according to the Ohio Revised Code (Section 5123.01)
“Habilitation” means the process by which the staff of the institution assists the resident in acquiring and maintaining those life skills that enable the resident to cope more effectively with the demands of the resident’s own person and of the resident’s environment and in raising the level of the resident’s physical, mental, social, and vocational efficiency. Habilitation includes but is not limited to programs of formal, structured education and training.

Habilitate (1) (http://www.merriam-webster.com/dictionary/habilitate)
- to make fit or capable (as for functioning in society)
- to qualify oneself

Habilitate (2) (http://www.yourdictionary.com/habilitation)
- to clothe; equip; outfit
- to train; make capable

History of Habilitation Programming in Ohio
Prior to 1967, the State’s role in providing habilitation programming in Ohio was largely limited to institutional settings that primarily operated under a medical model of service delivery (see diagram below). Examples of these institutional settings included the Ohio School for the Blind and the Ohio School for the Deaf. People with developmental disabilities were often placed in institutions or large residential facilities along with other people (such as those with mental illnesses, physical disabilities, etc.) when their families were no longer able to care for them in their own homes. In addition to providing basic care, the most progressive of these institutions also provided some type of habilitation programming, in which staff worked with the residents to help them develop their skills in various life activity areas (e.g., self-care, functional academics, communication, etc) with the goal of helping them become more independent. In some places, sheltered workshop programs were available for people with disabilities who were unemployed. The sheltered workshops provided socialization and vocational habilitation opportunities for people with disabilities who would otherwise be confined to their homes during the day.
In 1967, Ohio Senate Bill 169 created County Boards of Mental Retardation to assume administrative responsibilities of the education and workshop programs previously exercised by Ohio child welfare or public welfare boards. The bill also authorized local subdivisions (e.g. counties) to levy property taxes to maintain schools, training centers, workshops, clinics, and residential facilities for persons with mental retardation. The effect of SB169 was to create a Board of Mental Retardation and Developmental Disabilities (MR/DD)* in each of the 88 counties in Ohio.

*NOTE: In 2009, Ohio Senate Bill 79 removed the term "mental retardation" from the titles of state agencies, county boards, councils, commissions, and various funds that used the term. As a result, what were formerly known as County Boards of MR/DD are now officially referred to as County Boards of Developmental Disabilities in all 88 counties in Ohio.

As a result of the creation of County Boards of MR/DD, most (if not all) counties in Ohio began providing sheltered workshop programming for people with developmental disabilities (dd). These workshops focused on vocational habilitation of people with dd, through offering a variety of services, including “prevocational training” (simulated work which was unpaid) and simple assembly-type work that was paid on a piece-rate basis. Other types of vocational habilitation programming commonly offered included janitorial training and food service training. As resources were available, some sheltered workshops also offered habilitation programming in communication, functional academics, and physical development.

In Northwest Ohio, the Williams, Henry, Fulton, and Defiance County Boards of MR/DD combined their resources to jointly provide vocational habilitation programming for people with dd in the four-county area. The result of this effort was the creation of Quadco Rehabilitation Center. While the four County Boards of DD continue to offer habilitation programming at Quadco, they also offer other options to individuals with dd.

While sheltered workshops focused primarily on vocational habilitation programming for people with dd, residential facilities provided habilitation programming in other life skills areas such as self-help (bathing, grooming, dressing, etc) and daily living (cooking, cleaning, laundry, etc.).
Residential facilities also provided habilitation programming in communication, functional academics and physical development as resources allowed.

In the 1980s, the State of Ohio partnered with the federal government to provide Home and Community-Based (HCBS) waiver services to individuals with dd. HCBS waivers allowed individuals with dd to receive Medicaid-funded residential services in small community-based homes, rather than large institutions. For individuals living in the community via HCBS waiver funding, their habilitation programming in sheltered workshops could now be partially funded by Medicaid. More specifically, County Boards of DD were able to receive Medicaid reimbursement for part of the cost of providing habilitation services to those individuals.

The specific types (and names) of non-residential, “Day Habilitation” services that have been eligible for Medicaid reimbursement have changed several times in recent years. Perhaps most importantly, such funding is no longer limited to services provided by traditional sheltered workshops or to programs provided by County Boards of DD.

Currently, for individuals who are enrolled on an HCBS waiver, County Boards of DD can receive partial reimbursement for any services that meet the definition of “Adult Day Services,” (formerly referred to as “Day Habilitation”) which includes “Adult Day Support” and “Vocational Habilitation.” “Vocational Habilitation” refers to services designed to teach and reinforce habilitation concepts related to work including responsibility, attendance, task completion, problem solving, social interaction, motor skill development, and safety. “Adult Day Support” services refers to non-vocational day services needed to assure the optimal functioning of individuals who participate in these activities in a non-residential setting.

Historically, then, sheltered workshop vocational programming has typically focused on improving an individual’s work-related productivity. The primary objective for such programming was to help the individual improve the quantity (speed) and/or quality (accuracy) of their production. “Vocational Habilitation” services are now provided to individuals whose daytime services are primarily work-related (but not specifically focused on productivity per se), and those services may support productivity objectives for those individuals. “Adult Day Support” services, on the other hand, have a non-vocational focus.

In contrast to the medical model, the current model of service delivery is known as the Social model, as illustrated in the following diagram.
As mentioned previously, Adult Day Services (formerly known as Day Habilitation services) are a Home and Community-Based waiver service under Medicaid. As such, County Boards of DD receive partial reimbursement for the cost of providing Adult Day Services to individuals receiving HCBS waiver services. Those reimbursements help offset the cost of such services to local taxpayers. However, such funding comes with many “strings attached” in the form of additional rules and regulations governing how services are provided and documented.

The rule defining Adult Day Services describes specific requirements for providing these services. (You will be asked to read this rule later in this section.) While some of these rules are not new for County Boards of DD because they have already been required by the State of Ohio for many years, others—particularly requirements related to service documentation—are new. For many County Boards, ensuring that each and every one of these requirements is met can be quite challenging.

Another challenge in the modern day habilitation environment is that of “downtime” and boredom. Sheltered workshop objectives for individuals with dd have typically focused on increasing their work-related productivity. In order to meet those objectives, the workshop must be able to provide work for individuals with dd. In the past, sheltered workshops have typically been able to provide manufacturing/assembly-type jobs. As America has changed from a manufacturing-based economy to a service-based economy, it has become increasingly difficult for sheltered workshops to continue finding and providing those types of jobs to its workers. Consequently, the individuals who attend sheltered workshops often don’t have work to do, a situation commonly referred to as “down-time.” Of course, when there is no work to do, individuals with disabilities soon become bored, just like anyone else would in that situation.

To avoid such boredom, it is essential that Adult Day Services providers creatively design programs/services that actively engage individuals in meaningful activities, whether those activities are vocational or social, or otherwise promote some kind of opportunities for new learning.
Creativity is also needed to think of new ways in which individuals can participate in meaningful ways as contributing members of their communities. In recent years, people with disabilities have become increasingly more included in their communities—in schools, in work settings, and in places of worship and other community groups. Adult Day Services providers are challenged to design services that creatively promote the inclusion and community membership of individuals with dd.

A third challenge for County Boards of DD is working cooperatively with agency providers, especially with those who may be competing with County Boards in the arena of Adult Day Services. Until a few years ago, only County Boards of DD were able to provide vocational and other day habilitation services that were Medicaid-reimbursable. Today, however, any agency can become a certified Adult Day Services provider, as long as it meets the relevant rules and regulations. Consequently, County Boards of DD are challenge now more than ever to provide high-quality services that individuals with dd and their families need and want. If an individual is dissatisfied with his/her services from the County Board of DD, he or she may choose another Adult Day Services provider.

At the same time that County Boards of DD are competing with other providers, they also must work cooperatively with them. The County Board's Service and Support Administrators are responsible to write an Individual Service Plan for each individual served by the County Board of DD and to ensure each individual's health and safety. In order to do this, they must have a cooperative working relationship with all agencies that provide services to individuals with dd.

Connection Between Adult Day Services and Community/Supported Employment

As part of the array of Adult Day Services, County Boards of DD may also receive Medicaid reimbursement for “Supported Employment” services provided to individuals on an HCBS waiver. Supported Employment services are intensive, ongoing supports that help people with dd perform work in a regular employment setting, including self-employment. Supported Employment does not include sheltered work or other vocational services furnished in specialized facilities.

There are two types of Supported Employment services: (1) Enclave -- provided to individuals who work as a team at a single work-site (community business or industry) with ongoing support provided by on-site staff (including mobile work crews); (2) Community -- provided to individuals who work in an integrated community work setting, alongside employees without disabilities, and performing the same or similar tasks.

For more information on Supported Employment services, click on this link to the rule related to these services: [http://dodd.ohio.gov/rules/PDF/5123_2-9-16.pdf](http://dodd.ohio.gov/rules/PDF/5123_2-9-16.pdf)

If you have trouble accessing this link, you can also go to [http://dodd.ohio.gov/adults/community.htm](http://dodd.ohio.gov/adults/community.htm) and click on "HCBS Waivers—Supported Employment-Enclave and Supported Employment-Community."
Ohio’s Statues, Rules, Policies and Waiver Assurances
Regarding Day Habilitation

To better understand Adult Day Services, please click on the following link and review the Ohio Administrative Code’s rule related to Adult Day Services:
http://dodd.ohio.gov/rules/PDF/5123_2-9-17.pdf

If you have trouble accessing this link, you can also go to http://dodd.ohio.gov/adults/community.htm and click on “HCBS Waivers—Adult Day Support and Vocational Habilitation.”

This rule defines “Adult Day Support” and “Vocational Habilitation” and describes the conditions for providing day habilitation as a waiver service.

As described in paragraph 13 of this rule, Adult Day Services providers must be able to comply with all State regulations related to behavior supports plans for individuals served. This includes ensuring that direct service staff who are responsible for implementing behavior support plans receive training in a specific plan prior to implementing it.

Finally, some individuals with dd may need various types of therapies (e.g., occupational therapy, speech therapy) or other services during the day—services that may or may not be provided by the County Board of DD or other Adult Day Services provider. It is important for Adult Day Services providers (including County Boards of DD) to be flexible in their scheduling so that individuals’ Adult Day Services are coordinated with other needed services.

For more information regarding Adult Day Services in Ohio, click on the following links:
http://dodd.ohio.gov/adults/overview.htm
http://dodd.ohio.gov/adults/community.htm
http://dodd.ohio.gov/adults/activities.htm (click on the link to “Adult Day Services Overview”)

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Section 2:
Habilitation in the Context of Individual Planning

NOTE: Total time designated for this section is 10 hours.

Assignments for Section 2, located in the course Workbook:
- Section 2 Post-Test
- Activities 2A, 2B, and 2C
- Section 2 Reflections Exercise

General Guiding Philosophies
Our discussion of habilitation in the context of Individual Planning will begin with a review of several philosophies that should guide our approach to working with adults with developmental disabilities (dd). These guiding philosophies include age-appropriateness, normalization, least intrusive measures, dignity of risk, natural supports, accommodations, people first language, and human rights.¹

Age-Appropriateness
People with dd are at high risk of being stigmatized and misunderstood. According to Wikipedia, social stigma is “a severe social disapproval of personal characteristics or beliefs that are against cultural norms.” Social stigma often results from commonly held stereotypes. These stereotypes may include the notion that adults with dd are “perpetual children” and, as a result, adults with dd may often be treated as if they are children rather than adults.

To avoid reinforcing these stereotypes, we should be careful to avoid using teaching/training methods that may make an adult with dd look childish or different. We should avoid using childlike toys, games, or teaching tools. And we should be very aware of the way we interact with adults with dd, to avoid treating them as though they are children. For example, we should ask ourselves: When I interact with an adult with dd…
- What is my tone of voice? Do I talk to him/her as though I am talking to a child?
- Do I act as though I am the parent and he/she is a child who is to do as I say?

When working with adults with dd, we should strive to make sure we are using activities and events that are appropriate to their age, and we should interact with them in ways that convey a respect for them as adults. We should encourage adults with dd to participate in activities that are carried out the same, or as closely as possible, to the way the activity would be done by nondisabled adults. We need to be aware that our interactions and teaching practices effect

how other people perceive people with dd. If we treat them as adults, others will be more likely to view them as adults as well.

**Normalization**

The principle of normalization centers on the idea that individuals with dd should be encouraged to live lives that are just like those of their peers in the community. In our efforts to help and support people with dd, we need to be careful to avoid treating them as so “special” that they become separate and excluded from participation in activities with nondisabled people. We should be mindful that, although people with dd can benefit from “special” classes and events, they also need to be included in the same types of events in which nondisabled people participate.

Normalization can be promoted by encouraging individuals with dd to…

- buy and wear attractive and well-fitting clothing
- obtain attractive/stylish haircuts
- live in homes that are a part of regular neighborhoods
- access age-appropriate social activities

Normalization also means that, in working with adults with dd, we should strive to ensure that learning takes place through natural opportunities and in real situations. Because individuals with dd may at times have difficulty transferring what they have learned in one environment or activity to another environment or activity, we should attempt to provide learning activities within the natural environment.

**Least Intrusive Measures**

The idea behind least intrusive measures is that we should provide people with dd with the least amount of support needed for them to be successful. We should allow and encourage them to do what they can do for themselves, and allow for personal growth and independence. In our efforts to help and support people with dd, we need to be careful to avoid doing too much for them. When we teach someone a new skill, we become less intrusive by beginning to fade out of the picture and providing less prompting as the person begins to grasp the skill.

To use the least intrusive measures, we should also avoid trying to control individuals with dd—for example, by using an unnecessarily loud tone of voice or exaggerated facial expressions.

What is “least intrusive” will differ from person to person, and should be defined by the individual with dd, not by us. As with interacting with any individual, it is important that we get to know the person’s unique preferences, likes and dislikes, abilities, etc., to determine what teaching techniques are most acceptable to that person. An individual with dd may sometimes display “challenging” behaviors because we have misunderstood what he/she considers intrusive.
**Dignity of Risk**

All of us, whether we have a disability or not, need to be given the opportunity to take risks that are typical with everyday life. Allowing people with dd to take ordinary risks allows them to experience true growth and development. If we overly protect them, we will limit their growth and development. Part of our job is to encourage individuals with dd to develop the ability to make informed choices so they can make their own decisions and live self-directed lives (while balancing “dignity of risk” with our responsibility to ensure health and safety).

To learn more about the dignity of risk, please click on the links below:


**Natural Supports**

“Natural supports” are those that are naturally available in the community to all people. People with dd are often surrounded by support from paid staff members, and are not given adequate opportunity to develop real friendships with people who are not paid to support them. Natural supports may include, for example, family members, neighbors, people who go to the same church as the person with dd, classmates, or co-workers (for those employed in the community).

One way we can encourage the use of natural supports is to help people with dd to learn conversation and socialization skills, so they are better able to make friends with nondisabled people, outside the disability service system.

Organizations that provide services to people with dd can encourage the use of natural supports by recruiting volunteer “buddies” and identifying people in the community who have similar interests as a person with dd. We can also help promote the use of natural supports by observing and encouraging the natural bonds that develop between a person with dd and a new acquaintance.

To learn more about natural supports, please click on the following links:

[http://www.dds.ca.gov/Publications/docs/Natural_Supports.pdf](http://www.dds.ca.gov/Publications/docs/Natural_Supports.pdf)


**Accommodations**

One of the challenges of working with individuals with dd is trying to identify the most effective way to help them learn and function successfully, at home, at work, and in the community. To
meet this challenge, we must creatively look at ways we can accommodate a situation to best meet the needs of the person with dd.

An accommodation is a reasonable adjustment to our practices or to a setting, to make learning and successful functioning more accessible to the person with dd. In working with people with dd, accommodation may include (but is not limited to) any of the following:

- Adjusting the way we present information or communicate with the individual
- Adjusting the way we respond to the individual
- Helping the individual learn to use alternate communication methods
- Adjusting the individual’s schedule
- Adjusting the individual’s physical environment

Providing accommodations helps people with dd work around their limitations by finding different ways to perform a task they find difficult. This can involve adjusting either the environment or the task at hand. Assistive devices—whether technology or homemade devices such as pictures, symbolic reminders, or color codes—are examples of accommodations.

**People First Language**

Using people-first language means that we refer to individuals with dd as a person first, instead of as a disability. The idea behind people-first language is that disability merely means that someone operates somewhat differently in some way and therefore should not define a person.

People with disabilities do not want to be labeled and they do not want to be defined by their particular disability or disabilities. Therefore it is preferable to use "people first" language that places the emphasis on the person instead of on the disability. For example, instead of saying "the disabled" it is preferable to say "person with a disability." Instead of "the epileptic," say "person with epilepsy." Instead of "developmentally disabled," use "person with developmental disabilities." Other examples include: "person with cerebral palsy," "person with intellectual disabilities," "person with autism," "a person who is blind, deaf," etc.

People with disabilities also do not want to be referred to as a victim or object of pity. People with disabilities are not victims. Disability is just one aspect of the person. Avoid using "suffers from," "afflicted with," "bound," "confined," "sentenced to," "prisoner," "victim," or any other term that implies tragedy. For example, instead of writing "wheelchair-bound" or "confined to a wheelchair" use "person who uses a wheelchair." Instead of "victim of quadriplegia," use "person with quadriplegia" or "people with paraplegia."

Referring to a person as “handicapped,” “retarded,” and “crippled” only fosters stereotypes and perpetuates myths about people with dd. Using people-first language helps us avoid the use of labels, and encourages others to do likewise.

**Human Rights**

Perhaps most important of all of the general guiding philosophies, we must understand that people with dd have the same human rights as nondisabled people—for example, the right to free speech, the right to vote, the right to privacy, the right to marry. It is our responsibility to be aware of those rights, to protect those rights, and to act in ways that respect those rights. We
should also help individuals with dd understand their rights and help them learn to stand up for their rights.

One of the most fundamental of human rights is the right to make one’s own choices concerning where and with whom he/she will live, and how he/she will spend his/her time, regardless of ability.

In the State of Ohio, everyone who works with people with dd must be aware of Ohio’s Bill of Rights for People with Developmental Disabilities. Click on the following link to review those rights:  http://dodd.ohio.gov/rights/

**Single Coordinated Planning**

Many individuals with disabilities receive services and supports from several agencies for a variety of purposes. Typically each of these organizations are required to have some kind of written assessment of the individual’s abilities and service/support needs, and also a plan describing the services the individual will receive from them, including goals/objectives, persons responsible for various activities, frequency of services, etc.

Cathy, for example, lives in a home in the community with three other women who have developmental disabilities. She receives services and supports in her home and in the community from a local non-profit agency. She attends a sheltered workshop during the day, and has recently begun to receive assistance from BVR with finding a job in the community.

Rather than having three different plans for Cathy (i.e., a residential plan, a vocational plan, and a community employment plan), the County Board Service and Support Administrator* is responsible for overseeing the development of one single, coordinated plan for the individual that includes all of the various services and supports the individual needs from different agencies. By developing one single coordinated plan, the SSA can make sure that all parts of the plan are working together and that various service providers are consistent with each other in the way they support the individual, as well as to reduce unnecessary duplication of services.

*For individuals who live in an ICF/MR, the individual’s Qualified Mental Retardation Professional (QMRP) is responsible for overseeing the single coordinated plan.

The Service and Support Administration Rule (Ohio Administrative Code 5123:2-1-11) addresses the need for Single Coordinated Planning (Single Point of Accountability) as follows:

[Definitions] **“Service and support administration”** supports individuals in determining and pursuing goals and maintains the individual as the focus while coordinating services across multiple systems…  **“Single point of accountability”** means the identified service and support administrator who is responsible to an individual for the effective implementation and coordination of his or her ISP process.

(G) Single point of accountability

(1) A county board shall identify a service and support administrator for each individual receiving service and support administration who shall be the
single point of accountability for the individual and who shall perform the following duties:

(a) Assess the individual's need for services…
(b) Develop and revise the individual's ISP…
(c) Establish the individual’s budget for services…
(d) Assist the individual in choosing providers…
(e) Ensure that the individual's services are effectively coordinated and provided by appropriate providers…
(f) Monitor the implementation of the individual's ISP…
(g) Ensure that the individual has a designated person to provide daily representation…

(2) The single point of accountability may perform the duties set forth in paragraph (G)(1) of this rule with the assistance of appropriate others on the individual’s team. In order to receive such assistance, the single point of accountability shall:
(a) Maintain the responsibility to ensure that activities performed on behalf of the individual are completed in accordance with the ISP and to the benefit and satisfaction of the individual;
(b) Ensure that the person providing the assistance has a clear understanding of the expectations and desired outcomes of the task(s);
(c) Maintain contact with the person providing assistance as frequently as necessary to monitor the completion of the assigned task(s);
(d) Retain responsibility for all decision-making regarding service and support administration functions and the communication of any such decisions to the individual.

(M) Coordinating services

[The SSA as the single point of accountability] shall ensure that services are effectively coordinated and provided by providers, as identified in the ISP, by facilitating communication with the individual and among providers across all settings and systems. The person who is the single point of accountability for an individual shall perform this duty and shall directly communicate with all providers of residential and day program services through their employees who are designated as responsible for habilitation management and program management and to the designated staff of all other providers including, but not limited to, transportation services providers. Relevant sections of the ISP shall be shared with providers. Such communication, as applicable, shall include, but not be limited to, the following:
(1) ISP revisions;
(2) Relocation plans of the individual, including information necessary to determine the health, safety, and welfare factors of the proposed living situation;
(3) Hospitalizations, incarcerations, or other changes in individual status that result in suspension or disenrollment from services including, but not limited to, services under an HCBS waiver;
(4) Coordination activities to ensure that services are provided to individuals in accordance with their ISPs and desired outcomes;
(5) Results of the monitoring conducted pursuant to paragraph (N) of this rule.
Monitoring ISP implementation

[The SSA as the single point of accountability] shall, in accordance with policies and procedures that shall be established by the board and any protocols that may be established by the department, establish and implement an ongoing system of monitoring the implementation of an individual's ISP. The service and support administrator who is the single point of accountability for an individual shall perform this duty in accordance with the following requirements:

1. The purpose of this monitoring shall be to verify:
   a. The health, safety and welfare of the individual;
   b. Consistent implementation of services;
   c. Achievement of the desired outcomes for the individual as stated in the ISP; and
   d. That services received are those reflected in the ISP.

2. Areas to be monitored, as applicable to each individual, shall include, but not be limited to, the following:
   a. Behavior support;
   b. Emergency intervention;
   c. Identified trends and patterns of unusual incidents and major unusual incidents and the development and implementation of prevention and/or risk management plans;
   d. Results of quality assurance reviews; and
   e. Other individual needs as determined by the assessment process.

Developing a Vision of an Individual’s Optimal Self-Determination and Empowerment

What is a vision and why is it important?

According to Stephen Covey, one of “The 7 Habits of Highly Effective People” is to begin with the end in mind. This principle can be applied to the Individual Planning process for people with dd. As a starting point for developing an Individual Plan, it is critical that the entire planning team begins with the end in mind. Of course, that means that the entire team must be in agreement with what that “end” (desired result) is. Most importantly, that “end” should be driven and directed by the person with dd.

Vision is another word for the desired “end” or result of an Individual Plan. A vision is a description of a desirable future. Developing a vision for and with a person with dd helps the team see that person’s life through the lens of possibility (rather than the lens of limitations). It is the starting point for creating a bold new future for the individual.

To create a vision requires a fundamental understanding of what is important to the individual, and what he/she values and enjoys. It is critical that the person with dd “own” the vision—in other words, that the vision truly reflects what the individual wants and values. The Individual Plan then becomes the plan for how to make that vision become a reality. Without a vision, the...
process of developing an Individual Plan lacks direction and may not be personally meaningful to the individual whom it is designed to support.

“Vision” according to the LeaderShape Institute

A vision is...

- A powerful mental picture of what we want to create for the future
- Reflections of what the individual cares about
- Consistent with the individual’s core values
- Explores possibilities
- Involves risk-taking
- An expression of what the individual’s team members have in common and want to work on

Key Dynamics of a Vision:

1. **Vivid**
   The vision graphically describes a new future for the individual. The picture is compelling and exciting to the individual and his/her team. It is visual, exciting and optimistic. It does **not** lay out specific plans of action.

2. **Challenging**
   The vision shows a healthy disregard for barriers and limitations. It requires the investment of energy to transform the individual’s life from the present status into a new and exciting desirable future. A vision takes time and will not be accomplished overnight!

3. **Outward-Directed**
   The vision is not just about what the individual wants from others, but what the individual wants to become and do for and with others. It is about the individual’s place within the larger community. It represents the individual’s contribution to others.

4. **Expandable**
   A powerful vision requires input from others who care deeply about the individual and know him/her well. The vision is a “we” statement, not a “me” statement. Because it is expandable, it changes and evolves over time.

5. **Compelling**
   A vision must be exciting and meaningful to those who are part of its creation. It makes the heart beat a little faster when you imagine the results. It describes a future that people care about and want to invest in. The vision is based on passion for what is desirable, not fear of what is undesirable. The future reality of vision has an “intent” that focuses energy and creates a sense of purpose for those who commit to it.

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2 Source: The LeaderShape Institute, Faculty Manual/Vision Workbook (2011). Published by LeaderShape® Inc., Champaign, IL.
To create a vision of a desired future for a person with dd, the individual and his/her team must answer this key question: *What could the future look like for me, if I could have it any way I wanted?*

**Vision provides the basis for goals and objectives**
Once a vision has been created, an individual’s planning team can begin to identify goals and objectives and action steps that will move the individual toward the vision.

**Characteristics of Goals and Objectives**

**Goals**
- Are long-term
  - May take a year or more to accomplish
  - May not be immediately achievable
- Are somewhat broad in scope
  - Example: Ryan would like to better manage his anger.
  - Example: Kate would like to manage her own budget.
- Represent one piece of the individual’s vision or dream to come true
- Are relatively small in number (because they cover a variety of objectives and specific skills)

**Objectives**
- Are short-term
  - May be accomplished in relatively short time frames
- Are smaller, manageable steps toward meeting goals
  - Example: Ryan will practice at least 2 stress management techniques on a daily basis.
  - Example: Kate will use a calculator to add the cost of her monthly expenses.
- Represent specific, everyday tasks
- May be larger in number (because they represent a method of path to reach a larger goal)

**Self-Determination and Empowerment**
As mentioned above, it is essential that the individual “owns” his/her vision, and that the vision accurately reflects what is important to him/her. Ideally, the vision should be driven and directed by the individual with dd. Similarly, the goals and objectives toward achieving that vision need to be directed by the individual to the maximum extent possible. When the individual is in charge of his/her vision and his/her Individual Plan (goals and objectives), we say that the

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individual is “self-determined.” In order to be self-determined, the individual must be “empowered” to make decisions about his/her life, with the guidance of team members who care deeply about him/her and who know him/her well. Self-determination and empowerment go hand-in-hand. You cannot have one without the other.

The following paragraph describes why it is important for the service delivery system to allow individuals with dd to direct and control their own lives, including their services and supports.

“… The problem arises when services take over the life of someone they’re supposed to be supporting. When this happens, people and their families lose the freedom to control their lives – even lose the basic belief in their ability to do so. They also lose the relationships with other human beings that are basic building blocks of life. Instead they become surrounded by people who are paid to be with them, to organize, manage, direct and oversee their lives. At that point the social service system assumes a measure of control that most of the rest of us would find intolerable and it isolates them from other people outside the system, from the community…” (Taken from The Gift of Hospitality, by Mary O’Connell, 1988).

**Self-Determination**

According to Tom Nerney, from the Center for Self-Determination, there are five fundamental elements of self-determination: freedom, authority, support, responsibility, and confirmation.

**Freedom** to live a meaningful life in the community. The ability to make life decisions about where and with whom one lives and what important things one undertakes that parallels in every important way the decisions that those without disabilities make everyday.

**Authority** over dollars needed for support. The ability to control a targeted amount of public dollars together with private money in order to craft a life plan that results in the everyday freedoms that all Americans desire and the expectations that the lives of those with disabilities will mirror, with appropriate assistance when necessary, the lives of others in this society.

**Support** to organize resources in ways that are life-enhancing and meaningful. The organization of these resources in ways that are unique for the individual and address the support needed because of a disability with a more holistic way of planning and budgeting that address perennial issues often lost in the system of traditional long term care: a place to call home, sustained relationships, community membership and for adults the production of private income through the world of business and commerce.

**Responsibility** for the wise use of public dollars. The commitment for the wise use of public dollars and with added flexibility in public funding seeking a more cost effective way to support individuals with disabilities. From its very inception Self-Determination challenged the high cost of “serving” individuals with significant disabilities with very few discernable outcomes that would be acceptable to a person without a disability.

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4 Click on this link to review the full document: [http://www.northwestern.edu/ipr/publications/papers/goh.pdf](http://www.northwestern.edu/ipr/publications/papers/goh.pdf)

5 For more information, see the Center for Self-Determination website at [http://www.centerforself-determination.com/](http://www.centerforself-determination.com/)
Confirmation of the important leadership that self-advocates hold in a newly designed system.

Click on the following link to view a video (less than 5 minutes) of Mr. Nerney discussing self-determination:  http://www.youtube.com/watch?v=fBMzCCKEuss&feature=related

Empowerment
Empowerment is all about giving people with dd the “power” (authority) to direct their plans, so they can receive the supports they need and want in order to have a life based on their individual dreams and aspirations (i.e., visions).

All too often in the dd service delivery system, professionals approach individuals as an authority figure, using their power and influence to get the individual to agree to cooperate with what the professionals believe is in the person’s best interest. As a result, many individuals with dd become conditioned to submitting to authority figures. When this happens, the voice of the person with dd is neither expressed nor listened to.

The following is excerpted from “Doing Our Best Work” by Peter Leidy describes the importance of empowering people with dd to manage and control their services and lives.

We see ourselves as allies rather than managers or caretakers.

If you provide support to someone with a disability, how do you describe what you do? How do you see your role? The best examples of direct support that I have seen have the look and feel of people in alliance with one another. We’re on the same side. We have power together rather than “I have power over you because I’m your staff.” I assist you; I am your ally. I understand my role as a supporter, a relationship-builder, more than a manager of your life, more than simply a caretaker.

We’re on the same side. We have power together rather than “I have power over you because I’m your staff.” I assist you; I am your ally. I understand my role as a supporter, a relationship-builder, more than a manager of your life, more than simply a caretaker.

Teri described a recent interaction with one of the group home staff. "She told me to clean my room. I wasn’t in the mood to clean-- I told her I’d do it later. She said ‘You need to do it now.’ Finally I yelled at her. I said why are you always telling me what to do? I told her this was MY house and she is not my boss. Then I got in trouble.”

I wish this were an isolated incident. But it’s an example of an “us-them” mentality that leaves no room for seeing the whole person, for seeing positive possibilities. It’s power over rather than power with. Quality direct support does not look like this.

6 To review the entire document, go to this website:  http://www.peterleidy.com/human-services-articles.html and click on “Doing Our Best Work (.doc)”
When we can shift, and approach the work as allies with people, we see more of what we have in common as humans. This approach is more respectful and ultimately much more satisfying.

When direct support staff understand their roles primarily as paying attention to "cares" and caretaking, it not only may limit someone’s growth; it also may look to others—neighbors and other community members—like the person is not very capable....

The best direct support I know of comes about through relationships where people DO show up as good company, and see each other as allies -- not manager and managee, or caretaker and caretakee, but allies.

Empowerment is about giving choice, control, relationships, power, and freedom to the individual with dd. It is about giving them the ability and power to direct and manage the services they receive.

Empowerment involves…

- Giving the individual the power to influence decisions related to funding, staff selection and supervision, individual program planning, and outcome assessment. In self-directed services, people are empowered through individual budgets that give them decision-making authority over the expenditure of the funding that is allocated to pay for the services identified in their individual plans of care. The individual budget can increase a person’s access to the services they need by enabling them to purchase supports that are not available through the traditional systems of service delivery.7
- Discovering ways to extend and strengthen a person’s network of relationships and valued social roles.8
- Challenging family groups to discover more self-sustaining ways of creating the assistance that people need. This will reduce the power the service system has over people by decreasing their reliance on its money. This could include development and use of natural supports rather than paid supports.9

The Service and Support Administration rule (Ohio Administrative Code 5123:2-1-11) addresses self-determination and empowerment as follows:

(B) Decision-making responsibility
   (1) An individual shall be responsible for making all decisions regarding the provision of services, including requesting services and giving, refusing to give, or withdrawing consent for services, unless the individual has a guardian,

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in which case the guardian shall be responsible for making such decisions.

(2) Individuals, including those with guardians, have the right to participate in
decisions that affect their lives and to have their needs, desires, and
preferences considered.

(3) An individual who does not have a guardian or an individual's guardian may
designate another person, including a member of the individual's family, to
participate in the process of making decisions regarding services provided to
the individual in accordance with paragraph (P) of this rule…

(P) Designated person to provide daily representation

(1) Each individual receiving service and support administration shall have a
designated person to provide daily representation who is responsible on a
continuing basis for providing the individual with representation, advocacy,
advice and assistance related to the day-to-day coordination of services in
accordance with the ISP.

   (a) The role of the person designated is to assist the individual to keep the
   service and support delivery system focused on his/her desired
   outcomes.
   (b) The person designated shall be willing to interact regularly with the
   individual in order to maintain or develop a relationship that will allow
   him/her to fulfill this role.
   (c) A designated person who is not legally responsible shall not receive any
   privileged information without consent of the individual.
   (d) Neither the service and support administrator who is the single point of
   accountability for the individual nor any other person providing service
   and support administration shall be the person designated.

(2) The service and support administrator who is the single point of accountability
for an individual shall ensure that the individual has a person designated to
provide daily representation and shall:

   (a) Give the individual an opportunity, at least annually, to designate such
   person.
   (b) Make the designation if the individual declines to do so, taking into
   consideration the designated person's credibility with the individual, the
   person's understanding of the individual's desired outcomes, and the
   person's reliability. If an individual has no such person involved in
   his/her life, actions shall be specified in the ISP that will lead to the
   development of a circle of support for the individual.
   (c) Document the person designated, by name, in the individual's ISP.
   (d) Permit an individual to change at any time the person designated to
   provide daily representation.

(3) Paragraphs (P)(1) and (P)(2) of this rule are not intended to prevent an
individual from representing himself or herself or advocating on behalf of
himself or herself.
Balancing Self-Determination and Empowerment with Health and Safety Issues (and Other Issues Related to the Individual’s Welfare)

One of the greatest challenges in working with individuals with dd is respecting their right to self-determination and empowerment while also needing to ensure their health, safety, and welfare. What is our role when an individual with dd makes a decision or choice that will have a negative effect on his/her health, safety, or welfare, whether short-term or long-term? What is our role when an individual’s choices have negative financial consequences? What is our role when an individual chooses friends who take advantage of him/her?

For example:

- Pat has diabetes but wants to make his own decisions about what he eats. He especially enjoys drinking soda (non-diet) and eating chocolate chip cookies and pasta.
- Mary Ann wants to make her own decisions about her budget. She has a history of ordering things from catalogs and not having the funds to pay for the items she has ordered.
- Phillip enjoys hanging out with “friends” who have recently graduated from high school. He wants to invite them to his house for parties. When this has happened in the past, they have brought alcohol and have eaten all of the food in his pantry and refrigerator.

In seeking to find the balance between the individual's right to self-determination and our responsibility to ensure health, safety, and welfare we must remember that all of us—whether we have a disability or not—at times make decisions that are not in the best interest of our own health and safety. None of us are fully aware of the consequences of our decisions.

There is a natural tension between individuals’ right to self-determination (which includes visioning, empowerment, and dignity of risk) and the County Board employees’ responsibility to ensure health, safety, and welfare. Because of this tension, it is very important that the individual and his/her planning team develop a vision and plan that addresses his/her optimal (that is best or most favorable) level of self-determination and empowerment, while not placing undue risk on his/her health and safety. Generally speaking, this means that individuals with higher levels of cognitive ability – those who are better able to make informed decisions – will be granted a greater degree of self-determination, empowerment, and risk than those with lower levels of cognitive ability (who are less able to make informed decisions).

A key part of our role, then, is helping the individual make informed choices—that is, helping him/her understand the likely consequences of his/her decisions. This includes helping individuals with dd know how to find, evaluate and use information, which will better inform their decision making process. For individuals with cognitive disabilities, this can be particularly challenging.

Understanding Informed Decision-Making and Informed Choice

**Informed Choice:** The process by which an individual arrives at a decision. It is a process that is based upon access to, and full understanding of, all necessary information from the individual’s perspective. The process should result in a free and informed decision by the individual about what he or she needs.

(Source: [http://www.ncwd-youth.info/resources & Publications/definitions.php#informed_choice](http://www.ncwd-youth.info/resources & Publications/definitions.php#informed_choice))
Some individuals may have cognitive or intellectual challenges that limit their ability to understand complex abstract concepts, read or comprehend text or fully understand the implications of their choices and decisions. These cognitive limitations affect their ability to make informed choices – choices in which they understand the options available to them and the pros and cons (advantages and disadvantages) of each option.

“Informed choice” generally applies to decisions a person makes in the course of ordinary life—for example, where he/she lives and with whom, who his/her friends are, what he/she will wear, eat, etc. “Informed consent” on the other hand, generally applies to decisions a person makes concerning the programs and services he/she will receive or participate in.

Although “informed choice” and “informed consent” are not exactly the same thing, the following information on “informed consent” may be useful in guiding those of us who seek to help individuals with dd to make informed choices.

Informed Consent and People with Intellectual Disabilities

Informed consent requires knowledge of the legal and ethical considerations in supporting vulnerable populations in a respectful and non-patronizing manner.

**Principals Concerning Informed Consent**
Society and law require people to give consent, or at least assent, to major decisions concerning the person’s interests and values.

- **Consent** – a legally valid agreement to participate by someone who is fully informed of the risks and benefits
- **Assent** – a voluntary agreement to cooperate with a procedure or activity by a willing participant.

The courts have limited the rights of some persons with intellectual disabilities to give informed consent. In those cases a guardian is appointed to make legal or medical decisions on his or her behalf. However, even when a guardian consents to an individual’s plan it is important to assure that the individual also assents or agrees with the plan.

People with intellectual disabilities are presumed to have as much interest in choice and control in decision making as any other person.

- The courts have found that persons with intellectual disabilities have substantial liberty interests that merit full protection.

The decision-maker must address three elements before informed consent can be said to be valid. They are: capacity, information and voluntariness.

- **Capacity** – The person’s ability to express consent in a clear and meaningful way and to fully understand the consequences of a decision.
• **Information** – provided in sufficient quantity and at a level and in a manner appropriate to the person’s understanding, including information relating to the person’s ability to financially afford and maintain the option.
• **Voluntariness** – The person’s giving of consent without any perceived or real coercion.

The greater the risks involved in a decision, the greater the effort that must be made to assure that consent is valid. A decision-making matrix can be used to consider this principle.

**Figure A: Risk/Values decision-making matrix**

<table>
<thead>
<tr>
<th>Scrutiny Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Scrutiny</td>
<td>High risk decisions that are inconsistent with the person’s known values and interests</td>
</tr>
<tr>
<td>Moderate Scrutiny</td>
<td>High risk decisions that are consistent with a person’s known values and interests</td>
</tr>
<tr>
<td></td>
<td>Low risk decisions that are inconsistent with known values</td>
</tr>
<tr>
<td>Lowest Scrutiny</td>
<td>Low risk decisions that are clear or consistent with a person’s known values and interests</td>
</tr>
</tbody>
</table>

In cases where a person with an intellectual disability does not have the cognitive, communicative or educational capacity to make autonomous decisions or to give valid consent, they may need assistance to make decisions or express consent.

Assistance should be “least restrictive”.
• Only the minimal assistance needed to help the individual understand and exercise a fully informed choice should be offered. This allows the person with cognitive disability to maintain the greatest degree of independence in decision making and helps to avoid influencing a decision through inadvertent pressure or relationship.
• Any assisting decision maker should consult with and solicit the views of the person with an intellectual disability.

Assistant decision makers should set aside concerns about what might be in the best interests of the person with an intellectual disability and decide based on what the individual might have decided if he or she were legally competent to do so.
• This requires that the decision maker know the individual’s desires and his or her specific situation and may require consultation with the person, their family members, educators, and other supporters.
• When it is impossible to learn the person’s desires, the decision maker must use his or her judgment about what is best.

Persons with intellectual disabilities often need more information than others about specific rights or decisions.
• They may also need to be given general information or background facts that others are assumed to know (e.g., the advantages and disadvantages of various options).
• Consent involves seeking out ways to enhance the person’s knowledge base about their rights. This may be done through the use of a pictorial/text tool that outlines participant’s rights, gives examples and highlights the decision that can be made for each kind of information that is shared (e.g. what will happen, what might happen, what should happen, etc.).
• Those seeking consent should not confuse the person’s lack of information with his or her ability to make decisions. Knowing is not the same as deciding.

Valid consent must be voluntary and un-coerced.
• Coercion involves not only physical or psychological pressure but also subtle forms of pressure that occur. Examples include situations in which:
  1. A person with an intellectual disability has been served largely in situations where opportunities for choice making are limited. This person may say yes to every request or say no to every request.
  2. A professional approaches the individual as an authority figure and using his or her power and influence to suggest cooperation is best. The person may be conditioned to submit to authority figures or community helpers.
  3. A professional is a friend or someone who manages a support service that the individual with a cognitive disability needs. It must be clear that the friendship or service will not be withdrawn if the individual does not agree with the person’s request for consent.
  4. The person asking for consent is well known to the individual with a disability and the response they would like that person to give is conveyed through nonverbal communication. Some individuals with intellectual disabilities may be unable to separate their responses from that of a family member or friend and may be unable to make an independent decision or refuse a request from that person.

The rights of people with intellectual disabilities to exercise choice and control must be balanced by the need to protect vulnerable individuals from exploitation and abuse.
• The tension between enhancing autonomy and protecting individuals highlights the need for better communication, patient explanations and taking the time needed to understand the wishes of the person with an intellectual disability.

Documents that substantiate informed consent are often written in legalese which is unlikely to be understood by most persons with intellectual disabilities. Professionals must guard against requiring a person to sign a document that they can’t read or don’t understand to verify consent. Assure that the individual who signs a complex consent form has the opportunity to understand what he or she has signed. Present the information in short sections and modifying the text to a readability level that matches the individual’s oral comprehension.

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**Free Choice of Provider and Informed Choice**

A key part of self-determination is giving individuals the opportunity to freely choose who will provide the services they have chosen. For individuals who receive Medicaid-funded services, Ohio Law mandates how County Boards of DD ensure the individual’s right to a free choice of provider. (Medicaid beneficiaries are allowed to choose their health care professionals from a range of participating providers. This means that individuals with developmental disabilities who receive waiver services can choose any qualified Medicaid provider.)

Please click on the following link to review those mandates:
http://odmrdd.state.oh.us/rules/PDF/5123_2-9-11.pdf
• Review paragraphs (A), (F), (G), (H), and (I)
Your local County Board of DD most likely has a policy/procedure related to Free Choice of Provider. You may find it helpful to review that policy/procedure for purposes of completing Activity 2A in the course workbook.

When an individual first becomes eligible for services, it may be very difficult for him/her to make an informed choice about his/her provider, because of having limited experience with and knowledge of available providers. For the same reasons, if an individual becomes dissatisfied with his/her current provider, he/she may have difficulty selecting a new provider. County Board of DD employees can assist individuals with making an informed choice about their provider by:

- Helping the individual arrange to interview potential providers.
- Helping the individual arrange to interview other individuals who receive services from the provider.
- Providing information about the satisfaction level of others who have received services from a specific provider (if available).

**Reconciling Self-Determination with Assessment and Evaluation**

**Assessment and Evaluation**

The services each individual with DD receives from a County Board are based on his/her Individual Plan. The Individual Plan identifies the services and supports the individual will receive, from whom, and how often. It also identifies goals and objectives the individual would like to work on within a specified period of time.

*It is essential that the Individual Plan is based on the individual’s interests and vision for the future.* The purpose of the plan is to identify what is most important to the individual and the goals he/she wants to work on and to guide professionals in how they can help the individual achieve his/her self-determined goals. It is a roadmap of sorts, for how the individual can move from his/her current situation to his/her vision of a desired future.

A key part of the process of developing an Individual Plan includes assessment of the individual’s interests and preferences, likes and dislikes. This assessment is critical so that the Individual Plan is driven by the desires of the individual, not the opinions/wishes of other people.

Sometimes an individual’s likes or dislikes in one area may conflict with his/her interests or preferences in another area. For example, the individual may be interested in making more friends by participating in a local community group but doesn’t like to bathe or shower or do his/her laundry on a regular basis. In these situations the individual’s team should try to help the individual understand how his/her hygiene choices affect his/her ability to make new friends.

Another key part of the process of developing an Individual Plan is assessment of an individual’s functional abilities, which provides a basis for identifying his/her service and support needs. In other words, assessment of the individual’s functional abilities is important so that his/her team can help identify the services and supports he/she needs in order to meet his/her self-selected goals and vision. This may include assessment of the individual’s…
• physical abilities (ability to walk or use a wheelchair, see, hear, use his/her hands, etc.)
• communication skills (e.g., ability to express him/herself, ability to understand and follow instructions)
• ability to access community resources (e.g., post office, library, church, bank, etc.)
• learning and problem-solving skills (e.g., time management; money management)
• daily living skills (e.g., skills related to housecleaning, laundry, shopping, etc.)
• personal care and hygiene skills (e.g., toileting, eating, dressing, etc.)
• socialization skills (ability to make friends and maintain friendships)

Another aspect of assessment is identifying the individual’s unique gifts and abilities that enable him/her to make a valuable contribution to others in his/her home, work setting, and community. This aspect of assessment is important so that the individual is not viewed or treated as merely a recipient of services, but as someone who can give something of value to others.

The Service and Support Administration rule (Ohio Administrative Code 5123:2-1-11) includes certain requirements for how assessments are to be completed, as follows:

[Definition] "Assessment" means the gathering of comprehensive information concerning each individual's preferences, personal goals, needs, and abilities, health status and other available supports.

(I) Assessments
[The Service and Support Administrator] shall assess individual needs for serviced… and shall:

(1) After the initial request for services and at least annually thereafter, complete or coordinate and ensure the completion of assessments. The assessment process shall include all types of assessments based upon input obtained from the individual, the individual's guardian, the person designated… to provide daily representation, and the individual's team.

(a) The information obtained shall include the individual's likes, dislikes, priorities, and desired outcomes, as well as what is important to and for the individual, including skill development, health, safety, and welfare needs, as applicable.

(b) The completion of assessments and evaluations by licensed or certified professionals is not required annually, but shall be done at a time dictated by the needs of the individual.

Occasionally, an Individual Plan may also be partially based on a formal “evaluation” of the individual’s strengths and limitations. “Evaluation” is typically completed by a licensed or certified professional (e.g., psychologist, physical therapist, speech therapist, occupational therapist), and involves comparing the individual’s performance in some area with a “norm” or ideal standard. However, because our goal is not to “fix” the person, evaluations should be used only in limited circumstances and for specific purposes, as needed to help the individual achieve his/her goals. For example, a formal evaluation, by a psychologist, of an individual’s cognitive skills or intelligence may help identify ways in which an employer would need to adapt instruction/training to help the individual best learn job-related tasks.
Because the Individual Plan should be driven/determined by the individual, service providers must remember that the goal of such a plan is not to “fix” the individual so that he/she becomes like a non-disabled person, but rather to empower the individual to pursue his/her vision of a desired future, and to achieve his/her self-determined goals.

When conducting assessments of the individual’s interests, preferences, likes/dislikes, abilities, and needs, and when developing Individual Plans, County Boards of DD must follow certain requirements. Some of these requirements are found in the Adult Services rule of the Ohio Administrative Code.

Please click on the following link and review paragraphs (E) (1 through 7) and (G) (1 through 11).  http://odmrdd.state.oh.us/rules/documents/5123-2-1-06Effective1993-04-22.pdf

- If you have trouble accessing the Adult Services rule using that link, click on this link: http://odmrdd.state.oh.us/rules/ Then scroll down to Chapter 5123:2-1, County Boards of Developmental Disabilities, and click on the link for 5123:2-1-06 (Adult services).

Although each County Board uses its own unique assessment tool/format, some of the questions that the assessment should address are as follows:10

- What works: What makes you happy/successful? What is enjoyable to you? What calms you?
- What does not work: What makes you feel unsuccessful, unhappy, worse or upset?
- Gifts and Attributes: What do people who know and care about you think/say are your special skills and talents?
- Barriers to acceptance: What gets in the way of people knowing and caring about you?

In summary, then, the assessment should be a tool that the individual’s team uses to help identify the supports and services he/she will need in order to move toward his/her vision and to achieve his/her self-determined goals. Assessment should be used as a tool to support and empower self-determination, not to inhibit self-determination.

**Utilizing Natural Supports, Generic Services, and Community Resources**

One of the biggest challenges in providing services and supports to individuals with dd is helping them to use natural supports, generic services and community resources so they are not overly dependent on paid supports. There are two major concerns related to individuals being overly dependent on paid supports: (1) they may become segregated from nondisabled people; and (2) funding/resources for paid supports may not be adequate or sustainable over time.

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“Natural Supports” refers to the resources inherent in community environments that can be used for habilitative and supportive purposes. Natural supports include unpaid supports such as friends and family members who are willing to take the individual shopping, to a restaurant, to church, or to other community groups meetings, events, and activities. Family and friends may also take on the role of being a “community connector” by actively helping the individual develop meaningful relationships with others in the community. They learn to look first to natural supports, rather than to the paid service system, for ways to build a meaningful life for the individual.

Natural supports include generic services and community resources that are available to everyone in the community. These may include, for example:

- resources available at the local library (e.g., access to computers and the internet; free access to movies on dvd)
- health and fitness classes offered by the local hospital (e.g., exercise groups, nutrition classes)
- services offered by the local health department
- adult education classes offered by nearby colleges or schools (e.g., classes in learning to use computers, preparing for the GED, photography, etc.)

It is important for an Individual Plan to include and encourage the individual’s use of natural supports, to help him/her participate as much as he/she wants in the community, and to help the individual be seen and included as a valuable, contributing member of his/her family and community.

To learn more about natural supports and how to develop them, please click on the following link to read “Natural Supports… They’re All Around You.”

http://www.dds.ca.gov/Publications/docs/Natural_Supports.pdf

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Additional Resources (Optional):

“Teaching Decision-Making”
http://www.cec.sped.org/AM/Template.cfm?Section=Search&template=/CM/HTMLDisplay.cfm&ContentID=2498

“Real Life Quality Standards”

“An Affirmation of Community”

Waisman Center’s website on Natural Supports (including sections on “Shared Activities,” “Valued Roles” and “Real Relationships”)  http://www.waisman.wisc.edu/naturalsupports/index.php

“A New Way of Thinking”

Assignments for Section 3, located in the course Workbook:

- Section 3 Post-Test
- Activity 3A and 3B
- Section 3 Reflections Exercise

Identifying Vision/Desired Outcomes with the Circle of Support

The term “Circle of Support” is often used to describe the members of an individual's planning team. It is very important that an individual's Circle of Support not be limited to paid professionals who work with the individual. Ideally, most members of the Circle of Support will be unpaid friends and family members who know the individual well and play a significant role in his/her life.

The Service and Support Administration Rule (Ohio Administrative Code 5123:2-1-11) defines Circle of Support and Team as follows:

"Circle of support" means one or more persons who agree to meet on a regular basis to help the individual to identify and accomplish personal visions or goals. The majority of persons in a circle of support are not paid to be there and are involved because they care about the individual and they have made a commitment to work together on behalf of the individual.

"Team" means the individual's circle of support, the service and support administrator who is the single point of accountability for the individual, the person designated… to provide daily representation, direct support staff, providers, licensed or certified professionals and other persons chosen by the individual to help the individual think through possibilities and decisions. The purpose of the team is to provide written and/or verbal information relevant to the development of the Individual Service Plan (ISP) for the individual. Team members may be invited by the individual to actively participate in the development of the ISP.

For more information on Circles of Support, please click here:

Developing and Writing Individualized Statements of Vision/Desired Outcomes

The primary function of the Circle of Support is to listen to the dreams of the individual with dd and help the individual to clarify his/her vision of desired future outcomes. One aspect that is often overlooked in this process is giving the individual and his/her Circle of Support a few basic questions prior to the planning meeting, to help prepare them for the meeting discussion. Such
questions should prompt the individual and the Circle of Support to think about what and who is important to him/her, where he/she would like to live, with whom, and the kind of job he/she would like to have. Ideally, the individual will discuss these questions prior to the meeting with someone he/she trusts and communicates well with. That trusted person can then help the individual express his/her vision and desired outcomes during the planning meeting.

**Challenges to Developing and Writing a Vision/Desired Outcomes Statement**

There are a number of challenges that may arise in the process of developing and writing a vision/desired outcomes statement for an individual with dd. Some of these are as follows:

1. The individual with dd may not really know what he/she wants for his/her future.

   o In this situation, the Circle of Support may be able to help the individual clarify his/her vision/desired outcomes by discussing the following questions:
     - What are his/her interests? (What does he/she really enjoy doing? What makes him/her most happy?)
     - What situations should be avoided for this person? (What makes him/her unhappy?)
     - Who is most important to this person? (What relationships or people are important to him/her?)
     - What are the unique qualities and contributions this person has to offer?
     - What are his/her strengths? (What is he/she really good at?)
     - What is his life history? (significant highlights)
     - Based on the person’s interests:
       • What does he/she dream of doing or becoming?
       • Where would he/she like to work?
       • Where and with whom would he/she like to live?
       • What community groups or events would he/she like to be a part of?

   o It is important to note that sometimes individuals with dd do not have enough experience with various options to really know what they like or dislike, or what their interests are. For this reason, part of the Individual’s Plan may be for the individual to explore various options (related to work, community events, etc.) to help him/her better identify his/her interests and preferences.

2. For individuals with severe or profound limitations in cognitive skills, the individual may have difficulty comprehending and answering the above questions (e.g., may not understand abstract concepts such as “vision,” “future,” “interests,” “relationships,” etc.).

   o In this situation, the Circle of Support may need to develop a vision/desired outcomes statement on behalf of the individual. In this case, the vision should be consistent with what the team members know to be consistent with the individual’s interests, likes/dislikes, etc.
3. For individuals who lack assertiveness, it may be difficult to discern what the individual wants vs. what his/her family, friends, or professionals want.
   - In this situation, the Circle of Support should be reminded that their goal is to discover what the individual wants for his/her life, not to impose their own vision for the individual’s future. This requires team members to actively listen to the individual without interrupting or interjecting their own opinions or disagreements.

4. The individual’s vision/desired outcomes may conflict with that of one or more of the members of the Circle of Support.
   - If the individual’s vision conflicts with the vision of key members of his/her Circle of Support, it is important to discuss and work through such conflicts, because the individual will ultimately need those persons’ support in pursuing his vision/desired outcomes.

5. The individual’s vision may be limited by dependency on other people, a desire to please other people, or fear of failure.
   - Many individuals with dd have been conditioned over the years to depend on other people to make decisions for them. They are used to complying with what they think others want them to do, and/or have a desire to please others. In these situations, it is important for the Circle of Support to encourage the individual to express his/her dreams and to reassure the person that team members will not be disappointed or angry with him/her for sharing those dreams.
   - Other individuals with dd may have experienced failure in the past and are afraid to “dream big” for fear of more failure. These individuals may need a lot of reassurance to express their dreams, and their Individual Plan may need to ensure success with a number of small steps toward their vision, to build the individual’s confidence.

6. The individual may be satisfied with the status quo.
   - If this is truly the case, that’s OK! Many nondisabled adults are also satisfied with their current work, living arrangements, friendships, and community involvement.
   - The key here is determining if the individual is genuinely satisfied with his/her current status, or is just saying what he/she thinks the Circle of Support wants to hear, or isn’t aware of other options available. If the individual isn’t aware of other options, part of the Individual’s Plan may be for the individual to explore other options (related to work, community events, etc.) to help him/her better identify his/her interests and preferences.

**Assisting Individuals With Developing a Vision of Their Desired Future**

The following information is excerpted and adapted from “Increasing Person-Centered Thinking: Improving the Quality of Person-Centered Planning” [http://rtc.umn.edu/docs/pcpmanual1.pdf](http://rtc.umn.edu/docs/pcpmanual1.pdf)

When preparing to assist an individual with developing a vision of his/her future, consider the following:
RELATIONSHIPS
- What are the main patterns and themes in the individual’s network of relationships?
- What areas of relationship are missing? What would be important to build?
- Are there old friends or acquaintances from the past, with whom the individual would like to reconnect?
- Are there friends or acquaintances from the community that can be invited to join the Circle of Support planning meetings?
- Where could community members who would like to get to know this person be found?

PLACES
- What are the main patterns and themes in the places the individual spends time?
- Are there areas that are missing?
- Does the individual tend to go many places in a small group?
- Is the person really sharing community places, or just visiting them like a tourist?
- How can the person’s use of community places be utilized to strengthen his/her community membership?

HISTORY/BACKGROUND
- What are some of the themes found in the person’s history – for instance, many places lived in a short time, separation from family, etc.?
- Does the group really understand how this person’s life has been?
- How would you have felt at different times, if this had been your life?
- What is your and the group’s understanding of what is important to this person, given his or her history?
- What are some of the main themes of his/her life?
- Are there additional things you need to find out about his/her life?

PERSONAL THEMES
- What “works” for this person? What are his/her interests, gifts, and talents?
- What doesn’t “work”? Look for themes that will be important in building the Vision for the Future. For example, if the person doesn’t like loud noises or people telling him/her what to do.
- What will be important in where he/she would like to live?

QUESTIONS FOR REFLECTION ON THE QUALITY OF THE VISION
- Does the vision reflect a life as belonging to the services system, or is the vision one in which the person has a life equal to other community citizens?
  - Is the vision a community life or a services system life?
  - Is it a life inside the services system with some activities in the community?
  - Is the foundation for the vision a life as a typical community member?
- Are different parts of the vision distinguished, according to the following 4 life domains?

1. Work/meaningful activity
- What types of community jobs could you see the person doing?
- Does the vision reflect an individualized job, based on the person’s interests and gifts, versus an enclave or sheltered work setting?
If a job would not be the right expression for the person, are there meaningful activities described that support the person in contributing their unique gifts and talents, and supports them in being seen as a valued community member?

2. Home
   - What would this person’s own home, their own place, be like?
   - Does this vision reflect an individualized home with the support needed, versus a small group living situation?
   - If the person could live with anyone, who would they want that to be? (If that vision is to live with family or someone else that it’s not possible to live with, can the group identify the important elements of that preferred situation – for instance, a loving family, a young, energetic, caring person, etc.)?
   - What are their intimate relationships like – are they married, or in a relationship with a significant other? Do they have opportunities for sexual and romantic intimacy?

3. Friends/relationships
   - Does the vision include a wide variety of relationships?
   - Are there community members who would like to have this person as a friend, fellow club member, etc.?

4. Contribution in Community Life
   - Does the vision include valued social roles?
   - What community members have or should have the opportunity to appreciate this individual’s unique gifts and talents?

Next, please click on the following link to learn more about “Building Authentic Visions”: http://www.communityinclusion.org/article.php?article%20id=31&staff%20id=42

Identifying and Writing Goals and Objectives (with Measures)

After a vision of desired future outcomes is identified, the Circle of Support can then help the individual identify the long-term goals and short-term objectives that will help move him/her toward that vision. The goals and objectives help to chart a type of roadmap for how the individual will move from his/her current status toward his/her vision/desired outcomes.

A long-term goal (often an “annual” goal) is a broad statement describing estimated long-term (often yearly) outcomes for an individual, which addresses areas of identified need and will help the individual move toward his/her vision/desired outcomes. There is no “right” number of annual goals.

Goals are a written expression of direction that identify priorities for the person with dd. Goals set the direction for the training and supports to be provided to the person. Goals should be stated in positive terms, and logically tie back to the individual’s vision of a desired future.

Goal Domains

To assist the individual with determining his/her goals, it is often helpful to look at the relatively broad domains of life that are addressed in the individual’s vision/desired outcomes statement, such as living, working, playing/participating, and learning.
Living
Goals in this domain will pertain to the individual’s vision for where he/she would like to live. Examples of goals for this domain are as follows:
- Thomas will demonstrate responsibility as a roommate by completing his fair share of household chores.
- Valerie will pay her utility bills on time.
- Mike’s monthly spending will be within his monthly income.

Working
Goals in this domain will pertain to the individual’s vision for where he/she would like to work or otherwise spend time engaging in activities that are meaningful to him/her. Examples of goals for this domain are as follows:
- Sally will keep her current job at ______________________ [name of employer].
- Eric will obtain a job with health insurance benefits at ______________________ [desired place of employment].
- [For an individual who does not desire community employment:] James will interact appropriately with his staff and peers at ______________________ [name of day habilitation program], with a behavior support plan.

Playing/Participating in the Community
Goals in this domain will pertain to the individual’s vision for community-based activities in which he/she would like to participate, and ways in which the individual would like to contribute to the community by using his/her unique interests, gifts, and talents. Examples of goals for this domain are as follows:
- Annie will behave in ways that enhance her reputation in community settings.
- Meredith will volunteer at the local food pantry.
- James will participate in exercise classes at the local YMCA.

Friends/Relationships
- Sarah will improve her hygiene.
- Dalton will have more friends at work.
- Lynn will spend more time with ______________________ [name of unpaid friend or family member].

Other Goal Domains: Learning, Problem-Solving, Decision-Making, Personal Responsibility, Health, etc.
It is important to note that goals may also relate to numerous other life domains that can be relevant to the individual’s vision of a desired future. Four of these domains are listed below.

Learning
Knowledge and skills related to reading, using money, understanding numbers, using a computer, etc.

Problem-Solving
Understanding what to do in unusual situations

Decision-Making
Behaviors related to making good decisions and choices

Personal Responsibility
Behavior related to organizing one’s environment, planning one’s schedule, and/or time management.

Health
Knowledge and behavior related to one’s diet, exercise, and medical care
Examples of goals in these domains are as follows:

- **[Learning]** Lyle will use a calculator to balance his checkbook.
- **[Learning]** Cassandra will use the “Dollar More” method to make purchases under $20.
- **[Problem-Solving]** Pat will distinguish between emergency and non-emergency situations.
- **[Problem-Solving]** Kyle will know what to do if he is locked out of his house.
- **[Decision-Making]** Carla will choose to eat foods that are recommended for diabetics.
- **[Decision-Making]** Anthony will choose not to supply beer to his underage friends.
- **[Personal Responsibility]** David will keep his work area clean and organized.
- **[Personal Responsibility]** Sommer will get at least 7 hours of sleep per night.
- **[Health]** Katie will manage the symptoms of her diabetes by losing 20 pounds.
- **[Health]** Jon will increase his physical fitness through regular exercise.

Because goals are projected over long periods of time they are written in broad terms, but they are often written as observable behaviors. Verbs such as “demonstrate,” “improve,” “increase,” “develop,” “decrease,” or “complete” are words to describe the kinds of behaviors that can be observed.

These broad goals will then need to be converted into short-term objectives. A short-term objective is a description of a step needed to achieve a long-range goal. Short-term objectives serve as benchmarks to measure progress toward achieving long-range goals. The number of short-term objectives for each long-range goal will vary, depending on the individual situation. Some goals will have multiple objectives.

Remember that identifying objectives starts with finding out the outcomes the individual wants! Ask the individual what he/she wants to be able to do or know or participate in or receive assistance with. Brainstorm possible outcomes with the individual’s Circle of Support. Select those that best reflect the ones that are essential to helping the individual achieve his/her general goals and vision.

Objectives should also be based on formal and informal assessments of what the individual needs in order to achieve his/her long-term goals and his/her vision/desired outcomes.

**Objective Domains (as appropriate to the individual)**

Objectives may target an individual’s skills or behaviors in a wide variety of domains. Some of those domains are listed below, with examples of specific tasks or behaviors related to each domain. **NOTE:** The domains and lists below provide only some examples, and are not intended to be exhaustive.

It is important to note that objectives should be written only for those domains that are appropriate to the individual – in other words, those that are needed to help him achieve his/her long-term goals and/or vision of a desired future. A given individual may have several objectives in some domains, and no objectives in other domains.

**Self-care**

- Using the toilet
- Bathing
- Dressing
- Tooth brushing
- Eating and drinking
- Shaving
- Feminine hygiene
- Hair care (shampooing/rinsing, brushing, etc.)
- Nail care
- Skin care
- Hand-washing
- Eyeglass care
Communication
- Self-advocacy
- Expressing wants, needs and feelings (using words, signs, pictures, or adaptive communication device)
- Using a computer to send email messages or Facebook comments
- Writing simple notes
- Ordering a meal at a restaurant

Socialization
- Saying “please” and “thank you”
- Addressing others by their first name
- Appropriately greeting others
- Initiating conversation
- Ending conversation
- Inviting others to an activity or event
- Maintaining appropriate personal space
- Using appropriate voice volume
- Avoiding perseverating on a specific topic
- Participating in preferred recreation/leisure activities

Safety
- Locating and dialing emergency numbers
- Using household objects and appliances safely (knives, electrical items, etc.)
- Crossing the street
- Locking doors
- Protecting personal information

Perceptual Motor and Mobility Skills (Movements requiring hand-eye coordination and/or body-eye coordination)
- Using good posture
- Playing computer or video games
- Playing card games
- Using hand-held objects (pens, pencils, table utensils, etc.)
- Drawing
- Constructing/building objects
- Manipulating job-related items
- Walking and balance (with or without assistive device)
- Getting into and out of chairs
- Using steps
- Using a wheelchair
- Transferring from wheelchair (to toilet, chair, or bed)

Functional Arithmetic
- Using numbers
- Using money
- Measuring items
- Comparing “less” vs. “more”
- Telling time
Behavior Support
Behavior support objectives are typically designed to increase desirable behaviors and decrease undesirable behaviors. A few examples are as follows.

<table>
<thead>
<tr>
<th>Increase</th>
<th>Decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate verbal interactions</td>
<td>Use of profanity, screaming, name-calling, demeaning comments</td>
</tr>
<tr>
<td>Appropriate non-verbal interactions</td>
<td>Physical aggression (grabbing, slapping, pinching), violence (hitting/punching), inappropriate gestures</td>
</tr>
<tr>
<td>Appropriate use of objects</td>
<td>Throwing, smashing or otherwise breaking objects</td>
</tr>
<tr>
<td>Expressing emotions in an appropriate manner</td>
<td>Self-abuse (or other behaviors listed in the “decrease” column)</td>
</tr>
</tbody>
</table>

Vocational Skills
- Distractibility (time on task)
- Punctuality
- Quantity of work
- Quality of work
- Response to supervision
- Interaction with peers

Community Experience (and Access)
- Using personal transportation
- Using public transportation
- Using public services (library, post office)
- Using banking services (cashing a check; depositing money into a savings account)
- Participation in community activities
- Membership in community groups

Use of Adaptive Technology
- Using an adaptive communication board
- Using adaptive switches to operate devices in one’s environment (TV, radio, etc.)
- Using specialized computer software (for individuals with visual and/or hearing impairments)

Daily Living skills
- Doing laundry (using the washer and dryer; folding and putting away clean clothes)
- Cleaning house (sweeping, mopping, using the vacuum cleaner, dusting)
- Cooking and food preparation
- Washing and drying dishes
- Keeping home areas picked up
- Making a grocery list
- Grocery shopping
- Paying bills

Health Maintenance
- Taking prescribed medications
- Exercising
- Nutrition
Training Objectives vs. Assistance/Participation Objectives

The Individual Plan may include two types of objectives: Training objectives and Assistance or Participation objectives.

- **Training** objectives are intended to help the individual gain and improve upon his/her current skills. Training objectives should be measurable, so the individual and his/her Circle of Support can assess success and progress. They also require the individual to receive training of some type. When County Board of DD staff are responsible for providing this training, they typically must follow a written procedure for properly providing such training.

- **Assistance or Participation** objectives are intended to help the individual maintain his/her present level of skills or to participate in desired activities. They do not need to be measurable, and they typically do not involve specific techniques or procedures for staff to follow. For example:
  - Dirk will receive assistance with safely getting into and out of the bathtub.
  - Betsy will participate in weekly exercise classes at the local health center.

Training objectives may relate to the individual’s behavior, skills, knowledge, or attitude. They should also specify the conditions for achievement (e.g., level of assistance or prompting the individual will be given). Training objectives reflect what the individual will know, think, or do (e.g., how he/she will behave) as a result of the service provided. They should be written in measurable and observable terms.

The information in the following sub-sections pertains to writing Training objectives.

*Please also refer to Section 2 of this manual for more information on characteristics of goals and objectives.*

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Training objectives are sometimes called “behavioral” objectives. Behavioral objectives identify skills or activities that are observable and measurable. They help define the progress a person is expected to make in a specific domain. An objective is a specific statement of one step that is necessary to achieve a goal. Objectives are typically accomplished in a shorter time period than goals. A goal may consist of several behavioral objectives that specify the steps the person must complete to meet the goal.

Three critical elements of a behavioral objective are:

1. The behavior to be learned (Example: John will button his shirt.).
2. The conditions under which the behavior is to occur. (Example: *Given a verbal prompt to button his shirt, and the use of a buttoning hook, John will button his shirt.*)
3. How well or to what standard the behavior must be performed. This is also called the “criterion for success.” (Example: *Given a verbal prompt to button his shirt, and the use of a buttoning hook, John will button his shirt within 60 seconds, on 3 consecutive trials.*)

- The criterion for success may be expressed in terms of accuracy/quality, speed, duration, or quantity of the target behavior.

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12 Information in this sub-section is adapted from chapter 7 of *Developing Staff Competencies for Supporting People with Developmental Disabilities*, by J. F. Gardner and M. S. Chapman (1993).
5 Basic Steps to Writing Training Objectives

1. Identify the individual’s general goal, to help identify needed steps of desired change. Clearly indicate what the desired change is.

2. Identify what the individual’s behavior/knowledge/skill will look like once the change has occurred. Define if this means an increase, decrease, or to maintain.

3. Specify the amount of change that will signify a successful result. Apply these terms: How much, How Often, How Long

4. Specify what outcome should result from the successful provision of the service.

Next, translate these outcomes into the language of specific, measurable, observable behaviors. Identifying a criterion for success is important so that it is clear to the individual and his/her team when the objective has been successfully met.

Characteristics of Clear (Well-Written) Objectives

- Includes specific information concerning the task, steps, endpoint, desired change, result, or impact
- Includes the outcome that should result from successful provision of the service (i.e., specifically what is going to happen as a result of the service provision)
- Identifies the desired time frame
- Indicates how progress will be measured and how you will know when the service has been successful. Specifies when the objective has been accomplished.
- Uses observable and measurable terms
- Indicates how much of a particular service will be provided during a given time period

Examples of “Fuzzy” (Poorly-Written) Objectives

- Bob will increase self-sufficiency
- Bob will reduce violence.
- Staff will help Bob feel good about himself.

Examples of Well-Written Objectives

Goal: Bob will improve his self-sufficiency related to personal hygiene.

Objective: Bob will brush his teeth (or any other task related to hygiene that Bob selects), two times daily at his home, without verbal reminders from his support staff, for 10 consecutive days. Target date is:___________________.

Goal: Bob will improve his ability to manage stress.

Objective: When Bob is agitated at home or at work, he will use deep breathing techniques to calm himself and avoid using violence, with verbal prompting or visual cues from staff, for 30 consecutive days. Target date is:____________________.

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More information on Training (“Behavioral”) Objectives

A complete behavioral objective will:

- Identify the learner [the participant] (Who?)
- Identify the target behavior (What? -- use an action verb)
- Identify the conditions under which the behavior is to be performed (use words such as "when" and "in"; and include the level of prompting or assistance to be given); and,
- Identify criteria for acceptable performance.*
  *Criteria for acceptable performance may be increased over time, when the individual consistently demonstrates mastery (achievement) at the current level

Put differently, behavioral objectives should specify Who, What, When/How and How:

- Who: Who is the learner?
- What: What do you want this person to DO?
- When/How: When or how will the person know that it is time to DO the behavior? This could be a natural cue, such as getting up in the morning; it could be a verbal cue or almost any other type of appropriate cue.
- How: How will you AND OTHERS observing, know that the behavior has been accomplished? What is the measurable criteria for acceptable performance?

Note: Typically, well written goals, objectives and plans will contain time lines. The time line or expected completion date of an objective may, and often does, come before the expected date of completion for the overall goal.

More examples of poorly-written objectives

- Sarah will come to work without smelling badly.
- Annie will stop stripping her clothes off during community outings.
- Thomas will take out the trash.
- Dalton will try to sit quietly in his work area.
- Sally will transition in a timely manner.

More examples of well-written objectives

- Sarah will take a shower or bath before coming to work each day, given verbal reminders, for 10 consecutive days.
- Annie will remain fully dressed when she is in community settings, given visual cues by her support staff, for 30 consecutive days.
- Thomas will carry his trash to the curbside each Thursday morning by 8:00 a.m., with no reminders, for 8 consecutive weeks.
- Dalton will work for 30 minutes without throwing parts or shouting loudly at his co-workers, with no more than one verbal prompt, 3 times a day for 5 consecutive days.
- When the bell rings at 12:30 to signify the end of lunchtime, Sally will return to her work station by 12:33, without verbal prompting from her supervisor, for 10 consecutive days.

14 Source: [http://www.collaboration.me.uk/BEHAVIOR_MODIFICATION.php](http://www.collaboration.me.uk/BEHAVIOR_MODIFICATION.php)
Behavioral Goals and Objectives\textsuperscript{15}

A goal defines the end toward which effort is directed.

Objectives define an outcome for a specific behavior, and incorporate the following:
- The conditions under which a specific behavior is to be observed or expected to occur
- The specific behavior the individual will exhibit
- The criteria (standard or level of performance that indicates the objective has been successfully met).

Example
Goal:
Tara will increase her assertive behavior with peers.

Objectives:
1. Tara will identify verbally assertive responses when presented with alternatives, on 5 consecutive trials.
   - This is the easiest level of performance
2. When presented with a role play of a peer-related situation, Tara will state calmly what is bothering her, on 5 consecutive trials.
   - This is a more difficult level of performance, as Tara must demonstrate the skill
3. When feeling victimized by peers, Tara will state calmly what is bothering her, with one verbal prompt, 90\% of the time over a period of 4 weeks.
   - This is a most difficult level of performance, as Tara must use the skill in a natural environment, rather than an artificial training setting
4. When feeling victimized by peers, Tara will state calmly what is bothering her, with no verbal prompting, 90\% of the time over a period of 4 weeks.
   - This is the most difficult level of performance, as Tara must use the skill in a natural environment and not rely on prompting from another person.

Note: Because the word “calmly” is subject to interpretation, the Individual Plan should be clear and specific concerning what “calmly” looks like, in terms of Tara’s behavior. For example, while stating what is bothering her, Tara will:
- Maintain eye contact with the person she is speaking to
- Refrain from crying
- Refrain from yelling

Note:
- Goals and objectives should be always be customized to the individual’s needs and vision.
  - Avoid using “cookie-cutter” goals and objectives (i.e., the same ones for all individuals).
- Goals and objectives should be selected and driven by the individual and what he/she wants
  (with guidance from his/her Circle of Support)

\textsuperscript{15} SOURCE: http://edweb.tusd.k12.az.us/exced/forms03/Forms_pdf/Behavioral_Goals_Obj_021027.pdf
Numerous examples of goals and objectives can be found on this website.
Final Thoughts on Goals and Training Objectives

Selecting and stating clear long-term goals and measurable short-term objectives provides both service providers and individuals served with a focus for learning. Effective “teachers” begin planning by selecting and stating goals and objectives (as determined by the individual, with guidance of his/her Circle of Support). They then select appropriate materials, strategies and methods, and evaluation techniques to teach and measure the accomplishment of the objectives that lead toward accomplishment of goals. Both teaching and learning are more effective when goals and objectives are appropriate for the learners and stated in clear and measurable terms.

A long-range goal is the destination, or what the individual wants to be able to do over a long period of time. Goals are broad, long-range aims, that are difficult, if not impossible, to measure.

To enable individuals to reach long-range goals, each goal needs to be broken down into specific, measurable short-term objectives. Most long-range goals require that several objectives are met before the goal can be accomplished.

Goals are not usually clearly measurable

Objectives are: Good objectives have four characteristics: they are person-centered; they state an outcome and not an activity; they are measurable; and they are clear.

Student Centered
Measurable
Outcomes, not activities
Clearly stated

Person-Centered

Good training objectives focus on the individual with dd, not the staff person providing services and supports. Each statement should begin with the phrase "________ (name of individual) will...” Example 1 below is person-centered, while Example 2 is “teacher”-centered and would not be acceptable.

1. Fred will say “please” when making a request, with no verbal prompts, for 5 consecutive days.
2. I will teach Fred proper manners.

Source of all information in this sub-section: http://web.utk.edu/~mccay/apdm/longrange/longrange_b.htm
Outcome, not an activity

Good training objectives tell what the individual is expected to know or be able to do after the service/support or instruction is provided. As such, the statement is future-oriented and describes an outcome, not an activity. Example 3 below does not meet this condition. Rather than specifying an outcome, it cites an activity in which the individual will participate. We can rewrite this as an outcome, as shown in example 4.

3. Connie will participate in a Current Events class. (Note: This may be appropriate as an Assistance or Participation objective.)
4. After a 30-minute discussion of current political events, Connie will name two candidates who are running for President, in 3 consecutive sessions, with no verbal or visual cues.

Measurable

Good objectives can be measured. The verb used in an objective is very important. Some verbs are particularly vague. Notice the verbs in the objectives in examples 5 and 6.

5. Frank will know how to balance his checkbook.
6. Malinda will understand how to post a comment on her own Facebook wall.

The verbs make these objectives difficult to measure. We cannot look inside the individual’s head to see if the knowledge is there. Therefore, we must be careful to use verbs in our objectives that are measurable by watching an individual perform, listening to an individual, or analyzing an individual’s work. Consider the difference between the original objectives 5 and 6 above, and the way we have reworded them below to make them measurable.

7. Frank will accurately balance his checkbook, with no assistance, for 3 consecutive months.
8. Malinda will post a comment on her own Facebook wall that is understandable to others, without assistance, on 3 consecutive attempts.

Clear

Well written training objectives are also clear in describing the outcome. The objective should be understandable to the “teacher,” the individual with dd, and members of his/her Circle of Support. Consider Example 9.

9. Bonnie will compare three lunch options.
While we have used a descriptive verb (compare), we have been less than specific about what it is that we want the individual to compare. Do we want the student to compare the number of calories in each option, the fat content, the cost, or the over-all nutritional value? Different staff members may ask Bonnie to compare different aspects of lunch options, due to our lack of precision in stating the objective.

Always choose the wording of objectives very carefully. The objective should be a guide for staff behavior as well as a guide to how we will assess successful achievement. Make sure the verb describes specifically what the individual will be expected to do. We can clarify our objective as follows:

10. When given 3 lunch options, Bonnie will select the option with the fewest number of fat grams, with no more than 1 verbal prompt, on 5 consecutive occasions.

**Logical Sequencing of Goals and Objectives**

Appropriate sequencing of long-range goals and short term objectives is necessary if individuals are going to be able to master their goals and objectives. Therefore, the individual, with the help of his Circle of Support, must decide the best or most logical sequence of short-term objectives that will lead toward achievement of long-range goals. When good, thoughtful sequencing of goals and objectives occurs, the individual's opportunity for learning is enhanced. Without proper and logical sequencing of objectives, learning is more difficult and may not result in the desired outcome.

**Identifying Strategies and Resources/Supports Needed to Assist the Individual with Achieving his/her Vision/Desired Outcomes, Goals, and Objectives**

After the individual and the Circle of Support have clarified his/her Vision/Desired Outcomes, and identified Goals, and Objectives, they must then seek to identify what the individual needs in order to achieve his/her goals and objectives. This is often accomplished through a Needs Assessment. The Needs Assessment should identify obstacles and opportunities related to achieving the individual’s goals and objectives. Obstacles may include, for example, issues related to the individual’s disability (cognitive or physical limitations), attitudinal barriers in the community, or lack of resources. The needs should be prioritized, and strategies developed for addressing the needs that are identified as highest priority. Strategies should address the resources/supports the individual will need to achieve his/her goals, and include a plan for accessing or developing those resources/supports. Resources may include money, materials, information. Supports may include training, personal assistance, or natural supports.
Next, the Circle of Support should identify the commitments each team member will make to take action to implement the strategies identified (i.e., who will do what to address the needs and develop the needed resources and supports).

**Writing Progress Notes (based on data/documentation)**

After the above steps are completed, the individual and his/her Circle of Support will need to determine how often progress toward his/her goals and objectives will be reviewed, and by whom. Progress reviews should be recorded in written notes, and shared with the individual and members of his/her planning team, as determined by the individual (and in accordance with State and Federal requirements).¹⁷

The information included in progress reviews also depends on State and Federal requirements, as well as the policy of the organization providing services. Generally speaking, progress reviews should include a review of services provided for each goal and objective in the Individual Plan and reflect whether the individual has shown an increase, decrease, or maintenance of skill, knowledge, or behavior for each objective.

Progress reviews—especially for training objectives—are dependent upon the availability of accurate and relevant data. “Data” refers to the information staff record or collect related to an individual's goals and objectives. Data is typically found in the form of recorded notes and observations related to a specific objective, written by staff who work with the individual.

It is critical the data/documentation be *accurate* and *timely*. This means that staff members must seek to document their observations of the individual as quickly as possible after the observation has occurred, while it is still fresh and clear in their memory.

Data/documentation should also be *objective*. Staff should report only the objective facts of their observations (what they saw or heard or smelled), not their opinions or judgments or interpretations (unless requested to do so).

Accurate data/documentation is critically important, for the following reasons:

- It is a tool to ensure that services have been rendered in accordance with the Individual Plan.
  - For Medicaid waiver-funded services, it provides the basis for billing for services provided, and payment from Medicaid for those services. Failure to accurately document the provision of Medicaid waiver-funded services is very serious, and could constitute Medicaid fraud, potentially resulting in legal charges and loss of funding.

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¹⁷ State and federal regulations may stipulate how often progress reviews are to be completed. Such regulations may also stipulate who must receive copies of progress notes. Typically this includes the individual, his/her legal guardian, and each entity that provides services/supports to the individual.
• It helps the individual and his/her team to determine if the services are helpful and beneficial, or if they are not working and changes need to be made. In other words, it helps determine if the Individual Plan is successful.
  o If the individual is not making sufficient progress toward a particular objective, perhaps the techniques staff use for working with the individual need to be changed. Or perhaps the criterion for success needs to be made more achievable.
  o If the individual achieves an objective, he/she may wish to add a new objective that further helps him/her progress toward his/her goals and vision.

Data should be routinely monitored for (1) improvement/increase, (2) decline/decrease, or (3) maintenance of the individual's skill level, knowledge or behavior related to each objective. Data should also be routinely monitored for an individual's refusal to participate in a service.

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**Individual Service Planning: Components and Requirements**

For a good overview of the components of an Individual Service Plan (for individuals receiving Medicaid waiver-funded services), please click on the following link:

[http://dmh.mo.gov/docs/dd/4060.pdf](http://dmh.mo.gov/docs/dd/4060.pdf)

**NOTE:**

- This document was written for service providers in Missouri. The requirements for Individual Service Plans in Ohio are somewhat different.
- The term “Contingent” means that inclusion of that component will depend on the specific needs of the individual.

The Service and Support Administration rule (Ohio Administrative Code 5123:2-1-11) includes specific requirements for the development and review of Individual Services Plans (ISPs), as follows:

(J) ISP development

[The Services and Support Administrator] shall develop ISPs… [and] shall also:

1. Ensure that the development or revision of the ISP:
   a. Occurs with the active participation of the individual to be served and other persons selected by the individual, and, when applicable, the provider(s) selected by the individual;
   b. Addresses the results of the assessment process…and of the monitoring [of ISP implementation];
   c. Focuses on the individual's strengths, interests and talents;
   d. Integrates all sources of supports, including alternative services, available to meet the needs and desired outcomes of the individual;
   e. Occurs in accordance with rules adopted by the department.

2. Certify by signature and date that an ISP meets the following criteria for approval. This approval shall occur prior to implementation.
   a. All ISPs shall:
(i) Assist the individual to engage in meaningful, productive activities and develop community connections; and
(ii) Indicate the provider, the frequency, and the funding source for each service and activity; and
(iii) Specify which services will be coordinated among which providers and across all appropriate settings for the individual.

(3) Review and revise the ISP as appropriate under any of the following circumstances:
   (a) At the request of the individual or a member of the individual's team;
   (b) Whenever the individual's assessed needs, circumstances or status changes;
   (c) As a result of ongoing monitoring of ISP implementation, quality assurance reviews, and/or identified trends and patterns of unusual incidents or major unusual incidents…

To summarize Section 3, the process of developing an Individual Plan may be thought of as a process illustrated by the following figure

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CASE STUDY

DEVELOPING AN INDIVIDUAL SERVICE PLAN

Casey is 25 years old, and has a diagnosis of moderate mental retardation. When he went to school, he attended Special Education classes but was included with his nondisabled peers in recess, lunch, and music. He is physically healthy, but has difficulty using his right hand to grasp various objects. When Casey was in school, he attended the local Career Center and explored a variety of jobs, including food service, lawn care, janitorial services, cashiering, and manufacturing. He found that he really enjoyed doing lawn care, but did have some trouble with the tasks because of limited use of his right hand. He

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does mow his parents’ yard safely, using their push-mower (which can be started by turning a key), but has difficulty operating their grass/weed trimmer. His parents always compliment him on how nice the yard looks when he’s mowed it. After graduation, he was not able to find a job in the community, so he has been working at a sheltered workshop for about 3 years. He enjoys working at the sheltered workshop, is generally satisfied with his paycheck, and has made lots of friends there. He sometimes still wishes he could work at a lawn care job in the community, but doesn’t feel confident that he’ll be able to get that type of work.

Casey lives with his parents and 17-year old sister. His 20-year old brother goes to college and has his own apartment with some friends. When Casey visits his brother at college, he dreams about having his own apartment with friends. But he doesn’t make enough money at the sheltered workshop to be able to afford rent. And he would need someone to help him with cooking, cleaning, paying his bills, and reminding him to do his laundry – things that his parents do for him now.

Casey does not have a driver’s license or car. Although he lives within a 10-minute walking distance of downtown (including a couples of banks, the library, and post office), the walk can be very cold in the winter time and very hot in the summer time. The closest grocery store is also about a 10-minute walk away. He can ride a bike, but his parents don’t allow him to ride more than a couple of blocks from home by himself, due to safety concerns. Casey loves to go to the movie theater, but the closest one is about a 20-minute drive from where he lives. He would love to ride his bike further from home and, better yet, to have a driver’s license.

Casey goes to church on a fairly regular basis with his parents and has two friends there who always talk to him, regularly invite him to sit with them, and invite him to various church activities. But most of his friends are at the sheltered workshop, and they too have disabilities. Only one of his friends from the sheltered workshop has a driver’s license; but his friend doesn’t have his own car. Mike, one of his nondisabled buddies from high school, stops by occasionally to say “hi” and calls on the phone every now and then. But he seems pretty busy with his job and girlfriend. Casey would like to take his friend Carrie (who also was in Special Education classes) on a double date with Mike.

Other than going to the movies, Casey likes to putt-putt golf and drive go-carts. He loves watching NASCAR racing on TV and would love to go to a real NASCAR race every now and then.

After talking with his Circle of Support about his dreams, what he likes to do, and what he depends on others to do or help him with, Casey and his team developed the following Vision.

**Vision/Desired Outcomes Statement**

Casey would like to...

- Live in an apartment with one or two friends.
- Ride his bike to go places he enjoys within the city limits.
- Have a driver’s license and his own car OR have friends who can take him places on a regular basis.
• Take Carrie on dates, sometimes with Mike and his girlfriend
• Have his own yard care business

After identifying his vision, Casey’s Circle of Support helped him identify and prioritize goals to help him take steps toward his vision. He and his team decided it was most important for him to focus on starting his own yard care business, because that would help him have more money for renting an apartment, and maybe even buying his own car someday. Having his own yard care business will also help him have money to pay for gasoline when his friends with cars take him places.

Goal 1: Casey will save enough money to buy his own lawnmower and electronic trimmer.

Training Objective 1: (should be objective and measurable)
Casey will “land” at least 6 lawn mowing customers by March 31 of next year, with verbal prompting.

Assistance or Participation Objective 1:**
Casey will receive his parents’ assistance to help him make a list of neighbors to contact, to offer to mow their yards. They will help him develop and memorize a “script” for what to say when he makes these contacts.

Goal 2: Casey will improve his skills using a grass/weed trimmer.

Training Objective 2: (should be objective and measurable)
Casey will use a grass/weed trimmer to satisfactorily trim the edges of his parents’ sidewalks and driveway, with visual supervision and no more than 3 verbal prompts, on 5 consecutive trials.*

Assistance or Participation Objective 2:**
Casey will observe his dad operating the grass/weed trimmer for 30 minutes. He will also receive hand-over-hand assistance with operating the trimmer for 15 minutes.

Goal 3: Casey will learn to safely ride his bike within the city limits.

Training Objective 3: (should be objective and measurable)
Casey will safely walk his bike across Shoop Avenue, on 10 consecutive trials, with visual supervision and no more than 3 verbal prompts. *

Assistance or Participation Objective 3:**
Casey will receive safety supervision from his younger sister, while riding to the grocery store, once per week during the summer months.

*NOTE: Because all 3 goals indicate that Casey will improve his skills in some way, assistance/participation objectives would typically not be appropriate for these goals. These 3 assistance/participation objectives would typically be listed as training methods for helping Casey achieve the training objectives. They are listed here as assistance/participation objectives simply as examples.
**NOTE: When Casey masters this objective, a new objective will be written, with less prompting.

Additional Resources on Person Centered Planning and Circles of Support (Optional)

- [http://www.dds.ca.gov/Publications/docs/Person_Ctrd_Planning.pdf](http://www.dds.ca.gov/Publications/docs/Person_Ctrd_Planning.pdf)
- [http://www.youtube.com/watch?v=tvANuym5VXY](http://www.youtube.com/watch?v=tvANuym5VXY) (6-minute video)
- [http://www.youtube.com/watch?v=_WQ43eDBcTo&feature=related](http://www.youtube.com/watch?v=_WQ43eDBcTo&feature=related) (5-minute Powerpoint)

For a host of additional videos on Person-Centered Planning, go to [www.youtube.com](http://www.youtube.com), and enter “Person Centered Planning” into the search box.
Section 4: Training Methods

NOTE: Total time designated for this section is 4 hours.

Assignments for Section 4, located in the course Workbook:
- Section 4 Post-Test
- Activity 4A and 4B
- Section 4 Reflections Exercise

People with cognitive disabilities typically learn at a slower pace than those without cognitive disabilities. If you are taking this course, you are probably responsible for helping people with cognitive disabilities learn new skills and become more self-sufficient in some way. This section is designed to help you learn about training methods that can help you in working with people with cognitive disabilities.

It is important to remember that every person is a unique individual with unique learning needs and abilities. Therefore, the training methods that work for one person will not necessarily work for another person. It is essential that you, as a service provider, get to know each person’s unique needs and abilities. If you are responsible for writing training plans/strategies for helping individuals achieve their objectives, avoid using “cookie-cutter” or “one-size-fits-all” training plans, which are the same for all individuals. Although there certainly may be similarities in the training methods used for “Person A” and “Person B”, training plans should reflect the unique needs of the individual.

GENERAL TRAINING STRATEGIES

Many tasks that nondisabled people learn easily can be confusing and overwhelming to people with cognitive disabilities. Keeping in mind the need to tailor training methods to the individual, the following general training strategies are typically helpful for working with individuals with cognitive disabilities.

1. Focus on simple, concrete tasks and instructions. Avoid complex, abstract tasks and instructions. The word “complex” is defined as “Consisting of interconnected or interwoven parts” or “Composed of two or more units.” Many people with cognitive disabilities have difficulty learning tasks or following directions with more than a few steps. It is important to break complex, multi-step tasks into simple, smaller steps that are more manageable for the individual you are working with. This is often done through a process called Task Analysis, which will be reviewed later in more detail in this section.

18 All definitions in this sub-section are taken from http://www.thefreedictionary.com

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The word “abstract” is defined as “Not applied or practical; theoretical” or “Thought of or stated without reference to a specific instance.” Many people with cognitive disabilities have difficulty understanding language that uses abstract terms, such as “appropriate,” “self-determination,” or “safe.” These terms need to be made more concrete, in order for them to be understood and meaningful to the person.

The word “concrete” is defined as “Of or relating to an actual, specific thing or instance; particular” or “Existing in reality or in real experience; perceptible by the senses.” You can make your instruction concrete by providing exact directions and specific real-life examples and practical information that relates to things the individual can see, hear, or touch.

For example, the concept of “clean” is fairly abstract. If you are providing instruction in janitorial skills, and training an individual to clean a glass door, the individual may not understand what you mean by “clean” – unless you show him/her an example of a “clean” door, in contrast to a door that is not “clean.” You will need to teach the individual to look for spots, streaks, and smudges. By connecting the word “clean” to something the person can actually see with his/her eyes – spots, streaks, and smudges – you are making the concept of “clean” more concrete, which helps the person understand the practical meaning of “clean.”

Concrete reasoning tasks involve skills such as:
- Basic knowledge of names of objects, places, and people;
- Understanding of basic cause and effect relationships;
- Solving problems that have clear processes and logical solutions;
- Typically do not involve theory or complex thinking.

Simple, concrete tasks individuals have learned may later be connected into larger, more complex tasks through a process called “chaining,” to be described in more detail later in this section.

When working with people with cognitive disabilities, it is also important to make your instructions clear and concise (brief). Using too many words can be confusing to the person you are instructing. Also, some individuals may have difficulty understanding “if-then” instructions that require judgment. They may need instruction/training on how to make “if-then” decisions.

2. Gradually decrease the amount of assistance you provide.
When you are first providing training to an individual with cognitive disabilities, he or she may need a lot of direction, prompting, and assistance from you to complete even simple, concrete tasks. As he/she learns a task, you will want to reduce the amount of assistance you provide, so they become less dependent on your support. This process is called “fading” and will be discussed later in this section in more detail.

3. Be persistent – don’t give up quickly!
Sometimes people with cognitive disabilities need to make several attempts to successfully learn even a simple, concrete task. If they aren’t successful on their first attempt, don’t assume they can’t learn the task! Perhaps they just need to keep trying. Remember that for all of us, whether we have a disability
or not, making mistakes is an important part of learning. None of us are always successful in our first attempt at something. That is why we “practice” when we are learning to play an instrument or a sport. The individual may need encouragement to keep trying, especially when the task is challenging and his/her first efforts have not been successful. One way to encourage the individual is by focusing on his/her positive successes – that is, the part(s) of the task on which he/she has shown progress. In providing encouragement, remember to treat the person as an adult. Avoid treating the person as though you are the parent and he/she is a child.

If, after numerous attempts, the individual is still not making progress and is becoming frustrated, discouraged, or agitated, then consider trying a different training method/strategy. However, be sure you have given the current training method/strategy a good chance to succeed. Changing training methods too often or too quickly can be confusing to the individual, and can make it difficult to determine which training methods are most effective with the individual. If you have tried a particular training method/strategy for quite some time without seeing progress, be sure to consult with your supervisor or the individual’s SSA to discuss other methods that might be used.

4. **Be positive!**
Present tasks with enthusiasm, energy and a positive outlook on what the person can achieve, with the right accommodations and support. Do not react with pity, anxiety or other negative emotions when the person is having difficulty learning a task.

5. **Show first; tell later.**
Showing or demonstrating a task is often more effective than talking about it. Whenever possible, use demonstration first; use words later. People often learn best by seeing a particular task demonstrated before they hear instructions about how to do the task.

6. **Eliminate distractions as much as possible.**
If is not unusual for people with cognitive disabilities to be easily distracted by various factors in their immediate environment. For example, noises (including the voices of other people), bright lights, or even movement by other people can be very distracting. Generally speaking, settings which are relatively quiet and free from visual distractions (such as other people moving around, televisions, radios, etc.) provide the best learning environments.

7. **Use natural learning environments as much as possible.**
Whenever possible, training should be provided in the actual environment or settings where the task is most likely to be performed. For example, training in self-care skills (toothbrushing, hair care, shaving, etc.) and daily living skills (cooking, cleaning, doing laundry, etc.) are typically most effective if conducted in the individual’s own home. If training does not occur in the natural setting, the setting for the training should be arranged to be as much like the natural setting as possible. Doing so will make it easier for the person’s skills to transfer from the training setting to the natural setting. As much as
possible, however, you should avoid providing training in artificial environments, because many individuals have difficulty transferring their learning from one setting to another.

For additional strategies for providing training/instruction to individuals with developmental disabilities, click on the following links. Although this information is written for teaching students in educational settings, the same principles can be applied to working with adults in various settings.


**SYSTEMATIC METHODOLOGIES**

Most people, whether they have a cognitive disability or not, learn best through some type of systematic methods of instruction. Training that is presented inconsistently and haphazardly is likely to be confusing and not help the learning process. Therefore, before attempting to provide training to someone with a cognitive disability, it is important to have a plan using systematic methods of training.

Using systematic methods of training helps ensure that a particular task is being presented in a consistent manner to the individual. For example, it is important for Staff Person A to use the same methods as Staff Person B. Imagine that you wanted to improve your tennis skills, so you signed up for tennis lessons. On your first day of lessons, your trainer, Tina, taught you how to serve the ball. But on your second day of lessons, you had a different trainer, Tommy, who taught you a different technique for serving the ball. How confusing would that be? Similarly, the individuals we serve can become confused if different staff members use different training methods.

Likewise, it is important for a particular staff person to use the same training method from day to day. Using the tennis lesson example, perhaps you have the same coach (Tina) during every lesson. But imagine how confusing it would be if Tina taught you one method of how to serve during your first lesson, but then taught you a different method during your second lesson! How would you know if the first method worked or not?

Attempting to teach an individual something new without a systematic plan is like trying to bake cookies from scratch without a recipe! You are not likely to get the result you are hoping for!

The following is a brief overview of several key terms related to using systematic methods of teaching/instructing/training individuals with developmental disabilities. Several of these key terms will be reviewed in more detail later in this section.19

**Task analysis**

Task analysis is a process in which a task is analyzed into its component parts. The skill to be learned is broken down into small units/steps for easy learning. These steps can be taught through the use of chaining: forward chaining, backward chaining and total task presentation.

**Chaining**

Chaining involves teaching only one step at a time of a task analysis. When one step in the task analysis has been learned, training moves to the next step in the sequence. This process continues until all steps in the task have been learned. For example, a person learning to brush his/her teeth independently may start with learning to unscrew the toothpaste cap. Once he/she has learned this, the next step may be learning to squeeze the tube, etc.

For problematic behavior, chains can also be analyzed and the chain can be disrupted to prevent the problematic behavior.

*To see examples of forward chaining, watch the following videos:*

- [http://www.youtube.com/watch?v=liHREg_h7CM](http://www.youtube.com/watch?v=liHREg_h7CM) (Note that the sound for this video has very poor quality)
- [http://www.youtube.com/watch?v=jbPTSVuUaJA](http://www.youtube.com/watch?v=jbPTSVuUaJA)

**Prompting (Levels of prompting/intensity in supporting task outcomes)**

A prompt is a cue or assistance to encourage the desired response from an individual. Prompts are often categorized into a prompt hierarchy from most intrusive to least intrusive. There is some controversy about what is considered most intrusive: physically intrusive versus hardest prompt to fade (i.e. verbal). In a faultless (or “error-free”) learning approach, prompts are given in a most-to-least sequence and faded systematically to ensure the individual experiences a high level of success. There may be instances in which a least-to-most prompt method is preferred. Prompts are faded systematically and as quickly as possible to avoid prompt dependency. The goal of teaching using prompts would be to fade prompts towards independence, so that eventually no prompts are needed for the individual to perform the desired behavior. Types of prompts include the following (this is not an exhaustive list of all possible types of prompts):

- **Verbal prompts:** Utilizing words to indicate the desired response.
- **Visual prompts:** A visual cue such as a picture or checklist.
- **Gestural prompts:** Utilizing a physical gesture to indicate the desired response.
- **Positional prompt:** The target item is placed closer to the individual.
- **Modeling:** Demonstrating the desired response for the individual. This type of prompt is best suited for individuals who learn through imitation and can attend to a model.
- **Physical prompts:** Physically manipulating the individual to produce the desired response. There are many degrees of physical prompts, the most intrusive being hand-over-hand, and the least intrusive being a slight tap to initiate movement.

When using prompts to systematically teach a skill, it is not necessary to use every type of prompt listed above. Prompts are chosen based on which ones are most needed by and effective for a particular individual.

**Fading**

The overall goal is for an individual to eventually not need prompts. Fading involves slowly reducing the amount and intensity of assistance/prompting given. As an individual gains mastery of a skill at a particular prompt level, the prompt is faded to a less intrusive prompt level. This ensures that the individual does not become overly dependent on a particular prompt, or on the person providing the training, when learning a new behavior or skill.
Thinning a reinforcement schedule
Thinning is often confused with fading. Fading refers to a prompt being removed, whereas thinning refers to the spacing of a reinforcement schedule getting larger. For example, when an individual first begins to learn a skill, you may provide praise after successful completion of each step. But as he/she begins to demonstrate mastery of the task, you begin to provide praise after every-other step of successful completion. Some research indicates that an effective way to provide training is to decrease/thin reinforcement by 30% after the individual demonstrates mastery at the current level. Schedule thinning is often an important and neglected issue.

Generalization
Generalization occurs when an individual can perform a skill in different places, with different people, and with different materials. Once a skill is learned in one setting, with a particular instructor, using particular materials, the individual is given opportunity to demonstrate the skill in another setting, with another instructor, using somewhat different materials.

For example, if an individual has successfully learned to put on and zip up his/her coat at home, he/she may be given the opportunity to generalize the skill to other natural environments such as at work or at the homes of other people.

Shaping
Shaping involves gradually modifying an existing behavior into the desired behavior. If a child currently “plays” with a dog by hitting it, then the child’s behavior could be shaped by reinforcing interactions in which he/she touches the dog more gently. Over many interactions, successful shaping would replace the hitting behavior with patting or petting.

Shaping is often achieved by reinforcing “successive approximations” of the desired behavior. Reinforcing successive approximations refers to providing a reinforcement for doing something closer and closer to the desired behavior. For example: a college class decided to try reinforcing successive approximations to shape their instructor’s behavior so that he would give his lectures from the doorway. At first, every time the professor would sit behind his desk they would act uninterested and not pay close attention. But when he would stand, they would look at him intently and act more interested. After he was always standing, they started acting less interested if he was standing behind his desk and more interested when he was standing at the edge of his desk closer to the door. By the end of the month they had him giving his lectures from the doorway, which was their original goal.

Instructional Strategies: Planning the Instruction

20 Taken from: http://www.collaboration.me.uk/BEHAVIOR_MODIFICATION.php
21 Information in this sub-section is adapted from chapter 7 of Developing Staff Competencies for Supporting People with Developmental Disabilities, by J. F. Gardner and M. S. Chapman (1993).
The following information was written with regard to providing “instruction” to individuals with developmental disabilities. For the purposes of this course, the words “instruction,” “teaching,” and “training” are used interchangeably because they all refer to the same process.

Instruction should be a planned, systematic, and structured process. Learning, for the most part, does not happen accidentally. Successful planning enhances the individual’s ability to accomplish the goals and objectives in his/her Individual Plan. Teaching/training individuals with dd requires a systematic procedure that allows the individual to learn a skill in a step-by-step sequence. The methods of instruction should follow logical steps that lead from dependence to independence.

The following steps are recommended for planning instruction:

1. Determine if the behavior is simple or complex. If the behavior is complex, determine if a task analysis is needed.
2. Select the instructional methods and a strategy for eliminating assistance.
3. Determine your reaction to a correct or incorrect response.
4. Decide when to move to the next step in your instructional strategy.
5. Select instructional materials and the appropriate setting for instruction.
6. Identify opportunities for practice and generalization of the new behavior.

**Step 1: Determine whether the behavior is simple or complex.**

Simple behaviors are those that cannot be broken down any further. They stand alone and do not involve other behaviors. For example, sitting is a simple behavior. You would be unable to list behaviors that make up the behavior of sitting. Other examples of simple behaviors include looking, standing, or holding. Complex behaviors are a combination of several other behaviors. For example, driving a car is a complex behavior, involving hundreds of simple behaviors. The process of listing the simple behaviors that make up a complex behavior is called Task Analysis. You will learn more about task analysis later in this section.

**Step 2: Select instructional methods and a strategy for eliminating assistance.**

Five methods are frequently used in providing instruction:

1. Verbal Cueing
2. Modeling
3. Arranging the environment
4. Gesturing
5. Providing physical assistance

These are all “error-free” teaching approaches. “Error-free” methods ensure that the person learning a new skill makes a correct response and that learning takes place in a positive manner. They are intended to help the person be successful in learning a new skill by minimizing errors.

The goal of these methods is to help people to progress from dependence to independence in performing a skill or behavior. These methods are gradually withdrawn as the skill is learned. The process of reducing or eliminating these methods is called fading. Fading involves the gradual
withdrawal of assistance—providing less and less of a cue or prompt—until it is no longer needed. By systematically reducing the amount of assistance provided, fading contributes to independent performance of the behavior. Fading procedures should be listed in sequential, logical order from dependence to independence.

When providing instruction, the trainer should provide only the “least intrusive” type of assistance the person needs, as determined by the individual’s Circle of Support. For example, because gesturing is typically considered less intrusive than physical assistance, if an individual can learn a new skill using only gestures, the trainer should avoid using physical assistance because it is unnecessary.

Additionally, each individual method can vary in its level of intensity (amount of assistance). When providing instruction using any of these five methods, the trainer should provide the lowest level of intensity (amount of assistance) the individual needs to be successful. The individual may need a higher level of assistance at the beginning of the learning process, and a lower level of assistance as he/she begins to “master” the skill. That is why the level of assistance should be faded for each method as the individual begins to learn the skill.

**Verbal Cues**
Verbal cues involve using spoken words or spoken information to guide the person in learning the new skill or behavior. The level of specificity and direction involved in the instruction depends on the person’s needs. Verbal cues are generally appropriate for the person who understands 1- or 2-step commands, but they do not help the person who does not understand verbal messages.

Sample fading sequence for verbal cues:
1. The trainer says, “What should you pick up?” and then says, “the soap.”
2. The trainer says, “What should you pick up?” and then says “the so--.”
3. The Trainer says, “What should you pick up?” and then says, “the s----.”
4. The trainer says, “What should you pick up?”

Verbal cues can also be faded by decreasing the number of verbal cues given by the trainer—for example, from 3 to 2 to 1. They can also be faded by starting with clear, direct, specific instructions (e.g., “Put soap on your hands”) and moving to more vague “hints” or questions (e.g., “What do you do after you turn on the water?”).

**Modeling**
Modeling involves demonstrating the behavior to be learned. The amount of the behavior you model when you begin the instruction depends on the needs of the individual. Modeling procedures are generally appropriate for individuals who have the visual, cognitive, and motor abilities to imitate your movements. Modeling is not appropriate for persons who cannot imitate simple motor tasks. After modeling the appropriate behavior for a time, you include fading procedures.

Sample fading sequence of modeling procedures
1. The trainer says, “Take off your socks” and then grasps the top of her sock, pulls it downward until it comes off of her heel, then grabs the sock near her toes and pulls it off of her foot.
2. The trainer says, “Take off your socks” and then grasps the top of her sock, and pulls it downward until it comes off of her heel.
3. The trainer says, “Take off your socks” and then grasps the top of her sock.
4. The trainer says, “Take off your socks.”

**Arranging the Environment**

Making changes to some aspect of the person’s immediate environment can also help him/her to learn a task or behavior. The focus of this instructional strategy is on the environment, not on the individual. For example, using oversized bags can be helpful in teaching a person how to package products in bags. Fading can also be used with this method. Over time, the size of the bag can be decreased until a regular-sized bag is used.

**Gesturing**

Gestures are movements or expressions that bring about the desired behavior. Most people use gestures in communicating with others. For example, you may point to the desk when asking for a piece of paper. Or you may shake your head to express disapproval of someone’s behavior. Or you may develop a gesture code to indicate to a friend when you wish to leave a party. Gestures are effective teaching techniques for the person who needs only a little assistance in completing a desired behavior.

**Physical Assistance**

This procedure is commonly used for people with severe disabilities. It is also often used as a method for helping people learn activities of daily living, such as dressing and eating. It is also sometimes useful for teaching sequential motor tasks. Physical assistance can range from hand-over-hand, to guidance from the wrist or elbow, to tapping. Like other methods of instruction, it should be faded over time.

**Step 3: Determine your reaction to a correct or incorrect response.**

Successful use of error-free training methods requires that you decide ahead of time how you (and others who work with the individual) will respond to the person’s behavior – that is, how you will respond to correct and incorrect responses. If you do not plan your reaction, you (and others who work with the individual) may react inconsistently or randomly, which will likely delay and limit learning.

When deciding what your reaction will be, you must carefully consider the person and his/her abilities and preferred learning styles. When the person accomplishes a task or a step in the task, how will you react? More specifically, how will you reinforce the desired behavior? Will you use verbal praise? What exactly will you say? Will you smile, shake the person’s hand, give him/her a pat on the back, or give him/her a high five? Positive reinforcement should be provided whenever the person successfully performs the task at the current stage of the fading sequence, even though you have given assistance to him/her.

You must also decide what you will do if the person gives an incorrect response. Will you say, “No”? Will you ignore the response? Will you turn your head for 3-5 seconds? Or will you say, “Good try. Now try another way.”? Again, your behavior should be planned and consistent. If the person does not respond as desired, be sure to allow him/her plenty of opportunities to try again, and be sure to support his/her efforts and encourage him/her to keep trying, even if he/she is not initially successful.
Step 4: Decide when to move to the next step.
You must also decide when to move the person from dependence to increased independence—in other words, when you will move from the current stage of the fading sequence to the next stage. For example, assume you are using hand-over-hand assistance to teach a person to take off his/her socks. You will need to decide when to move from hand-over-hand assistance to guiding the person with your fingertips.

The time spent on each step in the fading sequence is extremely important. If you spend too much time on a step, or at a particular level of assistance, the person may become dependent on your help. If you move too quickly, however, the person may become confused. He or she may not have completely mastered the previous step, and moving to the next step will only decrease the chance for success. The decision to move to the next step depends on successful performance of the previous step. A general rule is to move to the next step in the sequence after the person demonstrates three consecutive correct responses.

Step 5: Select instructional materials and appropriate setting.
Selecting the materials and location for the instruction is also an important part of planning successful instruction. Decide on the materials in advance, and have them readily available when you begin the training process. The instructional environment affects the person’s learning. For example, does the person work best alone, or in a group situation? Whenever possible, teaching should occur in natural settings—that is, the place where the skill or behavior will be most frequently used/performed. For instance, dressing skills should be taught in the bedroom or bathroom, not in a classroom. It is best to teach a new skill step-by-step in a real-life setting.

Step 6: Identify opportunities for practice and generalization
Regardless of whether or not we have a disability, we all learn best when we have many opportunities to practice a newly learned skill. Practice helps us remember and refine our skills. This is especially true for people with dd, who have difficulty learning new skills. Therefore it is important to provide multiple opportunities for the individual to practice the new behavior or skill, first in the training setting and then in other natural settings. The process of transferring skills from the training setting to other environments and conditions is called generalization.

Providing time for the person to practice his/her new skill in natural settings is as important as having the opportunity to learn the skill to begin with. If the individual has few opportunities to learn and practice the skill in natural settings, you should question if it is a skill that is really important for the person to be learning.

What should you do if the individual is not showing adequate progress in learning?
If, after multiple attempts to train an individual on a specific step of the task, he/she does not show adequate progress in moving to the next stage of the fading sequence, you should re-evaluate the following aspects of instruction (in the order listed):

- The reinforcers used
Begin with a review of the reinforcers. Ineffective reinforcers will not motivate people to learn. Perhaps your reaction to successful performance (e.g., verbal praise, a pat on the back, etc.) is not an effective reinforcer or motivator for the individual. You may wish to consult with someone who knows the individual well to find out other possible methods of reinforcement or motivation for the person. Also, it is very important that you have a positive relationship with the person you are working with. Otherwise the person may resist your attempts to teach him/her, regardless of the type of reinforcement you attempt to provide.

If there is no change in performance after introducing the new reinforcer, review the task analysis. Are the steps in the task analysis too large? Is a particular step too difficult? If the individual gets “stuck” at a particular step, it may need to be further broken down into smaller steps.

If changing the task analysis still doesn’t result in progress, review the selected fading techniques. You may wish to add more stages to the fading sequence, so that fading occurs more gradually. Finally, if these efforts do not result in progress in learning, perhaps the objective is not appropriate for the individual.

**TASK ANALYSIS**

Tasks analysis is the process of breaking a complex task or behavior into a sequence of more simple tasks or behaviors—that is, into smaller, logical and sequential steps. In a nutshell, it is the analysis of how a task is completed, step-by-step. Task analysis simplifies the teaching of new skills by breaking a new behavior into logical steps within a sequence. The purpose of task analysis is to help simplify learning by focusing on helping the individual learn one step at a time.

To complete a task analysis, list the steps involved in the order they occur. You can do this from memory or by actually completing the behavior and listing the steps you performed. For example, consider the task of washing your hands. A task analysis might include the following eight steps:

1. Turn on water
2. Pick up soap
3. Rub soap on hands
4. Put soap down
5. Rub hands together
6. Rinse hands
7. Turn off water
8. Dry hands

The steps on the task analysis are listed in the order in which the behavior will be learned. You will notice that some of these steps can be further broken down into additional steps (i.e., broken down into more simple behaviors). For example, “turn on water” can be broken down into grasping the faucet, turning the faucet, adjusting the temperature, and controlling the water force. *The strengths/abilities*
and needs of the person should determine the number of steps in the task analysis. Some individuals will need the task to be broken down into numerous simple tasks/steps; other individuals will be able to learn the task in fewer steps.

FORWARD AND BACKWARD CHAINING

As mentioned earlier, teaching requires a systematic procedure that helps the individual to learn a skill in a step-by-step sequence. Two such procedures are forward chaining and backward chaining.

Forward chaining involves teaching the skill beginning with the first step in the task analysis, coupled with the first step in the selected fading sequence. The trials are presented until the criterion for movement to the next stage of the fading sequence is achieved. The instructor then proceeds to the second stage of the fading sequence while remaining on the first step in the task analysis. Instruction continues until the person performs the first step of the task analysis independently. The training session then moves to the second step of the task analysis.

Only after the individual completes step 1 of the task analysis with no assistance (no verbal cueing) does the instructor move on to applying the fading sequence to step 2 of the task analysis.

Forward chaining illustration:

<table>
<thead>
<tr>
<th>Task Analysis</th>
<th>Fading Sequence (Level of Assistance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Turn on water</td>
<td>A. Hand-over-hand assistance</td>
</tr>
<tr>
<td>2. Pick up soap</td>
<td>B. Guide hands with fingertips</td>
</tr>
<tr>
<td>3. Rub soap on hands</td>
<td>C. Tap hands to initiate</td>
</tr>
<tr>
<td>4. Put soap down</td>
<td>D. Verbal cue only</td>
</tr>
<tr>
<td>5. Rub hands together</td>
<td></td>
</tr>
<tr>
<td>6. Rinse hands</td>
<td></td>
</tr>
<tr>
<td>7. Turn off water</td>
<td></td>
</tr>
<tr>
<td>8. Dry hands</td>
<td></td>
</tr>
</tbody>
</table>

Backward chaining involves starting at the end of the task analysis. It involves teaching the skill beginning with the last step in the task analysis coupled with the first stage of the fading sequence. In other words, the instructor is concerned with applying the fading sequence to the last step of the task analysis. Trials are presented until the criterion for moving to the next stage of the fading sequence is achieved. Providing as much support as is necessary for all steps except the last, the instructor then proceeds to the second stage of the fading sequence. Once the last step in the task analysis is performed independently, the next to the last step in the task analysis becomes the focus of fading procedures. Individuals with DD often learn skills faster with the use of backward chaining.
Backward chaining illustration

Task Analysis

1. Turn on water
2. Pick up soap
3. Rub soap on hands
4. Put soap down
5. Rub hands together
6. Rinse hands
7. Turn off water
8. Dry hands

Fading Sequence (Level of Assistance)

A. Hand-over-hand assistance
B. Guide hands with fingertips
C. Tap hands to initiate
D. Verbal cue only

Whether you are using forward or backward chaining, for each step in the task analysis on which the individual has not yet received training, the instructor provides as much assistance as necessary to help the individual complete those steps (or the instructor may simply complete or demonstrate those steps for the individual). For example, while working on step 1 of the task analysis using forward chaining, the trainer provides as much assistance as needed for steps 2-8. While working on the last step of the task analysis using backward chaining, the trainer provides as much assistance as needed for steps 1-7.

Regardless of whether you use forward chaining or backward chaining, instruction should focus on teaching the individual one step of the task analysis, while moving through the stages of the fading sequence. Instruction moves from one step of the task analysis to the next when the individual demonstrates the ability to complete the current step without assistance. During the teaching process, assistance is provided to help the individual learn the current step in the task. This assistance must be systematically reduced (faded) to allow the individual to perform the step as independently as possible. After he/she has correctly completed the current step with the least assistance, you begin teaching the next step in the task.

FADING THE SUPPORT INTENSITY TYPE/LEVEL

The forward and backward chaining illustrations above present examples of a fading sequence using one specific type of training method at a time: physical assistance faded to verbal cue. However, it is important to note that training often involves a combination of the five types of training methods described earlier: verbal cueing/prompting; modeling/demonstrating; arranging the environment; gesturing; and providing physical assistance. When this is the case, the fading sequence will include various combinations of the types of assistance to be provided at each step. For example:

1. Hand-over-hand assistance with direct verbal cue (“Turn on the water.”)
2. Guide hands with fingertips with indirect verbal cue (“What should you do first?”)
3. Indirect verbal cue ("What should you do first?") followed by a gestural prompt (point to the water faucet)
4. Gestural prompt only (point to the water faucet)

**TOTAL TASK TRAINING**

Depending on the task and the individual’s abilities, it may be appropriate to use “total task training” rather than forward or backward chaining. With total task training, the individual receives training on each step of the task in each session, and is not required to master one step (i.e., perform one step independently) before receiving training on the next step in the task. In other words, the learner attempts all steps in the task analysis, from the beginning to the end, and reinforcement is provided at each step. This continues until the total task is mastered. Total task training is usually most appropriate for relatively simple tasks that the individual can readily learn. Forward and backward chaining is usually most appropriate for more complex tasks.

For two examples of total task training, click on the following link:

http://dmh.mo.gov/docs/dd/directives/4060ppt.pdf

**MORE ON CHAINING...**

With chaining, you are teaching specific steps in a task, one at a time. For example, let’s look at the task of teaching someone to prepare a peanut butter and jelly sandwich.

- With forward chaining, your first step might be to teach him or her to just get a plate out of the cupboard or retrieve the loaf of bread out of the breadbox within ten minutes of returning home from school. After learning the first step, the person would continue to complete the first step independently; however, you would then teach the next step (i.e. getting the jar of peanut butter out of the pantry).

- With backwards chaining, you may do all the steps for the person up to the very last step (or you may help the person do all steps up to the last one). In this case the last step may be putting the top piece of bread on the sandwich or returning the dish to the sink.

Chaining is very important in many situations. People who are of typical intelligence often learn things in chains. For example: driving a car is something that is learned a step at a time until it becomes second nature.

**A NOTE ON DOCUMENTATION AND DATA COLLECTION**

It is important to document the individual’s response at the specific step he/she is being trained on. In other words, you must collect data on each step of the task separately, to make the data useful—so that it teaches you and others reviewing the data where the individual is having problems with learning the task. The data will help you and other members of the individual’s team to determine where adjustments are needed to the training process.

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22 Adapted from: http://www.collaboration.me.uk/BEHAVIOR_MODIFICATION.php
**REINFORCEMENT**

“Reinforcement” is a very important part of training individuals with dd. To “reinforce” means to strengthen or increase in number. When applied to a training situation, we try to reinforce (strengthen or increase) particular types of behaviors and the performance of specific tasks, and we do this by rewarding the person after he/she demonstrates the desired behavior or performs the task.

The purpose of providing reinforcement is to encourage/motivate the person to repeat the desired behavior, or perform the task, again in the future. However, it is very important to remember that what is reinforcing or rewarding to one person may not be reinforcing or rewarding to another. Therefore, it is essential to make sure that the types of reinforcement you provide during training are meaningful to the individual you are working with. If you “reward” the person with something that is not meaningful to them, you are not likely to be successful in reinforcing the desired behavior!

Here are just a few possible methods of reinforcement:

- Verbal praise (“Good job.” “Way to go!” “That was great!” etc)
- Physical contact/expression (shaking hands; giving a high-five; giving a hug or squeeze around the shoulders, etc.)
- Food (in accordance with dietary considerations)
- Activities (giving the individual the opportunity to participate in a favorite activity or spend time with a favorite person)
- Tangible rewards (giving the individual the opportunity to earn something he/she really wants)

Just as the level of prompting/assistance should be faded as the individual learns a task, skill, or behavior, so also should the frequency and timing of reinforcement be “thinned.” When the individual is first learning a task, it is important to provide frequent reinforcement, immediately after he/she has correctly performed a step in the task analysis. However, after he/she has successfully performed a step a few times, it is important to decrease the level of reinforcement so the individual does not become overly dependent on the reinforcement. Reinforcement can be thinned either by providing the reinforcement less frequently or by delaying the timing of when you provide the reinforcement.

**“TRY ANOTHER WAY”**

Another systematic approach to training individuals with dd is called the “Try Another Way” method, developed by Marc Gold in the 1970s. To learn about this method, click on the following link and watch the 26-minute video: [http://www.mnddc.org/parallels2/four/video/video44-tryanotherway.html](http://www.mnddc.org/parallels2/four/video/video44-tryanotherway.html)

**Partial participation**

*Partial participation* is the principle that individuals with dd should be given the opportunity to participate in activities of their choice, alongside non-disabled individuals, to the extent that they are able, given needed supports and adaptations.

Many individuals with dd, especially those with severe cognitive or physical limitations, cannot fully participate in the same activities as nondisabled people, because they cannot fully perform certain tasks independently. They may lack the physical strength, coordination, or understanding that is necessary to
perform a task successfully or independently. However, they may be able to perform some steps of the same tasks as nondisabled individuals, with supports/assistance and adaptations. And they may be able to participate in certain parts of activities alongside nondisabled people. The idea behind partial participation is that all individuals, regardless of the severity of their disability, can at least partially participate in activities they choose and enjoy, so long as they are provided with the assistance and adaptations they need.

The principle of partial participation affirms the ability of individuals with dd to participate in activities of their choosing, regardless of the severity of their disability. This means that individuals should be given the opportunity to participate in activities they enjoy, even if they are unable to learn or independently perform every step of a task or activity.

When encouraging partial participation in an activity, the “instructor” (or other support person) does the part of the task that the individual cannot do. For example, the instructor may need to hand small items to an individual with poor fine motor function (rather than expecting the individual to pick up the items). Or the instructor may partially affix a label to an envelope, and then allow the individual to smooth down the label.

The better match an activity is to an individual, the more fully the individual should be able to participate in completion of the activity. However for some individuals with severe/multiple disabilities it may be extremely difficult to find activities that do not require high levels of assistance and support. Such individuals should not be excluded from activities just because they need high levels of assistance and support.

Partial participation also involves providing systematic instruction to help individuals learn the tasks, skills, or behaviors needed to participate as fully as possible in an activity. There are very few individuals who cannot successfully learn to perform at least one task in a given activity.

The following information on Partial Participation is taken and adapted from an article entitled “Principle of Partial Participation and Individualized Adaptations in Education Programs for Severely Handicapped Students.” [http://www.mnddc.org/parallels2/pdf/80s/82/82-WIP-TAS.pdf](http://www.mnddc.org/parallels2/pdf/80s/82/82-WIP-TAS.pdf)

Partial participation should result in an individual being perceived by others as a more valuable, contributing, striving and productive member of society. The aim of partial participation is to support the ability of individuals with dd to participate in as many environments and activities with nondisabled peers, friends, family, and community members as possible.

One of the fundamental premises upon which the principle of partial participation is based is that all individuals, regardless of the severity of their disability, have a right to services that allow them to be “the most they can be.” Allowing individuals to “be the most they can be” involves allowing them to perform, at least partially, as many different skills, to engage in as many different activities, and to function in as many different environments as is possible/feasible. Nevertheless, it is certainly possible to apply the principle of partial participation in ways that do not enhance the life of the individual in a significant or acceptable manner.
For example, 14-year old Juan has severe cognitive and physical disabilities. He has been enrolled in a computer class, in an attempt to increase his vocational skills. During class, he was taught to turn on a computer and to press keys on the keyboard randomly. Some might argue that Juan is partially participating in use of the computer. However, the intent of the principle of partial participation is to maximize the repertoire of the individual, and clearly this was not accomplished in the instruction provided to Juan.

Juan’s situation is a misuse of the principle of partial participation, for the following reasons:
1. Although Juan has learned to turn on a computer and to press keys randomly, it is doubtful that he will be valued or respect any more by others than if he could not perform these skills.
2. It is highly unlikely that Juan will be able utilize the “skills” to produce information that will be of functional use to anyone.
3. It is extremely doubtful that anyone will ever employ him to use a computer.
4. It is improbably that the environments to which he is allowed access have increased because he has learned to turn on a computer and press keys randomly.
5. There are many other environments and activities that can be utilized to provide more functional and valuable vocational training experiences.

Another significant aspect of the principal of partial participation is that of individualized adaptations. It is rarely, if ever, possible to allow or enhance partial participation without giving consideration to adaptations—that is, adjustments or modifications of typical environmental conditions. What’s more, the adaptations must be individualized according to the unique needs and abilities of the person.

An individualized adaptation is one that is personalized and enables a particular individual to participate at least partially in a chosen activity. This is done by enhancing the performance of existing skills, compensating for missing skills that will not likely be learned, and allowing for the learning and use of alternative skills. For example, in order to move around at the shopping mall, two individuals may need wheelchairs. Janice can move her fingers but not her arms and thus uses an electric wheelchair. Joe, who is totally deaf and blind, pushes his manual wheelchair and is guided by another person. Obviously, their different skill repertoires require different individualized adaptations.

There are several types of individualized adaptations, including:
• Personal assistance (verbal, gestural, physical, or supervisory assistance provided by another person)
• Adapting skill sequences (engaging in an activity using a different sequence from the one used by most nondisabled individuals). For example, when using the toilet, sitting down on the commode and then lowering one’s pants, rather than lowering one’s pants prior to sitting down.
• Specialized equipment or materials. This may include, for example, wheelchairs, switches, communication aides, or other devices.
• Social/attitudinal adaptations (changes in assumptions, judgments, beliefs, etc.).
Partial participation may be enhanced by:

1. Modifying materials
   - Zipper extender
   - Velcro fasteners
   - C-clamps to stabilize materials
   - Dowel grasps on puzzle pieces
   - Micro switch to activate toys (for children) or appliances
   - Materials being made larger or smaller

2. Modifying or altering task requirements (changing the rules)
   - When painting, using a roller rather than a paint brush
   - Reducing the number of items required to complete

3. Assistance from Others
   - Physical Assistance
   - Modeling/Demonstration
   - Verbal Prompting
   - Arranging the environment or materials in the environment

4. Providing Direct Assistance
   - Complete part of the task for the individual, where his/her disability limits potential for learning

For an actual example of partial participation, please watch a 2-minute video by clicking on the following link:  http://www.youtube.com/watch?v=PTZ47-u0tHU

Additional Resources (Optional)

To learn more about Task Analysis, review one or more of the following websites:
- http://www.behavioradvisor.com/TaskAnalysis.html (This site includes a link to a 7-minute video on Task Analysis and links to additional examples of Task Analyses.)

To learn still more about Task Analysis, watch one or more of the following videos:
- http://www.youtube.com/watch?v=khLJW2T1zJo
- http://www.youtube.com/watch?v=3cb1Xj9fh8
- http://www.youtube.com/watch?v=Hxp33AFda-k
To learn more about chaining and shaping, review the following websites and videos:

- [http://www.bbbautism.com/aba_shaping_and_chaining.htm](http://www.bbbautism.com/aba_shaping_and_chaining.htm)
- [http://www.youtube.com/watch?v=VmukszGCd8&feature=related](http://www.youtube.com/watch?v=VmukszGCd8&feature=related)
- [http://www.youtube.com/watch?v=b3MjkJFDGJ8Q&feature=related](http://www.youtube.com/watch?v=b3MjkJFDGJ8Q&feature=related)

To learn more about Partial Participation, click on the following links:


To learn about “Scaffolding Instruction” (similar to chaining and fading), review the following website: