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Reviewing an Individual Habilitation Plan: A Lawyer's Guide

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REVIEWING AN INDIVIDUAL HABILITATION PLAN: A LAWYER'S GUIDE

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I. INTRODUCTION

An attorney providing legal representation to a developmentally disabled person eventually must review an individual habilitation plan. However, the documents comprising such a plan are not ones with which most lawyers are familiar. The ability to analyze correctly the contents, identify deficiencies in the plan, and effectively utilize individual habilitation plans can be a tremendous assistance in case preparation and effective advocacy for a developmentally disabled client.

This article is not meant to be an exhaustive review of all aspects of individual habilitation plans. The author draws heavily on the experiences of an independent legal advocacy office which represented institutionalized developmentally disabled persons for a three year period.[1] It is hoped that this experience will be helpful to attorneys involved in the area of mental disability law.

II. LEGAL REQUIREMENTS FOR INDIVIDUAL HABILITATION PLANS

The purpose of an individual habilitation plan is accountability in serving the severely handicapped. The nature of a developmental disability is such that the handicapped individual is usually not in a position to evaluate, monitor, or advocate needed services. The

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1. Comserv Center for Legal Representation was funded through Grant #50-P-30544/6-03 Developmental Disabilities Program, Office of Human Development, Department of Health, Education and Welfare. The project was located on the grounds of the Los Lunas Hospital and Training School, the largest New Mexico institution for developmentally disabled persons. The project provided legal representation for developmentally disabled clients in civil commitment proceedings, periodic reviews of civil commitment, and a variety of other legal matters affecting the status, care and treatment of persons in institutions.

sorry history of inadequate services to mentally retarded and other developmentally disabled persons has necessitated "watchdog" mechanisms to ensure that severely handicapped people receive services which are designed to minimize their disabilities and maximize their independence.

The history of exclusion of mentally retarded persons from public schools, vocational training, employment, and transportation and the widespread isolation of such persons in large, impersonal institutions have been the impetus for numerous class actions[2] as well as sweeping legislative reform at both the federal and state level. Pertinent legislation includes the Developmental Disabilities Assistance and Bill of Rights Act,[3] the Rehabilitation Act,[4] The Education for All Handicapped Children Act,[5] amendments to the Social Security Act,[6] and extensive administrative regulations adopted to carry out the provisions of these federal laws. In addition, each state has adopted legislation governing admission into institutions, conduct of public education, eligibility for vocational training, and other statutes affecting handicapped persons.[7]

Scattered throughout these statutory schemes are references to the almost universal requirement that when services are provided to developmentally disabled persons, there must be a written plan stating long range goals and short range objectives for the proposed service. The plans must specify the method by which the service will be provided and the personnel who will be responsible. There is often the additional requirement that these services be rendered by the least drastic means[8] or according to the principles of

2. *See, e.g.*, Welsch v. Likins, 550 F.2d 1122 (8th Cir. 1977); Halderman v. Pennhurst, 446 F. Supp. 1295 (E.D. Pa. 1977), *modified*, 612 F.2d 84 (3d Cir. 1979), *rev'd*, 101 S. Ct. 1531 (1981); Gary W. v. Louisiana, 437 F. Supp. 1209 (E.D. La. 1976); Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom.* Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

3. 42 U.S.C. §§ 6001-6081 (1976 & Supp. III 1979).

4. 29 U.S.C. §§ 701-794 (1976 & Supp. III 1979).

5. 20 U.S.C. §§ 1401-1461 (1976 & Supp. III 1979).

6. 42 U.S.C. § 423(d) (1976); 20 C.F.R. § 404 (1980).

7. Parallel tables of state laws affecting handicapped persons on a number of specific issues are available from the American Bar Association, Commission on the Mentally Disabled, and have been published in the *Mental Disability Law Reporter*.

8. The legal concept of the "least drastic means" was described by the Supreme Court in Shelton v. Tucker, 364 U.S. 479, 488 (1960): "[E]ven though the governmental purpose be legitimate and substantial, that purpose cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved."

In institutional settings the least drastic means principle means that habilitation must be

normalization.[9]

The concept of individual habilitation planning assumes a thorough diagnostic base, a realistic goal for amelioration of the handicapping condition, and professionally adequate services to assist the client to meet the identified goals. Often identified in the jargon of developmental disabilities services as IHP's (individual habilitation plans) or IPP's (individual program plans), these service plans utilize the concept of "habilitation" rather than rehabilitation because they address the needs of persons who have failed to acquire certain skills and abilities during the developmental period.[10] The goal of an individual habilitation plan is not to reinstate abilities which have been lost through trauma, disease, or other catastrophe. Rather, the goal is to provide a mechanism for the handicapped person to acquire those skills and abilities which he was unable to learn because of the handicapping condition.[11]

Children in special education programs must be provided with an IEP (individual education plan). Clients who are enrolled in vocational rehabilitation services are entitled to an IWRP (individual work rehabilitation plan). The basic requirements for all these service plans are similar. Unfortunately, the deficiencies in individual habilitation plans all too often follow the same dreary similarity.

III. THE CLIENT INTERVIEW

Normally, the first step in reviewing the individual habilitation plan will be the client interview. An attorney should not represent a developmentally disabled client the lawyer has not met. Eventually, the interview process can be delegated to a paralegal; however, the attorney should clearly establish guidelines for the structure, con-

provided in as unrestrictive an environment as possible and that whenever possible habilitation should occur in settings other than institutions.

9. "Normalization" requires that a mentally retarded individual be treated as much like a non-retarded person as possible. The concept is grounded on the belief that a person responds to the way he is treated. *See* W. WOLFENSBERGER, NORMALIZATION: THE PRINCIPLE OF NORMALIZATION IN HUMAN SERVICES (1972); Mason & Menolascino, *The Right to Treatment for Mentally Retarded Citizens: An Evolving Legal and Scientific Interface*, 10 CREIGHTON L. REV. 124 (1976).

10. "Habilitation" is defined as a "program of treatment that affords the individual a reasonable chance to acquire and maintain those life skills that enable him to cope as effectively as his own capacities permit with the demands of his own person and of his environment and to raise the level of his physical, mental and social efficiency." It includes, but is not limited to programs of formal structured education. Gary W. v. Louisiana, 437 F. Supp. 1209, 1219 (E.D. La. 1976).

11. Habilitation must also be distinguished from treatment, which is the requirement of care for those who are committed as mentally ill.

tent, and method of reporting on such interviews. Depending on the degree of the client's handicap, the methods for interviewing developmentally disabled persons may vary substantially from traditional client interviews. The attorney will have to experiment with a variety of creative approaches to the interview to establish his own method for obtaining the maximum benefit to his case preparation. The following comments offer general guidelines.

It is important not to allow the diagnostic information which has been supplied on a particular client to predetermine the lawyer's expectations regarding the client's ability to understand and communicate with counsel. Service providers chronically tend to underestimate the abilities of their clients, particularly when the client is in an institutional residential setting. Although the attorney is not a clinician and should not attempt to make diagnostic evaluations, a common sense approach to the client's abilities as well as deficiencies should be used in deciding the weight to give the client interview.

In conducting an interview, particularly of an institutionalized person, it is important for the attorney to remember that the client may lack basic information about such matters as the role of a lawyer, confidentiality, and the legal process. What may appear to be retardation may in fact be a lack of understanding. The lawyer should begin by introducing himself as attorney for the client. The client should then be asked what he knows about lawyers and about what lawyers do. The interview will often continue with a brief explanation of an attorney's role in very simple terms, followed by questions to the client to make sure the explanation is understood.

Once the role of the attorney is clear, the interview can focus on the particular matter at issue. Clients often have very definite ideas about their lives and, given the opportunity, will provide valuable information about their programs, problems, and choices of living situation. The client interview may be the first opportunity for the client to express a choice and participate in decisions affecting his life, and his choices should provide the basis for advocacy efforts.

Although many severely disabled clients cannot participate effectively in the interview, the attorney should explain his role simply to all clients, even the most impaired. Many handicapped individuals have greater receptive language abilities than expressive language skills, and the client may understand more than he is able to express. Bypassing the interview because the client seems unable to

communicate may deprive the client of information regarding decisions which affect his life.

The attorney must also become skilled at communicating through methods other than speech. Some handicapped individuals who cannot speak communicate through language boards and can spell out questions and answers using lights, pointers, or electronic devices. Some nonverbal clients may have learned sign language; in order to communicate with them, the lawyer may need an interpreter. A word of caution on sign language systems: many institutionalized persons are not trained in a standardized system of signing, but have a highly individualized set of symbols which requires an interpreter familiar with that particular set of symbols. Any interpreter who participates in the interview must be informed of the need for confidentiality.

The attorney should explain the attorney/client privilege and the guarantees of confidentiality. Most developmentally disabled clients, particularly those in residential settings, are unaware that this privilege exists. They have become accustomed to information routinely passing to staff, parents, and teachers; they may be extremely reluctant to be candid because of their prior experiences. Therefore, the assurances regarding confidentiality must be expressly guaranteed and scrupulously maintained.

The interview, even if unconventional, should be kept professional both for the benefit of the lawyer and the client. Some mentally disabled individuals have not been instructed in basic social skills and may be unaware of appropriate behavior with strangers. Responses may vary from extreme shyness to inappropriate familiarity such as hugging and kissing. Such behavior should be politely discouraged; it should be pointed out that a handshake is sufficient. Dignity is enhanced for the client when the lawyer conducts the interview with the same decorum he would maintain with any other client.

The client interview is an excellent beginning in the process of maximizing the client's participation in the legal process. Although time consuming and occasionally frustrating, the interview can produce information about the client which is unavailable from any other source.

IV. INFORMED CONSENT

As part of representing a developmentally disabled client, the attorney will have to make numerous judgments about the capacity

of the client to share in the decisions affecting his case. Therefore, the lawyer will need to develop a thorough familiarity with the elements of consent. An excellent reference for consent requirements is the *Consent Handbook*.[12] This monograph provides a basic discussion of the elements of consent: capacity, information, and voluntariness. It also sets up a weighted system for evaluating the scrutiny which should be given to individual choices depending on the capacity of the client and the risk of harm or degree of intrusiveness to the client.

In addition to evaluating the client's capacity to give consent, the attorney will have to determine the client's ability to testify on his own behalf. Although it is not customary for mentally disabled persons to appear as witnesses, certain clients can be eloquent witnesses. This is particularly true when the issue is release from an institution. It should be remembered that alternatives to the witness oath may be allowed in certain cases, or the judge may choose to interview a client in chambers as with very young witnesses. The attorney should not automatically rule out the possibility of his client testifying merely because the client is developmentally disabled.

V. TESTING AND OTHER DIAGNOSTIC PROCEDURES

Any attorney who is reviewing particular individual habilitation plans must become familiar with the standardized tests and diagnostic instruments which are commonly used in evaluating developmentally disabled clients. Very broadly, these tests fall into two categories: those which measure cognitive abilities and those which measure adaptive behaviors.[13] There are basically two means

12. American Ass'n on Mental Deficiency (H. Turnbull III ed. 1977).

13. Tests administered by psychologists or certified testing personnel which are commonly used and are based on actual direct assessment of the client by the diagnostician include WAIS (Wechsler Adult Intelligence Scale) and WISC (Weschsler Intelligence Scale for Children). These tests measure verbal and performance levels of development in auditory and visual memory, sequencing, etc. The score derived from this scale is usually used as an Intelligence Quotient (I.Q.). Tests commonly administered to infants are the Bayley Scale of Infant Development and the Cattell Infant Development Scale. These instruments measure cognitive developmental abilities from infancy through pre-school ages. Scores are sometimes represented in terms of I.Q., but usually they are represented in terms of mental age.

Test instruments which rely on information from third parties include the Vineland Social Maturity Scale, which establishes a social quotient and social age based on information given by relatives or teachers concerning the individual's ability to feed and dress himself, carry out responsibilities, etc. This test was standardized in 1934. The American Association on Mental Deficiency Adaptive Behavior Scale is a more recent scale that also measures social abilities. The Fairview Scale, though not recognized as a standardized test,

of evaluating clients. The evaluator either administers the test directly or obtains information about the client from a third party. There are problems with each method of evaluation.

Most standardized tests which purport to measure cognitive ability require a high degree of verbal competence. Therefore a client who has an ancillary handicapping condition such as cerebral palsy, which may impair his ability to acquire language skills, will perform poorly on such tests, no matter how minor his degree of retardation. The diagnostician must have identified barriers to language skills and compensated for them if the test results are to be a reliable indicator of a person's mental ability.

Tests which are based on information supplied by a third party are only as reliable as the informant. When the parent is the informant, the data supplied may be colored by the parent's response to the handicapped child. When the informant is a direct care worker in an institution, the data may be affected by the individual worker's lack of knowledge of the client, lack of training in correct reporting procedures, or other factors.

Tests which purport to measure adaptive behavior may yield unreliable results when administered to an individual in an institutional setting. Adaptive behaviors are learned skills, usually acquired through a combination of experience and training. A person in an institution may not have had the opportunity to learn certain skills, even though he may not lack the ability to learn. Therefore, an individual may be penalized for the environmental retardation which is the result of institutionalization. Such diagnostic inaccuracies set up a vicious cycle wherein the client is treated with ever lower expectations by service providers, given decreased opportunities to acquire skills, and then tested for skills which he has not had the opportunity to acquire. The attorney thus should closely scrutinize the environment in which the adaptive behavior has been measured.

Finally, it must be realized that very few test instruments were standardized on an institutionalized population. Standards and standard deviations were generally set by sample populations who had never been subjected to institutional experiences. The reliability of transferring results on such test instruments to an institutionalized person is highly problematic.

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measures social abilities of institutionalized individuals. The score is based on abilities of handicapped people in comparison with other handicapped people of similar age.

VI. COMPONENTS OF INDIVIDUAL HABILITATION PLANS

The requirements of individual habilitation plans may vary slightly according to different laws or regulations, but the same general scheme is substantially followed.

First, the plan must be in writing. Although this requirement sounds ridiculously obvious, many service agencies fail to reduce their proposals for services to writing. When service providers attempt to sue under the Privacy Act or other statutory standards for client confidentiality to prevent the attorney/advocate from reviewing the individual habilitation plan, it is often because the agency has failed to comply with the requirement that the plan be a written document. No matter how comprehensive the services are claimed to be, the client has an absolute right to have those services documented in a written instrument.

The individual habilitation plan must contain a statement of the client's condition. This section of the plan usually includes a summary of the diagnostic instruments used, a profile of the client, and a measure of his disability. A common problem is that the needs section of individual habilitation plans may address a primary handicap, but fail to address secondary handicapping conditions. A needs assessment requires diagnostic procedures to be conducted in all areas of known or suspected exceptionality.[14] Frequently diagnostic information is provided concerning the level of mental retardation, but the diagnostic procedures fail to take into account the fact that the client is non-English speaking, suffers impairment in visual or hearing acuity, or has difficulties in motor ability. Such failures to recognize and test for other handicapping conditions may result in the client being identified as more severely retarded than he actually is. More tragically, the client may not be mentally retarded at all, but may have multiple handicapping conditions which result in poor performance on standardized tests. If the needs assessment is inaccurate, the service plan cannot possibly be adequate.

To analyze effectively the components of the individual habilitation plan, the attorney must be certain that the diagnostic information gives a fair, accurate, and comprehensive picture of the particular conditions of the client. Routinely, the attorney should check to see if there are recent evaluations in speech, hearing, vision,

14. Particular tests have been developed which purport to accommodate particular handicaps in their method. Whenever an ancillary handicapping condition exists, a multiple series of test instruments should be used.

coordination, motor ability, neurology, and general health. Often the client is incorrectly evaluated because a particular diagnostician failed to take into account the effect of other handicaps or exceptionalities.

Prior diagnostic information should be reviewed for two reasons. It may provide information about unexplained regression, which can be described as a general worsening of the client's condition or the loss of specific skills. Review of a client's past records commonly produces evidence of loss of an array of skills which had been mastered by the client and then lost through experiences such as prolonged institutionalization. For example, clients who had been able to feed themselves, walk, and toilet independently prior to admission to an institution may be unable to demonstrate any of those skills after years of institutional living. Absent a degenerative condition, the only explanation for this loss of skills is the chronic inadequacy of the services in an institutional setting.

A review of prior records also can provide evidence of recycling of skills training. This retraining may occur not because the client has lost the ability to perform a particular task, but because the staff has failed to recognize that the client has demonstrated a particular ability. Many developmentally disabled clients have severe deficiencies in communication abilities and are unable to tell a staff person that they can successfully complete a particular task. The only way the client can demonstrate his ability is actually to perform the task. If the evaluator never gives the client the opportunity to demonstrate his skill, the individual habilitation plan may contain goals which the client has already achieved, but which he is being forced to "learn" again because no one has accurately observed his ability. Such time consuming and unnecessary repetition of habilitation training leads inevitably to frustration on the part of the client.

Following a statement of the condition of the client, the individual habilitation plan must contain a recital of service needs in each of the identified areas of deficiency. For example, a client who is mentally retarded and also has spastic quadriplegia must have services which address the problem of the quadriplegia as well as the retardation. It is not sufficent to state that the "client needs a well structured program of habilitation," which is the rhetoric found in many individual habilitation plans. This section must detail the particular services the client requires to progress, despite his various handicaps. For example, a mildly or moderately retarded client

who is nonverbal may need training in the use of an electronic language board; a severely retarded client who is visually impaired may need corrective glasses and a program to help him wear them; a profoundly retarded client who also has cerebral palsy may need physical therapy.

The attorney reviewing this section of the individual habilitation plan should check to see if each of the handicapping conditions identified in the diagnostic section is also targeted for a specific treatment. If there are handicapping conditions which are not addressed by proposed services, there is an automatic area for inquiry. To be minimally adequate, the proposed habilitation services must provide a professionally accepted method for intervention in each of the identified areas of handicap.

The individual habilitation plan must set long range goals for progress of the client. For purposes of reviewing individual habilitation plans, "long range" means six months to two years. Shorter projections for long range goals are preferred because there is greater possibility for genuine accountability. The attorney, in evaluating the long range goals of a particular individual habilitation plan, should use common sense to determine if the long range goals are realistic for a client. There is often an unstated cruelty in the identification of long range goals which are clearly impossible for the client to achieve.

The establishment of a long range goal of independent living for a profoundly retarded, multiply handicapped client is obviously unattainable. Yet establishment of such goals is not uncommon. The purpose of setting long range goals is realistically to gauge the maximum progress the client can be expected to make and to provide a framework for planning the individual components of the total habilitation plan.

Realistic long range goals could include eventual placement in a sheltered work environment for a moderately/severely handicapped client; attainment of basic independence in self care for a severely/profoundly handicapped client; attainment of basic environmental awareness for a profoundly/multiply handicapped client.

The long range goals should be directed toward the client as a total person, rather than at particular aspects of the client's condition. Unfortunately, some long range goals identify particular developmental goals without coordination with a total developmental framework. Often long range goals can be in direct conflict with each other and can fragment the client's service plan.

Following the identification of realistic long range goals, the individual habilitation plan should set forth short term objectives. These short term objectives should comprise the building blocks of particular sequential skill development to accomplish the long range goals. It is appropriate that the short range objectives be directed toward particular areas of developmental progress. For example, if a long range goal is semi-independent living, a short term objective could focus on training in tasks such as learning to prepare breakfast, to use public transportation, and basic concepts of money management. If a long range goal is employment in a sheltered work environment, appropriate short term objectives could include learning to tell time, training in sequential task completion, and instruction in grooming and self care. If a long range goal is increased awareness of the environment, appropriate short term objectives could include development of eye contact, response to name, and tolerance of different positions.

One useful way to evaluate the short term objectives is to determine whether such objectives are identified in normal developmental sequence. Frequently, an analysis of particular habilitation plans shows short range objectives which are totally out of sequence. Although they should not be used as rigid criteria for evaluating individual habilitation plans, the attorney should develop a basic understanding of normal developmental milestones. This information will provide automatic "flags" for further inquiry if the objectives of an individual habilitation plan are totally out of sequence.

It is unsettled whether the developmental progress of a disabled person follows the identical sequence of nonhandicapped persons. However, it is clear that there are some skills and capabilities which are a prerequisite for the development of others. For example, it is unrealistic to expect a client to learn to sort objects according to size if the individual is unable to discriminate shape and size. Similarly, if a particular client is functioning on the developmental level of a two year old, it would be unrealistic to set immediate goals for that person to acquire skills which are ordinarily attained by a four or five year old. Check-lists for normal developmental progress are readily available and provide a valuable guide for the attorney in evaluating this portion of the individual habilitation plan.

It should also be pointed out that a handicapped person is not "just like a two year old" or "just like a four year old" or whatever age the diagnosticians have identified as the functional level. It is a characteristic of many handicapped persons that they develop

"splinter skills," that is, skills which are considerably in advance of normal expectancies for a particular developmental level. Although splinter skills are often characterized as aberrational developmental progress, this is incorrect. Splinter skills may be an indication of strengths in particular areas, or they may be the result of good habilitation planning and training. When such skills enhance a client's independence, they should be encouraged. For example, word recognition by an individual who cannot identify individual letters in the alphabet could be characterized as a splinter skill. However, the ability to identify signs for a bathroom is a more functional skill than the ability to identify particular letters. Habilitation planning for a severely handicapped person which includes a functional approach to sign recognition is a more useful plan for the client than one which concentrates on nonfunctional academic language skills. Thus, developmental sequences are useful in identification of plans which contain clearly unattainable goals for the client, but they should not be used to eliminate functional goals which the client may have the ability to master.

An additional factor which the attorney should consider in evaluating the reasonableness of short term objectives is the age of the client. It may be highly appropriate to concentrate on pre-academic skills for a relatively young child when it is impossible to accurately gauge the developmental potential. A young child who will have the benefit of adequate habilitation in his early years may achieve significant progress despite his handicapping condition. Therefore it is appropriate for a habilitation plan to emphasize those tasks which may lead to participation in a normal school program at a future date. However, it is not appropriate to identify the development of pre-academic skills for an individual who is in his late teens, his thirties, or his forties. At a certain point in the client's chronological age, a realistic assessment should be made of expectations for the client's academic progress. If this assessment indicates an inability to master cognitive skills, then the emphasis in habilitation should shift to the development of functional skills. For example, it makes sense for a habilitation plan to identify simple arithmetic as an academic goal for a handicapped child. However, if it becomes obvious after several years of appropriate special education that the mathematical skill is beyond the client's ability, then a realistic adjustment could be made to teach him basic shopping through number matching and subtraction with a small calculator, a more functional skill than pre-arithmetic.

The goal of all habilitation is to maximize the client's independence. However, some developmental disabilities service providers have lost a common sense approach to realistic goals for particular clients. Habilitation goals should be functional, age-appropriate, and within the ability of the of the client to attain. It is inappropriate, in most cases, to have the same goals for a fifty-five year old client and for a five year old. The attorney should not hesitate to question goals which are not functional for the client, age-appropriate, or within the ability of the client to master.

The identification of short term objectives on the habilitation plan should take into account the effect of secondary handicapping conditions. Goals are often identified which would be realistic for a client with respect to his cognitive ability, but which are clearly impossible because of the existence of a secondary handicapping condition such as cerebral palsy, visual impairment, or a mental health disorder. If a secondary handicapping condition appears to present a barrier to the client's achieving a particular objective, the attorney should investigate whether the habilitation plan provides for the additional handicap.

If the short term objectives are appropriate and reasonably related to the long range goals, the attorney should review the particular methods for training the client. Each identified objective for a client must have a clearly articulated method of habilitation described. The methods must be written in developmental and behavioral terms, be capable of measurement, and include criteria for determining success. The methods section of the habilitation plan must also name the person responsible for implementing the training, give the time and place at which the service will be provided, and state the expected date of completion of the program or the date on which standardized methods for measuring progress will be used.

Minimally adequate habilitation plans should include short range objectives and methods for habilitation training in each of the following areas:

A. *Physical/Motor*

This area includes all functions related to physical movement. In the case of a severely handicapped client or a very young developmentally disabled person, it might be appropriate to encourage development of gross motor skills such as head turning, reaching, and rolling. In the case of less severely handicapped persons, the focus in this part of the plan might be on the development of such

skills as walking, running, and balancing. Progress in gross motor development may lead to increased independence in mobility and self-care.

In addition, the habilitation plan should include the development of fine motor skills such as grasping and object manipulation. Both gross and fine motor skills are a prerequisite to mastery of a wide array of more sophisticated tasks. Only if a client has no difficulty in motor coordination and is nonhandicapped with respect to physical movement should this area be excluded from an individual habilitation plan.

B. *Language*

Perhaps the most important part of an individual habilitation plan relates to language development and the acquisition of communication skills. Mentally retarded persons generally have significant delays in language development; there are many ancillary handicapping conditions, such as cerebral palsy, which further impede the development of speech. However, progress toward independence is affected tremendously by the client's ability to communicate—to make his needs known and to follow directions from service providers. It is the opinion of many developmental disabilities professionals that some of the "behavior problems" which occur in developmentally disabled persons are a direct result of the frustrations due to impaired communication ability.

An appropriate language program should include a thorough diagnosis of the barriers to effective communication. In some cases the cognitive impairment is the primary cause of delayed language; in other instances it is a physical condition hampering the development of the mechanics of speech. Each client should be carefully evaluated for realistic goals in language development. Speech therapy should be provided when the language impediment is due to physical impairments which affect the mechanics of speech. If speech therapy cannot alleviate articulation problems, then the habilitation plan should utilize alternative methods of communication training. For example, training in the use of a language board is a highly appropriate alternative for a client who cannot speak because of a physical impairment.

For clients whose communication abilities are significantly impaired because of mental retardation, the emphasis in habilitation training should be on the development of systems through which the client can make his needs known and can respond consistently to

directions. There are many communication systems which are effective in developing communication abilities in severely handicapped individuals. The attorney need not become familiar with all of them, but he should determine that the plan provides for a system which can be easily used by the client in another setting. For example, service providers may develop their own system of signs or symbols for tasks such as eating and toileting. The problem with such unique systems is that the client can communicate only with a particular staff person, and therefore the communication ability is not useful with anyone else. Such situations can force the client to learn and utilize a variety of communication methods depending on the person he is dealing with. For a mentally handicapped person, such a situation is not only counterproductive, but may add significantly to the frustration inherent in being communication-impaired.

C. *Academic/Vocational*

A school age developmentally disabled client should be enrolled in a fully certified special education program. The attorney evaluating the individual habilitation plan should insist that the individual education plan be incorporated into any service plan for a school age person. The attorney should be familiar with the requirements for individual education plans as described in the Education for All Handicapped Children Act[15] and with statutes in his own state relating to special education.

For a school age person, the majority of the services to be provided as part of the individual habilitation plan will probably be incorporated into the education plan. A plan which lacks the education component will be impossible to evaluate. The specifications of federal law are clear and detailed, and the attorney should have little difficulty in evaluating such plans.

A more difficult aspect of evaluation of education plans is determining adequate follow-up for times when the individual client is not in school. This follow-up is particularly critical for residents of institutions. It is important that service providers working with a child outside of school hours reinforce the goals of the individual education plan. Frequently, school age residents of institutions encounter totally different expectations from their teachers and from staff who work with them outside of school. For example, a child may be receiving occupational therapy in school to teach him to

15. 20 U.S.C. §§ 1401-1461 (1976 & Supp. III 1979).

feed himself. He might be making good progress toward his goal during his school day, then return to his living quarters and be fed his supper by the attendant staff. Such a situation does not reinforce the skill, and it is confusing to the client. Left uncorrected, this lack of coordination can cause the child to regress in skills which are being taught in school.

An appropriate habilitation plan should include a method of informing non-educational staff of the goals in the child's educational plan and training in methods to reinforce these goals. Progress in motor development, communication, self care, and the like must be consistently encouraged during the child's day. Careful coordination among all personnel who interact with the child must be maintained.

In the case of a client who is not school age, this portion of the plan must include vocational training and objectives. The emphasis must be on the development of functional skills usable in an employment setting, whether sheltered or competitive. Appropriate components of this part of the plan could include training in attending to tasks, telling time, and use of public transportation, as well as the actual training in job related skills.

The vocational part of the individual habilitation plan should approximate as closely as possible the actual employment setting. Traditional approaches to vocational training follow a hierarchy of work expectancies. Work activity is the lowest level of vocational expectancy. Such programs do not contemplate placement in an actual work setting, but concentrate on activities which might be used in a nonremunerative activity center. Such a vocation is appropriate only for the most severely handicapped person.

Sheltered work is the next level of vocational training. Guidelines for sheltered employment have been adopted by the Department of Labor. An employer in a sheltered workshop must conduct time studies to determine worker productivity and pay the worker based on the actual rate of production. Sheltered workshops traditionally teach skills which conform to the contract for available work rather than skills for a competitive job.

Competitive employment is the highest level of vocational training. Such training programs assume that the client is actually capable of managing all the tasks associated with a regular job.

In evaluating this component of the individual habilitation plan, the attorney should ascertain whether the client is being trained for realistic vocational opportunities, considering his abili-

ties. Unfortunately, many programs place clients where there is an opening and fail to evaluate the particular client's vocational potential. Many clients are trained for employment below their capabilities because the only receiving program is a work activity center rather than the more appropriate sheltered workshop.

Few programs offer the client any choice in vocational training. Therefore, it is impossible to determine whether a failure to progress in a vocational program is due to the client's lack of ability or his lack of interest. If the vocational plan does not provide a choice, the client should be interviewed to establish his interest in the particular employment goal. If the client has no interest in the vocational objective, the attorney should negotiate for a more appealing vocational program.

Principles of normalization, as well as society in general, stress the value of work. However, rarely does a developmentally disabled person have any freedom of choice to develop this most important aspect of his life.

D. *Social*

This category in the individual habilitation plan includes all areas of services not included elsewhere. Although called by a variety of names, this area may include training in basic self care, use of leisure time, recreation, and socialization. This section is the hardest for the attorney to evaluate because of the lack of measurable standards. However, common sense dictates that the plan be checked for consistency of goals and methods.

Goals may be set for clients which are necessary neither for independence nor for more appropriate functioning. Blatant examples of such inappropriate goals include scheduling of social functions at totally inappropriate times (such as dances at eleven in the morning on a Thursday) or insistence on development of unnecessary skills (such as folding bedspreads). Appropriate goals should be directed at development of those skills which are necessary for independent living. It is much more important for a handicapped person to be able to prepare a simple meal or request directions than to use makeup or shine shoes.

An additional problem with this section of individual habilitation plans is that it is often unclear what criteria are being used for measurement of progress. For example, often a goal will be phrased "to interact with peers." Yet no method of evaluating such progress is given. Therefore, the client does not know whether this means he

has to get along with everyone, have a friend, or merely say, "Good morning."

Social goals are often a staff person's idea of appropriate behavior and do not reflect the handicapped individual's tastes and preferences. Since the ability to interact in a socially appropriate manner is a critical factor to a client's movement to a less restrictive setting, this section of the habilitation plan should be evaluated to assure that the skills taught will enhance the client's chance of such progression.

In addition to each of the components which must be present in habilitation plans, the attorney should ascertain whether the plans contain a minimum amount of structured professional habilitation services. The *Wyatt*[16] standards should be used as an evaluation guide.

VII. CONCLUSION

Habilitation plans are not usually documents with which an attorney has any familiarity. Although these plans may appear at first to contain a bewildering array of professional jargon, it is not difficult to become familiar with each of the areas which these plans must contain in order to be minimally adequate. An attorney who has developed a working knowledge of the habilitation planning process and the various components which the plans must contain can be an effective advocate on behalf of his developmentally disabled client.

16. Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom.*, Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).