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Reaction to Dr. Richard P. Melia's Presentation The Individual Written Rehabilitation Plan

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REACTION TO DR. RICHARD P. MELIA'S PRESENTATION THE INDIVIDUAL WRITTEN REHABILITATION PLAN

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It was a real challenge and honor to have the opportunity to react to such a comprehensive challenge prescribed by Dr. Melia. I share his observations of the 1966 St. Louis Conference and its relation to the current IWRP philosophy. I recall at that conference, a speaker suggested that all deaf clients should have visual examinations because of the significance of vision to the individuals rehabilitation plan. The reactor, such as I am doing, challenged the idea because of its impracticality and unnecessary delay in the clients progress toward rehabilitation goals. As you are well aware, today vision exams are required. I sincerely hope my reactions will not be so NEAR SITED as we move toward objective measurement of the rehabilitation process with deaf clients.

I must emphasize one very important aspect of the IWRP that often we professionals in the area of deafness tend to forget. Specifically I refer to the term INDIVIDUAL Plan. We are all aware of the stereotyped image of the general public about deafness. We are often guilty of the same generalizations. Because of deafness we cannot automatically assume all DEAF PEOPLE have language problems nor in fact do all deaf persons have communication problems to an extremely abnormal degree. The individual who is deaf does not "automatically" need speech and speech reading training, auditory training, sign language, nor that vast chasm known as personal adjustment training. The reading level of the client may not be critical to the individual nor the clients' employment, but may be primarily a reflection of our own personal standards for the client. Some people are happy and productive with a life style different than the one we feel they should have. Some people are content not reading and are employed successfully without "personal grooming" and the good ole American "bath everyday". Yet, communication, reading and personal adjustment training are almost standard fare for all deaf clients.

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The term "WRITTEN" does not, to me, mean merely writing on paper. A much more significant implication is that of joint planning and awareness of the client "what's going on". The "written" is just a reminder for the counselor/agency/client as to what has been agreed upon. Writing, as you well know, is an ineffective tool of communication with some severely handicapped deaf clients. Depending upon the case workers' skill to sign "SIGN-PAPER-NAME-YOU" the clients signature is generally a minor accomplishment, and may indicate the clients "ability to write his name". It may have no relationship to the clients participation and understanding of the PLAN.

There is an implication in Dr. Melia's remarks that P.L. 94-142 may have some positive effect upon the reading level of deaf clients. The over simplified interpretation of "Least Restrictive Environment" to mean "Mainstreaming" with inadequate support service may very well have an adverse effect on the already grossly inadequate educational success with deaf youngsters. Even with individual educational plans, some deaf students may be grossly cheated by a lack of expertise of professionals to consider language development rather than communication vehicles for young deaf children.

The reference to 38 state coordinators is very superficial. A significant number of the coordinators have other major responsibilities within the Agency and very few have "LINE AUTHORITY". In fact, some do not have input at the policy making and financial planning level in the administration. Despite these innuendos, there are 24% of the states that have NO state coordinator and probably no state plan of services. All states may report counselors; however, the competency of these counselors to communicate effectively with a broad range of deaf individuals is not indicated. In fact, few states that I know of, assure quality communication to deaf clients. The concept referred to by Dr. Melia, and the philosophy of JOINT planning may be seriously jeopardized without such assistance. Free interchange of thoughts, decisions, goals, feelings must occur between the counselor and the client. The critical area, most difficult to acquire for the hearing counselor, is the receptive skill in Ameslan. The idiomatic non-English syntax of ASL (most comfortably used by a substantial number of deaf people) leaves many of us to misunderstanding. "Basic" communication skills on the part of the rehabilitation case worker is grossly inadequate for development of an effective relationship with general deaf population.

In this specific area, ADARA formerly PRWAD had discussed repeatedly the basic "certification" or endorsement of standards to which the RCD must function for working with deaf clients. As past president of PRWAD, I share the responsibility for no professional standards by which the competent counselor should be measured.

Dr. Melia referred to the PAR study and use of legislative terms in IWRP's and the inappropriate language used for clients understanding.

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Certainly, with many deaf clients a plan may be written that would be understandable to the client. The use of transformational grammar with simply structured syntax, controlled vocabulary and word forms (morphology) could make the written plan much more appropriate to the understanding level of the client. We are NOT training counselors to utilize this very simple tool for writing IWRP's as well as letters to the deaf client with limited reading comprehension. Does the client have a legitimate right to appeal the program when the written plan is obviously beyond the reading ability of the client and clear documentation cannot be shown that the counselor has effective sign communication ability both expressively and receptively? In answer, effective rehabilitation counseling with the deaf clients is not "put a sign on him, give him a dose of 'counseling' and guidance' " put him to work in a print shop, her on a key punch, and run off another copy of the IWRP filling in a correct name and address on the blank.

If the IWRP is to state a long range goal, services with intermediate objectives, a time frame and objective evaluation as implied (mandated?) then the key to services to severely handicapped deaf clients lies in the Vocational Evaluation. The reference made to the University of Tennessee/ Auburn/NYU publication "Deaf Evaluation and Adjustment Feasibility" is appropriate. One must recognize, however, that report is about the most comprehensive document on Vocational Evaluation of deaf clients to the present date. It certainly in no way is comprehensive. The people who put it together were practitioners who had experience in both deafness and vocational evaluation. They were about the only totally knowledgeable people throughout RSA Region IV. The shortage of personnel in this field is abominable. Where are the training programs to meet this critical need in effective implementation of the IWRP? How can long range goals be derived when only an interview assessment is possible? This very fundamental lack of expertise and lack of personnel preparation, to me, is a major barrier to development of the IWRP.

I can visualize a situation where the communication ability of the deaf client would be critical to long range goals as well as intermediate objectives such as training and ultimate job placement. The evaluation of the clients communication would be critical to plan development. Specifically, an assessment is needed of the clients communication ability as it relates to a situation;

How does client communicate both expressively and receptively with:

1. Peers
2. Counselor/interpreter
3. Non-familiar people
4. Potential employer or instructor

In such an instance the clients speech/speech reading, reading/writing, body language and facial expressions as well as signing skills would be important.

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Likewise would be their need for development of the skill and a time frame with an objective evaluation. To my knowledge, there is no vehicle for other than a subjective observation by the case worker. Shall the IWRP include such an initial goal? If so, how can this area be evaluated as to clients progress?

The rehabilitation plan for many deaf client needs to include some specific well defined behavior relating to communication ability, independent living skills, and knowledge of community resources. As a "cultural group" one may assume many deaf people do not have access because of communication barriers. Among those are such critical services as Health, Welfare, and Education as well as enrichment areas relating to cultural activities provided most citizens. The deaf persons' mode to communication and the apathetic attitude of the agency toward the deaf persons' need will impede use of many community resources in IWRP development. Although, ideally each public service and every professional service provider should meet the communication level of the client, this will simply not occur immediately despite the mandate of Section 504. The implications for the rehabilitation agency is the use of the community service via an interpreter. In fact, the interpreter may be the only key by which many deaf people can realize their rehabilitation goals. The serious shortage of competent interpreters may drastically effect the provision of services and almost certainly effect the TIME frame for services. An objective as simple as an employment interview may be delayed because there is no interpreter available. Indeed the job opening may be gone in a matter of hours in a tight employment market. The tragedy to the deaf human being in need will far outweigh any "evaluation" of effectiveness of service. Truly the deafness rehabilitation size and organization are factors that can be contributed toward the IWRP, however, the implementation of the plan is dependent upon human resources. Until the critical needs of competent quality personnel are met, the philosophy of the IWRP may remain in discussions such as ours, here, in this time and place.

Since I was asked to speak from the standpoint of the "personnel training" component of rehabilitation you may have anticipated my reaction to your paper. Throughout your presentation you referred to long range goals of IWRP, however, a very significant intermediate objective which we have not evaluated is the quantity and quality of professional personnel. The time frame for reaching this objective extends well beyond one week, one month or 3 months "crash course" currently supplying the major number of personnel to the field.

In closing these are some very fundamental questions that effect the implementation of the IWRP. I challenge you to consider these topics:

1. To what extent does the IWRP describe the *specific* handicap imposed by deafness/hearing impairment on the *individual* client?

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2. How can we assure quality communication skills on the part of the case worker for JOINT development of the IWRP?
3. What techniques/facilities can be utilized to identify the clients long range goals and describe the steps "intermediate objectives"?
4. What are the current and future personnel needs and specific skills necessary on the part of service providers?

In summary Dr. Melia says the IWRP behavioral objectives are based upon a mutual agreement between the counselor and client on long range goals through a process of intermediate steps along with objective measures.

The inherent assumption is that the counselor has (1) knowledge of the handicapping aspects of the disability on this specific individual; (2) can relate to the individual sufficiently to identify steps toward the goal; (3) can objectively measure outcomes.

The severely handicapped deaf client as well as even the highly capable deaf client who has limited English skills demand very special ability on the part of the resource provider to develop an INDIVIDUAL. . .WRITTEN. . . plan of REHABILITATION. The lack of "services" must affect the plan.