PERCEPTIONS OF CAREPROVIDERS CONCERNING THE NORMALIZATION/ DEVELOPMENTAL MODEL'S REPLACEMENT OF THE MEDICAL MODEL AS THE BASIS FOR PROVIDING EDUCATION AND TRAINING TO THE INSTITUTIONALIZED ADULT WITH DEVELOPMENTAL DISABILITIES

DISSERTATION

Presented to the Graduate Council of the
University of North Texas in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF PHILOSOPHY

By

Sharon Coutryer, B.A., M.S.
Denton, Texas

May, 1993

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Previous research suggests that careproviders' attitudes and perceptions significantly influence the type and quality of services received by institutionalized adults with developmental disabilities (IADD). This study explored attitudes careproviders hold concerning training needs of the IADD and their service model orientation. It traced the history of training people with developmental disabilities and provided a brief review of the medical, developmental, and normalization models of service delivery.

The conceptual framework upon which this study was based proposed that staff perceptions and orientation concerning service delivery to the IADD can be conceptually related to five factors in a research model. They were identified as: (a) careprovider's characteristics; (b) working environment; (c) previous careprovider experience; (d) developmental disability history within the careprovider's family; and (e) self-reporting of a service

delivery orientation. This study examined only a portion of this model (factors a, b, and e). The response sample included 370 professionals and paraprofessionals, aged 17 to 72 years, who were employed at a large residential facility serving individuals with developmental disabilities in Denton, Texas. The respondents were predominantly female (76.5%), Caucasian (72.2%) with slightly less than 75% having more than a high school diploma.

The instrument, a self-administered questionnaire, consisted of three parts; Careprovider's Service Model Orientation; Careprovider's Perception of Training Needs; and, Demographic Information.

Data were analyzed through the use of regression, chi square, and analysis of variance tests. Findings revealed several significant relationships between: professional status and perceptions of training needs of the IADD; professional status and service model orientation; professional status and reported service model orientation; professional status and attitude toward the medical model; and, professional status and attitude toward the developmental model. Significant relationships were not found for four additional hypotheses that were included the study.

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CHAPTER I

INTRODUCTION

The need of the institutionalized adult with developmental disabilities (henceforth referred to as "IADD") for culturally normalized education and training has been increasingly recognized and accepted by society. A factor which has contributed heavily to this growing recognition is the contribution made by numerous individuals and organizations, who vigorously pursued improving public awareness of the needs and rights of the IADD. Historically, some persons who are viewed as advocates for the IADD include Sequin, Howe, Wilber, and recently Wolfensberger. Organizations which also contributed to the increased public awareness include the National Association for Retarded Citizens and Advocacy Inc (47, 67, 76). As a result of these individual and organizational efforts educational, rehabilitation, and human rights legislation have been passed which mandated that the IADD be provided normalized services (69, p.2). "In recent years many facilities throughout the nation were ordered to reassess their priorities and reorganize their administrative structure in order to comply with the law to provide quality treatment and education to their clients" (3, p.vi). Many

of these facilities did not hasten to implement these new programs or attempt to comply with these court orders because they had been using for many years what Scheerenberger calls the "medical model" approach for services. With this model the medical director has almost total control over the treatment, care, and training programs provided the IADD. The medical model focuses mainly on providing the "physical health and safety" needs of the IADD (custodial care), and treats "mental retardation as an illness" (79, p.193).

Currently residential institutions and other training facilities have to comply with stringent standards and guidelines designed to improve the quality of life of the IADD and to raise the quality of treatment, education, and training provided (3, p.vi). These standards and guidelines are based on new and dynamic principles that have had a significant impact on the way training programs are conceived, designed, and implemented (68, 32). Two of these principles include; the "developmental model" and the "normalization principle."

The concept of the "developmental model" which, according to Crosby is predicated on the belief that "every individual (no matter how handicapped (s)he may be) possesses some potential for growth and development" (19, p.66). Individuals are viewed as having the potential for growth/progress no matter how severe their developmental

disability might be. The basic goal of all training for adults who are developmentally disabled should be to maximize their human qualities.

The "normalization principle," parallels training/ programming with the normal patterns of the culture and draws the adult with developmental disabilities into the mainstream of society. According to this principle the adult with developmental disabilities should be helped to live as normal a life as possible (101, p.148).

Given these more recent models, training programs for the IADD have been revised. These revisions were not based on the traditional medical model which focuses on meeting the medical/physical health needs of the IADD. These revisions, however, are based on the developmental and normalization models which views the IADD as being capable of developing more normalized skills. In this process of programming changes and revisions, administrative staff and program developers need to become aware of the perceptions, feelings, and attitudes of the careproviders who are responsible for training the IADD. The careprovider's perceptions can significantly influence the rate and ultimate success of the IADD's training programs (43, p.40).

The area of particular concern for this study is the perceptions of the IADD's careproviders and the identification of the service model which their perceptions support.

Statement of the Problem

Has the normalization/developmental model replaced the medical model as the basis for providing education and training to the institutionalized adult with developmental disabilities?

Purposes of the Study

The purposes of this study:

1. To identify the education and training needs of the institutionalized adult with developmental disabilities as perceived by Denton State School (DSS) Employees.
2. To determine if the perceptions of the DSS Employees are oriented towards the medical model's or the developmental/normalization model's view of service.
3. To determine the association between length of employment and the DSS employees' perception about the education and training needs of the IADD.
4. To determine the association between length of employment and the DSS employees' orientation towards the medical or developmental/normalization model for service delivery.
5. To determine if there is any difference between DSS professional and paraprofessional employees' perceptions about the educational and training needs of the IADD.
6. To determine if there is any difference between DSS professional and paraprofessional employees' support of

the medical or developmental/normalization model for service delivery to the IADD.

7. To determine if there is a significant difference between DSS employees' support of the medical or developmental/normalization model for service delivery to the IADD when controlling for professional status and tenure.

Research Questions

In order to complete the purposes of the study, the following research questions were proposed:

1. What are the perceptions of the careproviders concerning the education and training needs of the institutionalized adult with developmental disabilities?
2. Do the perceptions of those careproviders who have worked with this population for 10 or more years differ in service model orientation when compared with those who have worked less than 10 years? (Is there a relationship between tenure and service model orientation?) Do they differ in their perceptions concerning the training needs of the IADD?.
3. Are there differences in the perceptions of the professional and the paraprofessional staff at Denton State School concerning the educational and training needs of the clients they serve? Do their perceptions

support the medical or the normalization/developmental models' orientation?

Hypotheses

1. The perceptions of employees at DSS, regarding the educational and training needs of the IADD, will differ based on their length of employment at Denton State School.
2. The perceptions of paraprofessional employees, regarding the educational and training needs of the IADD, will be different when compared to the perceptions of the professional staff at Denton State School.
3. The perceptions of employees at Denton State School, regarding the educational and training needs of the IADD, will be related to the age of the employees.
4. The service model orientation of employees who have worked at Denton State School for 10 or more years, will differ from that of employees who have worked there less than 10 years.
5. The service model orientation of DSS paraprofessionals, will differ from the service model orientation of professional employees at Denton State School.
6. The service model orientation of DSS employees will differ significantly between groups when controlling for professional status and length of employment at Denton State School.

Definitions of Terms

The following terms are defined as they pertain to this study:

Developmental Disability:

This term means "a severe, chronic disability of a person that: 1) is attributable to a mental or physical impairment or combination of mental and physical impairments, 2) is likely to continue indefinitely, and 3) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated" (13, p.5).

Institution:

For this study the term institution will refer to a place of residence and work for a large number of individuals with developmental disabilities, cut off from the wider society, providing long term care, and staffed by shift employees (30, p.117; 35, p.xiii).

Mental Retardation:

For this study, mental retardation will be defined as "significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period" (38, p.11).

Normalization:

This term is defined by Wolfensberger as "the utilization of culturally valued means in order to establish

and/or maintain personal behaviors, experiences, and characteristics that are culturally normative or valued." It refers to helping individuals live a style of life that is as close to normal as possible (101, p.148).

Professional Staff:

For this study the term professional staff will refer to Registered Nurses, Licensed Vocational Nurses, Medical Doctors, Unit Directors, Assistant Unit Directors, Psychologists, Behavior Therapists, Habilitation Professionals (eg. Speech, Physical, and Occupational Therapists), Social Workers, Chaplains, and Qualified Mental Retardation Professionals (QMRPs) currently employed full or part time in a campus-based position at Denton State School.

Paraprofessional Staff:

For this study the term paraprofessional staff will refer to Residence Trainers, Therapist Technicians, Residence Supervisors, Assistant Residence Supervisors, Recreation Therapists, Qualified Mental Retardation Professional's Assistants (QMRPA), and Vocational Trainers who are currently employed full or part time in a campus-based position at Denton State School.

Length of Employment at Denton State School:

The actual length of employment at Denton State School will be requested from the employee's last hire date.

Age of Staff:

The actual reported age will be requested and age intervals will be created to provide for easier analysis of data.

Level of Care Criteria:

Individuals who receive residential services from Denton State School are assigned a "level of care," which are based on these criteria:

A. ICF-MR LEVEL I:

Individuals eligible for the ICF-MR I program have the potential to participate in training programs that will prepare them for placement in a less restricted living environment. These individuals would benefit from:

- learning self-help skills (independent living skills)
- learning how to locate and access community resources
- learning how to manage their money
- learning household management, and
- participation in a vocational program.

The individual is fully ambulatory or mobile non-ambulatory and may have maladaptive behaviors that require programmatic intervention but do not prevent their participation and self-direction in the active treatment of the program.

B. ICF-MR LEVEL V:

Individuals eligible for the ICF-MR V program may need assistance and supervision in the refinement of self-help skills. These individuals may require:

- training in social interaction skills

- training in care of possessions
- training in work skills and behaviors
- training motor skills, and
- training in leisure/recreation skills.

The individual may require daily supervision and management to ensure completion of scheduled activities, and they may have maladaptive behaviors. Health care needs may also exist for the individual which require daily supervision by licensed nursing personnel, but does not interfere with participation in active treatment programs.

C. ICF-MR LEVEL VI:

Individuals eligible for the ICF-MR VI program requires extensive assistance and supervision in the completion of self-help activities. These individuals may require:

- highly structured environments with supervision
- nursing intervention and medical supervision
- training in developing sensory motor skills
- training to acquire socially appropriate behavior
- training in basic self-help skills, and
- training in leisure/recreation skills.

Individuals may require daily supervision to ensure compliance with daily routines and group activities, and they often have maladaptive behaviors which require intervention. Health care needs may also exist for the individual which require daily supervision by licensed nursing personnel, but does not interfere with participation

in active treatment programs. The individual must be able medically to be out of the bedroom area for active treatment during waking hours. (41)

Adaptive Behavior Level (ABL):

The term Adaptive Behavior is defined by the American Association on Mental Deficiency (AAMD) as the degree to which an individual meets the standards of personal independence and social responsibility expected of the person's age and cultural group (86, p.14; 67, p.25). Edgar A. Doll is known as the major pioneer in the objective assessment of adaptive behavior (27). According to Doll, adaptive behavior encompasses a wide range of areas or domains. He classified eight categories of items which are utilized to assess adaptive behavior, they are: "self-help general; self-help dressing, eating; communication; self-direction; socialization; locomotion; economic; and occupation" (83, p.7). Individuals who receive comprehensive services (ie. residential, vocational, educational, etc.) from Denton State School are assessed to determine their adaptive behavior level. An assessment of an individual's adaptive behavior provides a comprehensive picture of the person's abilities (60).

A. ABL LEVEL I (Mild Mental Retardation):

An individual who functions at this level have these capabilities:

Self-help General: These individuals have mastery of most life skills with occasional reminders. They require guidance and supervision in working and living activities.

Self-help (Dressing, Eating, Grooming, etc.): These individuals are completely independent in all self-help skills, and can buy their own clothing with help.

Communication: These individuals understands and communicates utilizing complex verbal concepts. They are able to use the telephone and can write simple letters.

Self-Direction: These individuals usually prefers to initiate their own activity. They are conscientious about work and will assume responsibilities but need guidance for tasks such as health care, care of others, or complicated occupational work.

Social: These individuals can interact cooperatively or competitively with others. They may belong to church groups or some recreational group. They enjoy watching TV, participating in bowling, and dances, but not activities that require rapid complex planning.

Locomotion: These individuals can go about their neighborhood without assistance. They can use a bicycle, skates, skis, or any equipment requiring good coordination.

Occupational: These individuals can cook simple foods and plan simple meals. They can perform everyday household chores, such as cleaning, dusting, and washing dishes. They can engage in semi-skilled jobs.

Economic: These individuals can handle their own money, count change and make purchases.

B. ABL LEVEL II (Moderate Mental Retardation):

An individual who functions at this level have these capabilities:

Self-help General: These individuals demonstrate emerging self initiation in functional living skills. They are capable of working and living in a highly structured and supervised environment.

Self-help (Dressing, Eating, Grooming, etc.): These individuals are independent in most self-help skills.

Communication: These individuals can hold a simple conversation and use complex sentences. They may be able to read sentences, ads, and signs with comprehension.

Self-Direction: These individuals may initiate most of their own activities. They may be conscientious in assuming responsibilities.

Social: These individuals may interact cooperatively or competitively with others.

Locomotion: These individuals have good body control, and good gross and fine motor coordination.

Occupational: These individuals can prepare simple foods which require mixing. They can perform routine chores, such as emptying garbage, dusting, and washing dishes.

Economic: These individuals can add coins to equal a dollar with fair accuracy and can make minor purchases.

C. ABL LEVEL III (Severe Mental Retardation):

An individual who functions at this level have these capabilities:

Self-help General: These individuals demonstrate partial acquisition of functional living skills. They require 24 hour supervision and need assistance and prompting to initiate routine tasks.

Self-help (Dressing, Eating, Grooming, etc.): These individuals can feed themselves with a spoon and fork, can drink from a cup without spilling, and requires assistance with cutting meat. They require supervision while bathing.

Communication: These individuals' speech is usually clear and distinct. They may be able to recognize signs and words, but can not read with comprehension.

Self-Direction: These individuals may ask if there is something to do. They may make an effort to be dependable in carrying out responsibilities.

Social: These individuals may spontaneously participate in group activities. They may have friendships which are maintained over weeks or months.

Locomotion: These individuals may run, skip, hop, dance, and go up and down stairs, using alternating feet. They may be able to throw a ball and hit a target.

Occupational: These individuals can help with simple jobs such as bedmaking, sweeping, and can set and clear a table before and after meals.

Economic: These individuals may realize that money has value but does not know how to use it. They can make minor purchases with a note. (38).

Assumptions and Limitations

The relevant assumptions and limitations of this study are detailed below. These assumptions include the following:

1. It is assumed that the participants will fully understand all items presented on the questionnaire.
2. It is assumed that the participants will reply honestly and accurately to the questionnaire.

The limitations of the study include the following:

1. The participants are employed in one geographical area in Texas; therefore, the results are not generalizable to dissimilar populations in other parts of the country.
2. The study will be limited by the knowledge and perceptions of those responding to the survey.
3. The study will be limited by the ability of the researcher to synthesize the data gathered.

Delimitations of This Study

The participants in this study will be limited to professionals, and paraprofessionals who are currently employed full time or part time in a campus-based position at Denton State School (See Appendix A).

This document does not represent an evaluation of Denton State School's human resources development or training outcomes. It's purpose is to provide an overview of the history of training provided individuals with developmental disabilities, identify careprovider's perception of the training needs of the IADD, and present their service model orientation.

Significance of the Study

Careproviders have been identified as having the responsibility to further the IADD's development by providing opportunities for formal and informal instruction (71, p.iii). Research has shown that careproviders "have the greatest impact" on the lives of the IADD (43, p.35), have "the most contact and develop the strongest relationships" with the IADD (90, p.161), and have "an important role in the care, training, and education" of the IADD (20, p.586; 82, p.290). Some researchers even go so far as to state that "staff members play a critical role" in providing effective habilitation programs for the IADD (90, p.386).

The research literature indicates that the attitudes and perceptions of the individuals who provide care and training for people with developmental disabilities significantly influences the type and quality of services delivered (20, 28, 29, 37, 45, 58, 88). Rees, Spreen, and Harnadek contend that "attitudes are an important influence

on the daily lives of people with mental retardation, affecting how these individuals are taught and accepted as well as what treatment and services are available to them" (70, p.81). Ferrara states that the careprovider's attitudes "can not only influence" individuals with developmental disabilities' performance "but can, in fact, undermine the acquisition of behavior skills" perceived by program developers as needed (31, p.147). Babow and Johnson found that careproviders were generally negative in their attitudes about mental retardation which influenced the services they provided (7). Wolfensberger discovered during his early encounters with human service workers that the majority of them "held very negative attitudes" towards people with mental retardation and that the "prevailing patterns translated negative attitudes into negative life experiences" for people with mental retardation (98, p.4). Wolfensberger also states that careproviders who have "positive attitudes towards" the IADD will extend to them "opportunities for positive participation" in education, training, and other types of daily life activities (98, p.2).

Many individuals who provide training in the institutional setting view adults with developmental disabilities as totally dependent and unable to acquire and maintain basic life skills. This perception may adversely affect the development of training programs, and the

selection of methods and training strategies. When careproviders believe the adult with developmental disabilities is unable to benefit from intervention efforts and focus on addressing only the health and safety needs of the client (medical model), opportunities for that individual to receive instruction directed at achieving more normalized skills may not be incorporated in their training program. Attitudes and perceptions which demonstrate a belief that adults with developmental disabilities possess the potential for growth and are capable of learning (normalization/ developmental model) will produce training programs which promote that growth (11, p.22; 14, p.129).

CHAPTER II

REVIEW OF THE LITERATURE

A discussion of the literature related to this study includes six major parts: (1) The History of Training People With Developmental Disabilities, (2) The Medical Model of Service Delivery, (3) The Developmental Model of Service Delivery, (4) The Normalization Principles and Service Delivery, (5) Summary of the Literature, and (6) History of Denton State School.

The History of Training People With Developmental Disabilities

Historically society has attempted to deal with people who are mentally retarded in three ways: (a) education was attempted to rid the individual of their retardation; (b) segregation was utilized in an attempt to protect society from people who were mentally retarded; and (c) in some cases people with mental retardation were destroyed. A graphic summarization of how society has viewed individuals with developmental disabilities is shown in figure 1. It provides a historical perspective of the development that has taken place in the past, and the foundation from which current service delivery models have emerged.

A HISTORY OF MENTAL RETARDATION

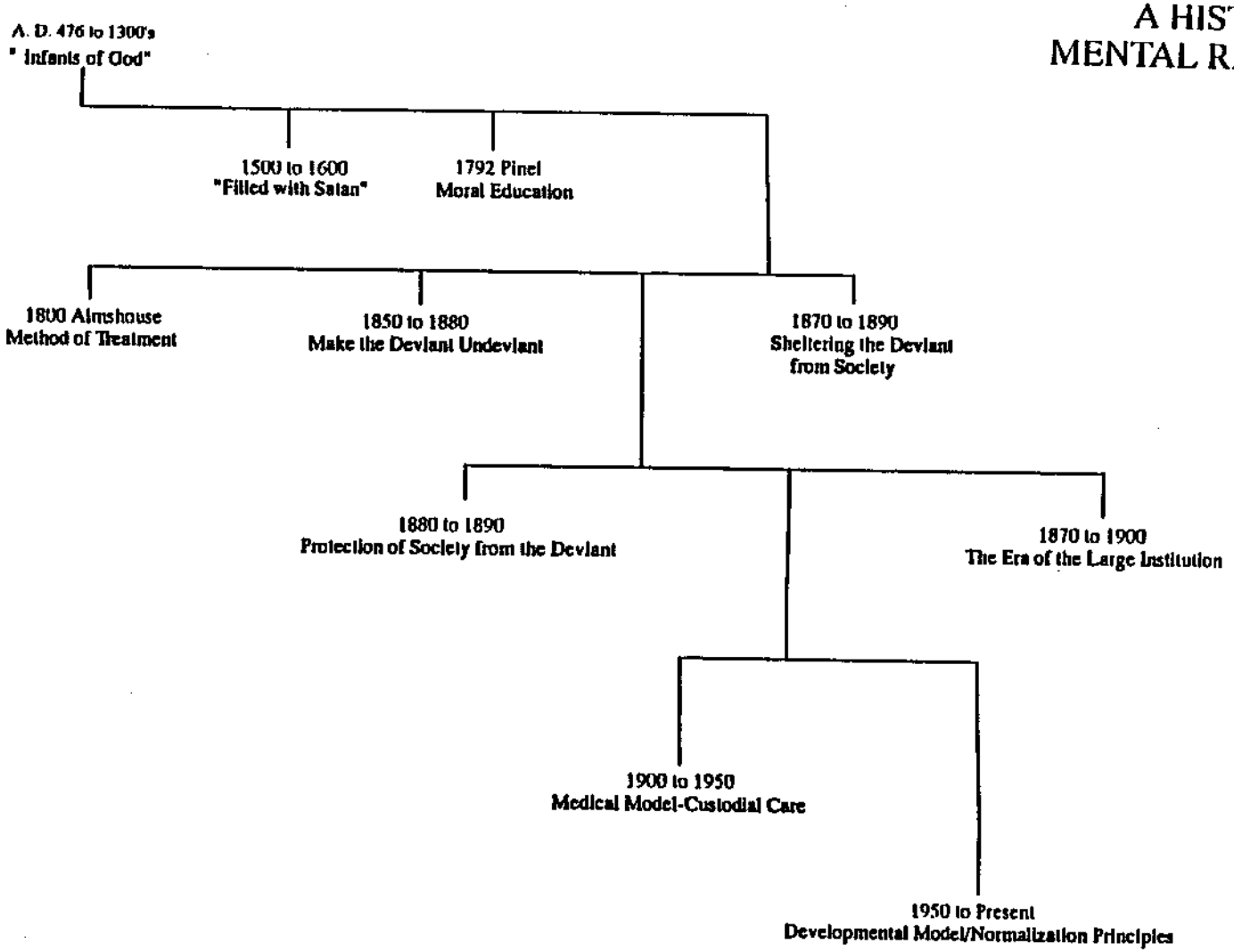


Figure 1

Issam Amary has expressed that individuals who were "mentally retarded have been recognized since the early times of humanity because of their inability to cope and perform" (3, p.3). Family roles were rarely provided for the sibling who was mentally retarded. The overwhelming belief was that individuals with mental retardation did not possess the skill necessary to "assist in hunting, farming, or building the family home" (3, p.3). As a result, they were treated as objects of scorn and persecuted. Amary states:

> To justify this action of mistreatment and neglect, each society labeled the (individual who was) mentally retarded with a description befitting their specific era, thus in ancient time, the mentally retarded were labeled as weak and feeble individuals who brought shame to their own family, and in order to protect the family name and honor, the mentally retarded were neglected, abandoned and, in many cases, exterminated. (3, p.3)

Historically people with mental retardation were looked upon as fools, jesters, and in some cases as being 'filled with Satan'. Members of early societies held beliefs that people who were mentally retarded were sick, subhuman, and criminally deviant. These prevailing attitudes tended to reaffirm their "fears and superstitions; consequently, prison-like asylums were constructed to house" people who were "mentally retarded and mentally ill" (3, p.4).

About 1850 small institutions were founded in the United States to educate and train individuals who were mentally retarded. These temporary boarding schools were

developed using a 'family model' and were situated within the city limits. They were designed to provide "intensive education aimed at diminishing intellectual impairment and increasing adaptive skills" (102, p.32). When the individual with mental retardation was to have learned a desired skill, he was to be returned to society. These facilities were not envisioned to be permanent homes but gradually these schools or "educational centers faded into 'asylums' as professionals and the society at large grew disillusioned with the perceived failure of such small systems to provide instantaneous cures for all their students" (102, p.32). Education was no longer viewed as effective in diminishing an individual's level or degree of mental retardation.

During this period a strong feeling and attitude that society was in danger emerged. For the next 25 years individuals who were developmentally delayed were believed to be responsible for all types of social deviancy. This contributed to a growing demand for individuals with mental retardation to be segregated from the larger society to protect society from contamination. Large institutions were opened in many states to house and "protect 'innocent victims of fate' from the larger society which might do them harm. Thus began, somewhat benevolently, the emergence of permanent custodial care" (102, p.32). Those dealing with people who were mentally retarded during the period between

1870 and 1890 desired to shelter them from society by "providing protective and inexpensive care in large facilities set in pastoral surroundings" (102, p.32).

During the second half of the nineteenth century individuals who were mentally retarded were considered to be a major menace to society. Many institutions housing individuals with mental retardation were developed through out the country such as state schools and large hospitals. The prime purpose as well as the attitudes emphasized the idea of habilitation of individual with mental retardation and stressed the teaching of useful skills (3, p.5).

While there were undoubtedly some positive gains in the area of training individuals with mental retardation, the onset of the great depression of the 1930's increased the plight of the individual who was mentally retarded. During this period, Amary explains that:

> The lack of money and resources, coupled with the populace's demand for jobs, brought to the state institutions a large number of people who lacked knowledge, training, understanding, and interest in the treatment of ... (people who were) mentally retarded. (3, p.6)

Consequently, he describes institutions during this period as serving as "detention camps for the undesirable elements of society", and the employees as being "their guards" (3, p.6).

The second half of the Twentieth Century is marked as the beginning of a new era of optimism. It is viewed as a time of enlightenment in regard to providing programming and

training for the IADD. It is also a time in which the courts and legislation have recognized the need to extend to people who are mentally retarded the dignity and rights that historically have been withheld from them. Persons with developmental disabilities today are viewed as having the same basic human needs as all persons. Additionally, they are viewed as having unique developmental needs which require careful planning and specialized services.

The philosophical underpinning of this new movement, which desires to "foster those behaviors that will maximize the human qualities of the IADD, increase the complexity of their behavior, and enhance their ability to cope with their environment," is the principle of normalization (3, p.vii). Principles of normalization are based on the idea that each person has the right to experience a style of life that is normal in their culture.

During the past 20 years many facilities recognized their responsibility to enhance the functional ability of each resident. This led to a reshaping of their organization and a reevaluation of their program emphasis. As a result of this process the interdisciplinary team approach was incorporated into the organization's procedure for developing programming. This approach utilizes the expertise of teachers, qualified mental retardation personnel, psychologists, social workers, and therapists in addition to the physicians. Intervention strategies were

designed and called individualized habilitation plans which are based on the total needs of the individual with developmental disabilities (84, 89).

Other changes included the removal of the medical model, "in which the physician enjoyed ultimate control over treatment decisions," which centered on providing only that care which was required to maintain the life of the IADD (103, p.68). With this model the physician's view was unchallenged and as a result,"the mentally different person was deemed 'ill' and such efforts at treatment were concentrated on curing the 'illness'" (103, p.68). Since the second half of the twentieth century the medical model has been replaced by the developmental model as the basis for providing care and treatment to the IADD. Amary indicates that:

> The philosophy underlying the developmental model is one of developing those skills that will hopefully lead to the reintegration of the individual into society. Adoption of the model has led to an increase role in the care of ...(individuals who are) Mentally Retarded Developmentally Disabled for those other than physicians. For example, one now finds in institutions for ...(individuals who are) mentally retarded developmentally disabled that those trained in vocational rehabilitation, special education, psychology, or in other non-medical professions, often play the most important role in providing care for the resident. (3, p.8)

Thirty five years ago the medical model formed the orientation which was held by those individuals charged with the responsibility to provide care, treatment, and programming for institutionalized adults with developmental

disabilities. These employees believed that the IADD "only required to be physically taken care of, fed, clothed, protected from harm, and above all, kept away from the so-called normal community or society" (3, p.3). In these settings very little training, took place. In cases where programming or training did occur (eg. self-help programs that involved teaching feeding, toileting, and dressing skills) it was to provide basic functional skills that benefit the careprovider, instead of enabling the adult with developmental disabilities to acquire more normalized skills.

Today the institution has a responsibility to protect and nurture the dignity, health and development of each individual, providing services according to the standards written for residential facilities serving people who are mentally retarded. Included in these standards are statements which require institutions to help each individual:

1. Develop their physical, intellectual, social and emotional capacities to the fullest extent.
2. Live in an environment that is conductive to personal dignity while in the residential setting.
3. Continue development of those skills, habits, and attitudes essential to adaptation in contemporary society. (4, p.40)

Issam Amary and Wolf Wolfensberger summarized how people who are mentally retarded have historically been perceived by society:

1) Throughout history, mentally retarded people have been grossly misunderstood. They have been underestimated in many areas, particularly in personality characteristics. They have been labeled as dangerous, impulsive, delinquent, repulsive, untrustworthy, aggressive, queer, unable to learn, and stupid. (3, p.3)

2) For many decades, people in much of society, and perhaps even more so in human services, despised (individuals who were) retarded and wanted to have absolutely nothing to do with them. It was taught that mental retardation was hopeless ..... (98, p.2)

The challenge now is to ensure that those who are employed in human services, particularly in the field of mental retardation, and who are entrusted with the task of developing training programs for the IADD do not harbor remnants of our past in the form of attitudes and perceptions which reflect dehumanizing beliefs about the IADD.

The Medical Model of Service Delivery

The medical model is representative of the early dominant ideology relating to service delivery in the field of mental retardation. The development of the medical model of mental retardation spans a period of over 2000 years. According to Peter Conrad and Joseph Schneider it is "one of the most deeply rooted systems in our society." Its roots are found in Hippocratic medicine of classical Greece (17, p.71).

In terms of the history of mental retardation and its domination by the medical model within the United States, the 19th Century was a significant period. The literature reveals that it was during the second half of this period that the service orientation for providing treatment and care for individuals with mental retardation moved into the medical territory. In 19 Century America a large number of institutions were built and run by superintendents who were also medical doctors. It is also noted that these medical superintendents contributed greatly to the creation of a "virtual monopoly over the treatment of mental retardation" (17, p.71). During this period the founders of the institutions believed that individuals with retardation "could be made normal" (110, p.3). Initially optimism was very high concerning the care and treatment the individual with mental retardation would receive within the institutions. They were to be taught in such a manner that was believed would result in "reawakening them into a 'normal' human existence" (110, p.3).

By the 1850's the early optimism of institutional cures had waned as a result of "social pressures and therapeutic disappointments" (17, p.71). Individuals with mental retardation were viewed as patients who had illnesses or suffered from diseases and required treatment from a medical doctor (who was usually the superintendent of the institution). Consequently, a move from habilitative to

custodial care was adopted in the institutions with the medical model as basis for treatment. This was based on the belief, which was prevalent, during this period that "any human problem could be addressed through the lens of the medical model"(17, p.71). Conrad and Schneider noted that "at the dawn of the 20th Century the medical profession had a firm dominance over the conception and treatment of mental retardation yet possessed no 'successful' medical treatment" (17, p.71).

When the medical model is used as a basis for providing services to individuals with mental retardation there is a conceptualization of the individual as being diseased or defective. Steve Baldwin states that one of the major disadvantages of this model "is the resulting stigma which stems from an association of 'abnormality' with 'illness' and 'disease'" (8, p.8). It is also believed that this stigma may account, in part, for the inaccurate beliefs that are currently held by members of society concerning individuals with developmental disabilities (34).

Developmental Disabilities and Medical Disease/ Illness

Wolf Wolfensberger describes the medical model as retaining,

> the perception of a deviant person (person with mental retardation) as a sick patient who after diagnosis is given treatment or therapy for his disease in a clinic or hospital by doctors who carry primary administrative and human management responsibility, assisted by a hierarchy of paramedical personnel and therapists, all this hopefully leading to a cure. (103, p.22)

This model views individuals with developmental disabilities as people who are sick and requires medical intervention. According to Sterling Garrard and Julius Richmond, "the presence of mental retardation per se does not imply pathological processes or defects with in the individual" (33, p.4). Only after a medical exam is completed can a physician determine if an individual with mental retardation possesses a medical defect. Research has shown that people with mental retardation have "an increased frequency of medical abnormalities, i.e. signs of central nervous system dysfunction, particular diseases, and syndromes, when compared to the nonretarded population" (33, p.4). This does not, however, support the medical model's view that all individuals with mental retardation suffer from medical defects or diseases. The literature also reveals that, "a number of medical entities are associated with retardation but at different probability levels, and few, if any, show a perfect correlation" (33, p.4). Garrard and Richmond expressed the fact that for individuals with Down's syndrome, "the association is so strong that the recognition of the condition at birth is considered tantamount to the identification of mental retardation...." (33, p.4). They also stated that "in neurofibromatosis, on the other hand, the association is relatively weak with no more than 10 to 20 percent of persons with the disease who also manifest retardation" (33, p.4). In conclusion, research has

indicated that "at most, a particular medical syndrome establishes the probability of a general association with mental retardation" and that there are no direct relationships "between a specific medical diagnosis and any specific learning or adaptive behavior of a retarded person" (33, p.4). It has also been noted that:

> Because of its arbitrary delineation, mental retardation is not a relatively homogeneous condition in the sense of a medical disease. The majority of the retarded population, for example, does not differ medically in significant ways from the general population. (33, p.5)

A minority, however, preempts medical attention. This would include individuals with brain impairment, chemical imbalance and neurotransmitter difficulties. As a result of physicians' and other medical staff's orientation of treating individuals with disabilities as sick, it is noted that "medicine has traditionally equated mental retardation with pathological defects within individuals" (33, p.5). However, mental retardation should not be viewed as a medical disease. Individuals with mental retardation "do not have fixed behaviors, but rather, have potentialities for learning and behavioral change, even within severe biomedical constraints" (33, p.5).

Characteristics of the medical model found in the institutions for individuals with developmental disabilities during the 19th and 20th Centuries embodied:

1. a concentration on addressing the health needs of the individuals but over looked the human value needs such as respect and normalization;
2. a perception of the individual with developmental disabilities as a diseased organism;
3. a provision of services which could only be furnished by the medical doctor, who was in most cases the superintendent of the institution; and,
4. the establishment of plans of treatment for the individual with developmental disabilities that gave "the impression of a balanced team approach, but in the constraints of the medical model the physician's role as healer is superior to all other disciplines" (35, p.47).

The resulting disenchantment of society and service providers with the medical model of mental retardation created an interest in other service models.

This presentation of the medical model is not intended to oppose the practice of providing sound medical care. It is a review of an attitudinal set and programming strategies which hindered habilitation efforts and the development of the individual with mental retardation's ability to make independent choices and to cope effectively within their society by "fostering passivity, dependency, and submissiveness" (74, p.23).

The Developmental Model of Service Delivery

The developmental model resulted from early attempts to identify the causes and to explain the nature of mental retardation. The developmental model is "based on the assumption that all" individuals with developmental disabilities "have potential for growth, learning, and development" (74, p.23). Further premises state that individuals with mental retardation, like all human beings, develop in a sequential and predictable way throughout their life span, and that a trainer's task is to determine the developmental level of each individual with mental retardation and to provide experiences appropriate for that level (74, p.23).

In its most general form, the developmental view emphasizes the similarities between the functioning of individuals with and without developmental disabilities (53, p.317-319). According to the Piagetian point of view, "growth or changes in behavior follow a developmental hierarchy"; "behavior acquisition moves from simple to more complex responses"; and, " more complex behavior is the result of coordinating or modifying simpler component response forms" (40, p.8).

Developmentalists conceptualize the cognitive growth of individuals with developmental disabilities in three ways: (1) "as progressing through the same cognitive stages that individuals without developmental disabilities traverse"

(similar sequence hypothesis), (2) "as having a similar structure of intelligence as individuals without developmental disabilities at each level of development" (similar structure hypothesis), and (3) "as responding to environmental factors in the same ways in which all individuals respond" (109, p.29).

The similar sequence hypothesis predicts that individuals with and without developmental disabilities pass through the same stages of cognitive development, differing only in the rate at which they progress and the ultimate ceiling they attain (95, 96, 107, 108). In Piagetian terms, "the sequence from sensorimotor to pre-operational to concrete operational to formal operational thought is predicted to occur" in individuals with developmental disabilities, "in exactly that order" (109, p.29). Piaget's research supports the view that "similarities in sequence should apply to all individuals, irrespective of cultural, intellectual, or neurological characteristics" (109, p.30; 66). Weisz and Zigler concluded, after conducting numerous research projects, "that the evidence indicates that the same stages of development appear in the same order in individuals with developmental disabilities and non-disabled persons" (96, p.849).

The similar structure hypothesis states that the person with developmental disabilities develops the same cognitive structures as the non-disabled person (95). The

developmental model emphasizes the similarities between the cognitive structures and functioning of individuals with and with developmental disabilities. It assumes that individuals with developmental disabilities have cognitive characteristics that individuals without disabilities have (44, 106). According to Steve Baldwin, the individual with developmental disabilities' "physical, social, and emotional development" tends to "follow a series of general developmental stages" (8, p.6).

Historically, programs designed for individuals with developmental disabilities were based on their performance on diagnostic exams. These exams were usually standardized tests designed for measuring intelligence or identifying an individual's degree of mental defect. The individual's calculated score was used to identify their classification. Their classifications were in turn used to determine the type of programming received. Often the intelligence classification assigned to the individual was considered to account for all aspects of his/her behaviors (educational, vocational, social, etc.). From this single criterion many individuals with developmental disabilities were labeled as not possessing (nor having the potential to learn) the skills necessary to contribute in any way to society. Habilitation was not considered a possibility for these individuals (61). In 1951, Kirk and Johnson published a book of classifications which identified the type of

programming that was considered to correspond with the calculated scores (46). Individuals whose IQ score was "0 to 25" were identified as "Idiots" and were to "require complete custodial care and supervision." According to Kirk and Johnson these individuals could not learn even the most rudimentary task. Others who scored "25 to 50" were identified as "imbeciles" and were considered to be able to learn to say some basic words, to benefit from training "to care for his bodily needs", and to be able to follow some basic routines. A score of "50 to 70" resulted in an individual's being identified as a "moron." These individual were believed to be able to learn to read, write, and do simple math. They were assumed to possess "some degree of educability in the area of social and occupational competence" (19, p.64). This approach to developing programming did not take into account the fact that an individual's performance on the exams just reflected their current status and not what skills or learning they would have a potential for obtaining in the future. Nihira, Foster, and Spencer expressed that this and other misuse of the first intelligence test contributed to the public view of individuals with disabilities as undesirable in the community (61). Kenneth Crosby claimed that:

> If an individual were classified as an idiot, there was obviously no need to try to teach him or her to talk or to acquire even simple self-care skills, such as eating, since by definition idiots were unable to learn to talk or to acquire self-care skills. The environments provided such persons, usually in large

> state institutions, afforded no need for them to talk, or to develop other skills. Under these conditions, the self-fulfilling prophecies engendered by the diagnoses naturally turned out to be true. Individuals failed to develop skills and abilities that their classifications said they could not acquire. (19, p.64)

Once diagnosed as "moron", "severely retarded", or "uneducable" an individual with developmental disabilities is likely to have programs developed and their environment structured to preclude their developing to a higher level of functioning. Although, according to the developmental model every human being has the potential to grow and to develop skills, if the opportunity for the growth is not provided then that individual will not develop those skills (19, p.65).

Three principles were identified as forming the foundation of the developmental model. They are distinguished as:

1. Development begins at conception and continues throughout the lifespan of every human being. Life is change, and to be alive is to be changing. Every person, no matter how handicapped he or she may be, is a dynamic, not a static being. (19, p.66)

The developmental model supports the view that there should be a continual evaluation of an individual's level of function with added revisions of their habilitation/training plan which reflects their present functioning level.

2. Human development ordinarily progresses in a sequential, orderly, and predictable manner, in which the skills learned at one stage of development become the foundation for acquiring the skills of the next stage. In general, development progresses from simple to more

> complicated behaviors that increase the individual's ability to cope with, and gain mastery over, his or her environment, and that enhance those qualities and characteristics that distinguish human beings from other forms of life and that are defined by the culture as normal. Although within such a progression the development of each person is subject to his or her uniqueness and variability, developmental sequences can be identified and the course of development can be planned. Therefore, it is possible to set goals for the further development of each handicapped person and to assess the developmental progress of each individual, no matter how handicapped he or she may be. (19, p.66)

Based on this model, every individual with developmental disabilities is considered to possess some potential for growth and development. Even though some individuals may not respond to selected programming, efforts to maximize their level of functioning should not be abandoned. Their programming should be reevaluated and modified to reflect their current level of functioning.

3. Even though the potential for development is present, development does not occur unless the environment provides suitable opportunity for its occurrence. The rate and direction of development may be significantly modified by manipulating certain physical, psychological, and social aspects of the individual's environment. Therefore, it is possible to introduce into each individual's environment programming interventions that will enhance the individual's development, no matter how handicapped he or she may be. (19 p. 66)

Individuals with developmental disabilities should be provided a range of opportunities to experience stimulating challenges (77). Research has shown that even persons with severe levels of developmental disabilities can make strong gains in social adaptation if placed in an enriched

environment (18). Based on these statements, services provided should be arranged in such a way that promotes development of culturally desired behavior, increasingly complex behavior, and behavior that would afford the individual maximum ability to cope with and exercise control over their environment.

The developmental model was originally utilized with the IADD in the 19th Century when institutions were first established in United States. The initial intent was to provide education, training, and habilitation for the person with mental retardation not custodial care. Today the developmental model is being utilized to provide the IADD with services that will enhance their level of functioning. Services are designed to provide each IADD the maximum amount of program stimulation and support required to enable them to reach their full potential. These services are being provided every individual no matter how developmentally disabled they may be. The developmental model applies to all IADD at any stage of their life. Everyone has developmental needs which can be addressed by the developmental model (19, p.80).

The Normalization Conceptualization of Service Delivery

The philosophy currently guiding the provision of services to individuals with mental retardation is the normalization principles. Scheerenberger contends that, "no single categorical principle has ever had a greater impact

on services for mentally retarded persons than that of normalization" (78, p.116). The principle of normalization originated from the Danish mental retardation service practices in 1959. It was introduced in North America in the late 1960's by Bank-Mikkelson and Nirje (63, p.363).

There are three main proponents of normalization; Neils Bank-Mikkelson, Bengt Nirje, and Wolf Wolfensberger. There are also three definitions of normalization found in the literature as defined by these supporters. Neils Bank-Mikkelson defines normalization as "letting the mentally retarded obtain an existence as close to normal as possible" (103, p.27). Bengt Nirje's concept of normalization differed slightly from Bank-Mikkelson's original idea. He defined the concept as "making available to the mentally retarded, patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream of society" (63, p.363). He viewed normalization as a lifestyle which should be available to all individuals with mental retardation. Wolf Wolfensberger made a more significant change in the concept when he defined it as the "utilization of means which are culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible" (103, p.27). According to Wolfensberger's definition not only was the environment of people with developmental disabilities to be changed to

reflect the normal but also their behaviors. His definition viewed normalization as a foundation for education, training, and treatment services as well as environmental conditions.

Wolfensberger's definition is often identified as the most widely accepted one today. Gary Mesibov maintains that, the principle of normalization as presented by Nirje, 1969 and Wolfensberger, 1972, "has played a vital role in improving services" that are currently provided for individuals who are developmentally delayed (55, p.30).

The Concepts Of Deviancy/ Devaluation and the Normalization Principle

Deviancy has been defined as "behavior or appearance that is outside the social norm" (56, p.3). Wolfensberger has expanded this definition by stating that:

> In order to understand why normalization calls for the creation and support of socially valued roles and life conditions for people, it is first necessary to understand the concepts of deviancy and devaluation. A person can be considered 'deviant' or devalued when a significant characteristic (a'difference') of his/hers is negatively valued by the segment of society that constitutes the majority or that defines social norms. While numerous differences do exist among individuals, it must be clearly kept in mind that differences by itself does not become a deviancy unless/until it becomes sufficiently negatively value-charged in the minds of observers. Thus deviancy can be said to be in the eyes of the beholder, and thus is also culturally relative. (100, p.23)

Wolfensberger identifies three categories which all cultures tend to place differences which may be defined at one time or another as deviant:

1. "physical differences and bodily impairments;
2. overt and covert behaviors;
3. attributive identities of people" (eg. language, ethnic group, nationality, etc.). (100, p.23)

Wolfensberger also asserts that within society :

1. Devalued persons will be badly treated;
2. The (bad) treatment accorded to the devalued person will take on forms that largely express the societal role perception of the devalued person or group;
3. How a person is perceived and treated by others will in turn strongly determine how that person subsequently behaves. (100, p.23)

Individuals with disabilities are frequently perceived as deviant within society (104). As an example, one only needs to consider the history that was presented in the beginning of this chapter which presented a review of the attitudes society held in regard to educating, training, and managing people with mental retardation. According to Wolfensberger, "the literature of retardation is richly endowed with allusions to the alleged subhuman nature of" individuals who have mental retardation, "and with labels that suggest subhuman status" (100, p.24).

Seven core themes are identified for normalization which are viewed as important aspects of the theory and its application to services. They are:

1. Normalization is extensively concerned with the identification of unconscious (usually negative) dynamics within human services that contribute to

the devaluation and oppression of certain groups of people in a society, and provides conscious strategies for remediating the devalued social status of such people (100, p.25);

2. A human service should do everything within its power.... to prevent its clients from being role-cast as devalued (deviant). If its clients are, in fact, already devalued, it should try to break the negative roles that have been imposed on such clients, and to establish such clients in positive social roles and in as many life areas as possible (100, p.25);

3. People who are socially devalued need to experience not only life conditions that are relatively common and prevalent for ordinary citizens, but optimally even those conditions that are clearly valued by the culture (100, p.26);

4. Adoption of the "developmental model" for service delivery. If properly implemented, the developmental model can lead to tremendous client growth because of its positive presumptions about the abilities of every person to grow, its high demands and expectancies, an its requirement that effective.. techniques and adaptive equipment be used in order to help people develop or function (100, p.26);

5. Normalization requires that the models provided to devaluated persons are people who function routinely in more appropriate, and hopefully even valued fashion (100, p.27);

6. Normalization implies that the social image of (devalued) people be enhanced. (This could be accomplished by providing them with positive images) (100, p.27);

7. Normalization requires that, to the highest degree and in as many life areas as feasible, a devalued person or group have the opportunity to be personally integrated into the value life of society. This means that as much as possible, (devalued) people would be enabled to: live in normative housing ..., and with valued people, be educated with their non-devalued peers; work in the same facilities as ordinary people; and be involved in a positive fashion in worship, recreation, shopping, and all other activities in which member of society engage (100, p.27).

The principles of normalization should be applied to every individual with developmental disabilities. When applied the principles should serve as a guide for medical, educational, social, and psychological services that are provided the IADD. Normalization means a normal rhythm day, normal routine of life (where one lives, works, and spends leisure time), and also opportunities to encounter normal developmental experiences (9).

Summary of the Literature

The purpose of this study was to determine if the normalization/developmental model has replaced the medical model as the basis for providing education and training to the institutionalized adult with developmental disabilities. Relevant literature was reviewed within the categories of: the history of training people with developmental disabilities; the medical model of service delivery; the developmental model of service delivery; and the normalization principles and service delivery.

The provision of a range of services (including care, treatment, education and training) to individuals with developmental disabilities is influenced to a great extent by whatever model the service deliver decides to use. The review of literature has provided an overview of the history of training individuals with mental retardation, and also a review of the medical, developmental and the normalization conceptual models. These models are recognized in the field

as having had a significant impact on the delivery of mental retardation services in the USA. Each of these models attempts to address the needs of individuals with developmental disabilities.

The medical model has been the tradition service model utilized by institutions serving individual with developmental disabilities. Roo points out that "custodial care and hospitalization" which are both based on the medical model, "are no longer the primary purposes of the institution" (75, p.329). The majority of the IADD "are not ill and hence do not require hospitalization" nor custodial care (75, p.329). Today the normalization/developmental model is utilized which is based on the view that all individuals with developmental disabilities should be provided the opportunity to live an existence as close to typical as possible (81, p.8; 80, p.201; 75). Developmental disabilities are not viewed as a static phenomena. Individuals are believed to possess the potential to learn and develop new skills when provided the opportunity to grow.

Recent trends, which involves the utilization of the normalization/developmental model in the provision of residential, vocational, educational and training services, indicate that improvements have taken place within institutions for adults with developmental disabilities. These include; an increase in the number and types of

services provided, improved education and training programs, and an increase in the number of professionals employed in the facilities.

Research indicates that persons with developmental disabilities can learn far more than was ever thought possible (2, 92). Recent projects (91, 93, 94) document how individuals with severe, profound, and moderate mental retardation who were thought to be "unable to participate in competitive work settings or earn meaningful wages, experience dramatic increases in their earning power after participation in supported employment" (paid work that takes place in regular or normal work settings) (48, p.413). Competitive employment can become a successful reality for many individuals with developmental disabilities if they are provided with the opportunity, training, and support necessary to fulfill the job requirements (97, p.270).

Henry Cobb contends that "the history of mental retardation has largely been the history of social attitudes" (16, p.11). The literature revealed that individuals with developmental disabilities are present in all societies, and the way in which they are accepted or viewed in a particular society is related to the social-political approach of the country to disabilities (105, p.3; 110, p.1). According to Wolfensberger, "all human life is valuable", and that "this value surpasses economic restrictions" (103, p.223). He also suggests that:

> What a person is capable of doing or becoming depends less on what he was, or what his history may disclose, or what level IQ he may have, or how he has been labelled. His potential for normal behavior will depend more on the kind and quality of opportunity he may be offered. (103, p.160)

The normalization principles and developmental model are implemented in our society not 'because they save money' but because they are considered by services providers to be the best possible means to provide individuals with developmental disabilities appropriate and timely opportunities to fulfill whatever potential they may have.

History of Denton State School

Institutions established for people with developmental disabilities have a history of initially providing services founded on the assumption that these individuals were incapable of learning. Services were also provided based on the conception that it was appropriate to furnish no more than custodial care and a caring environment. Denton State School, in part, also shares this history even though in 1960 when they opened, training was viewed as the institution's major purpose for being established. Training was to be provided to address "whatever role the person is to play in adult life in the community, if possible; in the institution, if necessary" (26, p.1).

A review of the literature recounting Denton State School's (DSS) early history, revealed that the medical and developmental models were used exclusively, or concurrently

as a service delivery model since DSS's inception. Statements like this were encountered in the literature:

> In this school, a child is given every opportunity for successful experiences and companionship, and there exists a therapeutic climate of acceptance, warmth, and security. (26, p.1)

In order to provide services to individuals with developmental disabilities separate groups were created which consisted of: 1) individuals with developmental disabilities who were identified as having "severe physical disabilities," and, 2) those who were considered to be "physical normal" (26, p.1).

Individuals who had severe physical disabilities received care and treatment from the medical staff which usually involved of a team of nurses. Their services were fashioned after the medical or hospital model as indicated by this statement:

> These students require the type of services that would normally be given at a general hospital. (26, p.2)

They were identified as being "completely bedfast" and received services that involved providing for their health, hygiene, and safety needs (medical model). These individuals were provided, if any, only limited opportunities to participate in training activities designed, to develop or, to assist them in achieving their learning potential.

The second group, those identified as "physically normal," received services which were, in part, based on the

developmental model. These programs included: recreational therapy, on and off campus vocational rehabilitation services, functional and practical education, training in everyday living experiences, and religious education classes taught on individual dormitories. Individuals in this group received training to develop skills that would enable them to secure future positions in the community.

Denton State School's Utilization of the Normalization/ Developmental Model for Service Delivery

As stated previously, Denton State School shares with other large residential institutions a similar history in terms of their initial employment of the medical model as basis for providing services to individuals with developmental disabilities. However, emphasis in the past 20 years at Denton State School has been placed on ensuring that people with developmental disabilities are no longer treated as inadequate, incompetent, or in any way unfit for society. There has been an effort to perceive the IADD as individuals who require the same rights and privileges as any other citizen.

This view of people with developmental disabilities has given rise to concerns which have been expressed about the quality and quantity of services that have been offered to meet their needs. In 1976 Denton State School addressed these concerns by becoming certified as an Intermediate Care Facility for the Mentally Retarded (ICFMR) by the Health

Care Financing Administration (a division of the Social Security Administration). This represented a major turning point in Denton State School's delivery of services to individuals with developmental disabilities. As a result of being certified by the ICFMR program, Denton State School (DSS) was required to follow and received assistance with implementing standards which provided a format for organizing services for the IADD and assuring that they met quality standards (based on the developmental model). Following the ICFMR certification, DSS also gained access to federal funds which were used to increase the number of professional and paraprofessional staff employed at DSS, and to increase the number of less restrictive living environments available for the IADD.

In 1991, Denton State School received accreditation by the Accreditation Council for Services for People with Developmental Disabilities (ACDD). This accreditation has been noted, by professionals in the field of Mental Retardation, as placing "Denton State School among the elite providers of services" to persons with developmental disabilities in the nation (21, p.1). Denton State School had to be in compliance with ACDD's standards in order to receive accreditation. These standards reflect advancements in the field of mental retardation and emphasize the rights of individuals with developmental disabilities (32). According to the philosophy underlying these standards, each

individual with developmental disabilities:

1. has a capacity for growth and development (developmental model);
2. should have access to services that enhance his or her development, well-being, and quality of life;
3. should have access to the most normal and least restrictive social and physical environments consistent with his or her needs (normalization principles); and
4. services should be delivered in accordance with a single, comprehensive individual habilitation plan that is developed, monitored, coordinated, and revised by members of a duly constituted interdisciplinary team. (1, p.2)

Denton State School is a residential facility which provides campus based services to 664 individuals with developmental disabilities. Denton State school employs approximately 1800 professional and paraprofessional staff with diverse backgrounds. The largest number of employees are trainers who provide direct services in the living units or homes. DSS also employs its own medical staff, dentists, psychologists, social workers, various therapists, and chaplains. In addition, DSS has kitchen staff, custodians, maintenance staff, transportation workers, secretaries, clerks, and administrators.

Denton State School's employees provide active education and training programs to every IADD who resides in the living units. Individuals of all ages and functioning levels receive training activities which may consist of: formal education and training, language and speech therapy, vocational activities (including employment within the community), behavior management, motor training, activities

of daily living training (including dressing, toileting, and self feeding), and leisure training. Services are provided that will enable the IADD to lead purposeful and fulfilling lives, interacting with those around them in meaningful ways (23).

Over the past 20 years, Denton State School like other residential institutions has experienced shifts, in the scope, content, and number of services provided the IADD (49, p.343). The adoption of the Normalization/ developmental model has provided an ideological base that has acted as a catalyst with respect to the services provided the IADD. This research investigated the influence as well as the maturation of the normalization/developmental model as currently utilized at Denton State School. The elements which were focused on in this research effort were the perceptions held by Denton State School's professional and paraprofessional staff concerning training needs, and their service model orientation (See Appendix B).

CHAPTER III

DESIGN OF THE STUDY

Plan of the Study

This study utilized the descriptive research methodology. According to Merriam and Simpson it is "one of the most commonly used methodologies in the study of adult education and training" (54, p. 57). Descriptive studies are used to describe information, "facts, and characteristics of a population or area of interest" (54, p. 58). Data for this study were collected by the use of a self administered questionnaire. According to Miller the questionnaire has many advantages such as: "it reaches people who are difficult to locate, it provides greater uniformity in the manner in which questions are posed, it gives the respondent a sense of privacy, and it lessens interviewer effect" (57, p.97).

The questionnaire used in this study consisted of two parts. The first part assessed employees' education and training perceptions for the IADD, and their service delivery model orientation; the second obtained data on selected socioeconomic factors and personal characteristics. A copy of the questionnaire is included in Appendix C.

Conceptual Framework

There is a paradigm which provides structure to the development of the data set and the full paradigm is presented below:

Broad Conceptual Framework for Data Development

Careprovider's Perceptions/Orientation concerning service delivery can be conceptually related to five factors in a research model to address issues surrounding the institutionalized adult with developmental disabilities. These factors are presented below as:

A. The personal characteristics of the careprovider;

B. The characteristics of the state school work environment;

C. The previous careprovider experiences of staff;

D. The developmental disability history within the careprovider's family; and,

E. Self-selection/reporting of a service delivery orientation.

These five factors are measured in the following manner (utilizing items from the Demographic Information (DI) section of the questionnaire):

A. The Personal Characteristics:

What is your sex?

What is your race/ ethnicity?

What is your age?

What is your education level?

In what city did you receive most of your elementary and secondary education (grades K thru 12)?

What is your current Marital Status?

B. The Characteristics Of The Work Environment:

What is your current position?

How long have you worked at Denton State School?

How long have you worked in your current position?

What shift do you work?

What home do you work on, most of your time?

C. The Previous Careprovider Experiences:

Did you have any prior work experience (before working at DSS) with developmentally disabled (MR) individuals?

Were you ever a careprovider (before working at DSS) for your parents, children, or relative?

D. The Developmental Disability History In Family:

Are any members of your family developmentally disabled?

Have any past or present members of your family been institutionalized (living in a State School or Community Facility)?

E. Self-Reporting Of Service Delivery Orientation:

What Service Delivery Model best describes the type of training/services you currently provide the individuals with developmentally disabilities (MR) that you work with?

Paradigm Scope for Dissertation

For the constraints of this dissertation only a portion of that paradigm is analyzed and presented. That segment is diagramed below:

Paradigm Scope for Dissertation Analysis of Data

The paradigm construction for the dissertation analysis explored relationships involving concepts A, B, and E above in the following 6 hypotheses.

Hypothesis 1 (Null):

> The employee perceptions regarding the educational and training needs of the institutionalized adult with developmental disabilities (IADD) will not differ significantly based on their length of employment at Denton State School.

The test statistic of this hypothesis was regression analysis. For this analysis perception of training needs was created as the sum of the score values obtained from the Careprovider Perception of Training Needs (CPTN) section of the questionnaire. Perception of training needs (CPTN) was identified as dependent interval-level variable and tenure was treated as an interval-level independent variable.

Hypothesis 2 (Null):

> The perceptions between paraprofessionals and professionals regarding the educational and training needs of the IADD will not differ significantly.

The test statistic of this hypothesis was one-way analysis of variance. For this analysis, Perception of training need was created as the sum of the scores obtained from the Careprovider Perception of Training Need (CPTN) section of the questionnaire. Perception of training needs (CPTN) was

identified as an interval-level dependent variable and the two groups (paraprofessional and professional) as the nominal independent variables.

Hypothesis 3 (Null):

> The perceptions of employees at Denton State School regarding the educational and training needs of the IADD will not be significantly related to the age of the employees.

The test statistic of this hypothesis was regression analysis. For this analysis, Perception of training need was created as the sum of the scores obtained from the Careprovider Perception of Training Need (CPTN) section of the questionnaire. Perception of training needs (CPTN) was identified as an interval-level dependent variable and age as an interval-level independent variable.

Hypothesis 4 (Null):

> The perceptions between Denton State School employees with less than 10 years tenure and those with 10 or more years of tenure will not differ significantly in service model orientation.

The test statistic of this hypothesis was one-way analysis of variance. For this analysis, service model orientation (medical- normalization/developmental index) was created as the sum of the scores obtained from the Careprovider Service Model Orientation section of the questionnaire. The Service model orientation (medical- normalization/developmental

index) is identified as an interval-level dependent variable and tenure (less than 10 years and 10 years or more) as a nominal-level independent variable.

Hypothesis 5 (Null):

> Professionals and paraprofessionals employed at Denton State School (DSS) will not significantly differ in their service model orientation.

The first test statistic of this hypothesis was one-way analysis of variance. For this analysis, service model orientation (medical- normalization/developmental index) was created as the sum of the scores obtained from the Careprovider Service Model Orientation section of the questionnaire. The Service model orientation (medical-normalization/developmental index) was identified as an interval-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

The second test statistic for this hypothesis was Chi square analysis. For this analysis reported service model orientation was created by using the item #16 from the Demographic Information section (DI-16) of the questionnaire. Reported service model orientations (DI-16) was identified as a nominal-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

The third test statistic of this hypothesis was Chi square analysis. For this analysis attitude toward normalization was created by using the item #46 from the Careprovider's Service Model Orientation section (CSMO-46) of the questionnaire. Attitude toward normalization (CSMO-46) was identified as a nominal-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

The fourth test statistic of this hypothesis is Chi square analysis. For this analysis attitude towards the medical model was created by using the item #47 from the Careprovider's Service Model Orientation section (CSMO-47) of the questionnaire. Attitude toward the medical model (CSMO-47) was identified as a nominal-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

The fifth test statistic of this hypothesis was Chi square analysis. For this analysis attitude towards the developmental model was created by using the item #48 from the Careprovider's Service Model Orientation section (CSMO-48) of the questionnaire. Attitude toward the developmental model (CSMO-48) was identified as a nominal-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

The sixth test statistic of this hypothesis was the Chi square analysis. For this analysis, attitude toward

normalization (norm-scale) was created as the sum of the Careprovider's Service Model Orientation scores (range was from 48 to 240) the midpoint of the possible range was used to create a two dimensional scale. Attitude toward normalization (norm- scale) was identified as a nominal-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

Hypothesis 6 (Null):

The service model orientation of DSS employees will not differ significantly between groups when controlling for professional status and length of employment at Denton State School.

The first test statistic of this hypothesis was multiple regression analyses. For this analysis, service model orientation (medical- normalization/developmental index) was created as the sum of the scores obtained from the Careprovider Service Model Orientation section of the questionnaire. The Service model orientation (medical-normalization/ developmental index) was identified as an interval-level dependent variable; professional status (paraprofessional and professional) and tenure (less than 10 years and 10 years or more) as nominal-level independent variables.

The second test statistic of this hypothesis was Chi square analysis. For this analysis, attitude toward

normalization (norm-scale) was created as the sum of the Careprovider's Service Model Orientation scores (range was from 48 to 240) the midpoint of the possible range was used to create a two dimensional scale. A score was considered to represent a high normalization attitude on the scale if it was above 144.5 1 scale and low normalization attitude if the score was below 144.5. Attitude toward normalization (norm-scale) was identified as a nominal-level dependent variable; professional status (paraprofessional and professional) and tenure (less than 10 years and 10 years or more) as nominal-level independent variables.

The intent of the present study was to investigate the perceptions of careproviders concerning the normalization/ developmental model's replacement of the medical model as the basis for providing education and training to the institutionalized adult with developmental disabilities. A questionnaire was utilized to assess the attitudes and perceptions of the careprovider concerning the education and training needs of the IADD. In addition the personal characteristics of the careprovider were also obtained via the questionnaire.

Population and Sample

The target population consisted of approximately 889 professionals and paraprofessionals employed to provide campus-based education and training services to adults who are developmentally disabled at Denton State School at the

time of the study. The participants in this study were limited to all medical doctors, registered nurses, licensed vocational nurses, unit directors, assistant unit directors, residence trainers, therapist technicians, qualified mental retardation professional assistants, chaplains, social workers, recreation therapists, habilitation therapists (speech, occupational, and physical therapists), psychologists, behavior therapists, qualified mental retardation professionals, residence supervisors, assistant residence supervisors and vocational trainers currently employed full time or part time in a campus-based position at Denton State School.

Protection of Human Subjects

The rights of the participants in this study were protected throughout the procedure. Data were collected only after permission had been obtained from the participating state school.

All participants were given a written explanation describing the purpose of the study. The explanation included the name of the researcher and the purpose of the study. Subjects were informed of the procedure and time requirements to complete the study. The participants were also instructed that the completion of the questionnaire was voluntary, involved no known risks, that they could chose not to complete the questionnaire and that their participation or lack of participation would not affect

their employment. Additionally, the subjects were advised that all information would be anonymous, how to receive the results if desired, and how to contact the researcher for any additional information.

Confidentially and anonymity was further maintained by requesting that subjects not place identifying marks on the questionnaires. The following statement was printed on all questionnaires:

> COMPLETION AND RETURN OF THIS QUESTIONNAIRE WILL BE CONSIDERED AS INFORMED CONSENT TO ACT AS A SUBJECT IN THIS STUDY.

Procedure For Collection of Data

Before data collection was implemented, approval was requested and obtained from the Committee for Human Subjects of the University of North Texas and also from the Utilization Review Committee and the Institutional Review Board of Denton State School.

The survey materials (questionnaires with coverletters which explained the purpose of the study) were distributed to each of the four residential living areas at Denton State School (Cedar Falls, Eastfield, Timberhill and Westridge) following this procedure: Initially the questionnaires were delivered to the Qualified Mental Retardation Professional (QMRP) Facility Managers at each of their homes by the researcher. The QMRP Facility Managers provided a copy of the questionnaires to all residence trainers, residence

supervisors, and assistants employed in their home. Completed questionnaires were returned to the QMRP, who then placed them in the Residential Units' Questionnaire Drop-box. The Drop-boxes were situated in a centralized and easily accessible area on the unit.

The Researcher also distributed the questionnaires to the nursing staff, social workers, medical doctors, habilitation therapists, psychologists and the behavior therapists at their weekly professional meeting. These completed questionnaires were returned to the distributor at the meetings. The questionnaires for the chapel staff, and also the recreational and vocational trainers were delivered to the Director of Education and Training department by the researcher. The Director distributed them at his weekly professional meeting for completion by department staff. When these questionnaires were completed they were returned, by the director, to the researcher.

TIME FRAME

Tuesday (7/14) through Thursday (7/16):	Survey materials were delivered to the QMRPs for distribution and completion by staff employed in the homes.
Tuesday (7/14) through Friday (7/17):	Questionnaires were distributed at the professional meetings for completion and collection.
Tuesday (7/14) through Thursday (8/6):	The questionnaires were distributed to all Denton State School professional and paraprofessional employees for completion.

Friday (8/7): (approximately 3 1/2 weeks after delivery)	All questionnaires and Drop-boxes were collected by the researcher from all campus sites.

Instrument

No pre-existing tool was found to meet the criteria of this study. In order to assess the careprovider's perceptions and attitudes towards the education and training needs of the IADD a modified questionnaire designed by Booth in 1989 for use with careproviders of adults with mental retardation was utilized. This questionnaire was originally developed in 1975 by Gottlieb and Corman (36) and was based on studies surveying public attitudes towards individuals with mental retardation. Ferrara (31) updated the instrument in 1979 to include items based on the works of Wolfensberger (103), Nihira and Nihira (62), and the National Association for Retarded Citizens (59).

In Ferrara's study, a sample group consisting of parents of children with mental retardation were asked to answer questions concerning their own child. Additionally a second group of parents were asked to answer questions about children who were retarded in general. Both parent groups were asked to complete a Likert scale questionnaire that consisted of 50 items. Each statement was presented in a five point Likert format requiring ratings on a continuum ranging from "strongly agree" to "strongly disagree." For this questionnaire the highest possible score was 250

(rating of 5 X 50 questions). The mean scores for the two groups in the study were 121.9 for the parent group who referred to their own children, and 151.5 for the group who responded to questions concerning the general population (31, p.149).

Booth modified Ferrara's survey instrument to elicit careproviders' attitudes toward normalization activities for their clients. The attitude scale used in her 1989 study consisted of 44 items and was used to assess three factors: "segregation in the community, perceived physical and intellectual handicap, and attitude toward the least restrictive residential alternative" (12, p.33). Booth's questionnaire yielded a possible range of scores from 44 to 220.

The present study developed a modified version of Booth's questionnaire to assess careproviders' attitudes towards education and training activities provided institutionalized clients with developmental disabilities. For this study, the five point Likert scale survey questionnaire, consisted of 48 items which uses 16 items from Booth's questionnaire and 32 items which the researcher developed and added concerning the developmental and medical model's orientation to service provision. The words 'my mentally retarded clients' from Booth's questionnaire were replaced with 'the people with developmental disabilities that I work with' in this adapted version. As indicated in

the diagram for this dissertation study, questions included in the Careprovider's Service Model Orientation section of the questionnaire were designed to assess 3 factors: attitudes towards normalization, developmental model, and medical model as bases for providing service to the IADD (See Appendix D).

The second part of the questionnaire was designed to assess the perceptions careproviders have concerning the training needs of the IADD. The items included in this section were obtained from a review of 10 sources (5, 10, 24, 42, 50, 52, 65, 72, 86, 106) which are utilized by program developers at Denton State School. Nineteen training areas were identified and included in the questionnaire.

Validation by Jury Panel

Content validity for the instrument was established by submitting it to a panel of judges (three experts in the field of mental retardation: Dr. Sigrid S. Glenn, Director of the Center for Behavior Analysis at the University of North Texas; Ms. Nancy Bridenthrall, Director of Program Coordination at Denton State School; and, Dr. Joe Thurmon, Director of Human and Information Resources at Denton State School) who were asked to assess the questions for clarity, adequate directions, comprehensiveness, and relevance of the questions as a means to elicit data to answer the research questions. The questionnaire was revised based on the

recommendations received from the judges. After the questionnaire was validated by the panel, it was piloted.

Pilot Study

The completed instrument was administered to 10 Denton State School employees. These employees were chosen from 10 different positions included in this study. They were chosen from each residential unit, and from the Campus Vocational Department. One week later the questionnaires were readministered to the same group of employees. The results were examined for test-retest reliability. The pilot study was also utilized to assess the readability, clarity, and the amount of time required to complete the questionnaire. A coverletter, which explained the purpose of the study, was given to the individuals who participate in the pilot study.

CHAPTER IV

ANALYSIS OF DATA

The purposes relevant to this study were: (a) to identify the education and training needs of the institutionalized adult with developmental disabilities (IADD) as perceived by Denton State School (DSS) Employees; (b) to determine if the perceptions of the DSS Employees are oriented towards the medical model's or the developmental/ normalization model's view of service; (c) to determine the association between length of employment and the DSS employees' perception about the education and training needs of the IADD; (d) to determine the association between length of employment and the DSS employees' orientation towards the medical or developmental/normalization model for service delivery; (e) to determine if there is any difference between DSS professional and paraprofessional employees' perceptions about the educational and training needs of the IADD; (f) to determine if there is any difference between DSS professional and paraprofessional employees' support of the medical or developmental/ normalization model for service delivery to the IADD; and (g) to determine if there is a significant difference between DSS employees' support of the medical or

developmental/ normalization model for service delivery to the IADD when controlling for professional status and tenure.

The response sample included 370 professionals and paraprofessionals who are currently employed full time or part time in a campus-based position at Denton State School (of the total 879 possible respondents for the study 370 completed and returned questionnaires which is equal to a response rate of 42%). Data were collected for this study by a questionnaire which was administered at Denton State School. The questionnaire consisted of three parts; Care-provider's Service Model Orientation (CPSMO); Careprovider's Perception of Training Needs (CPTN); and, Demographic Information (DI). Possibly the individuals who completed the questionnaire may represent a biased group in terms of their making the decision to participate in the study and completing the lengthy questionnaire.

Before data analyses were carried out, returned questionnaires were edited for multiple responses, missing values, and out of range responses (6, p.377). In order to prevent respondent bias, questions were worded so a rating of 1 indicated a positive response for some questions and for others a rating of 5 indicated the most positive or more normalized response. Responses were transformed and recoded so that the higher score always represented the more favorable or positive (normalization/developmental) attitude

expression. The higher the total score, the more positive the attitude was toward the normalization/developmental model. Based on the research design, data obtained from respondents to the questionnaires were systematically analyzed to address each of the research hypotheses. The data were tabulated and coded for statistical analysis at the University of North Texas' Data Entry Center.

Data from the demographic (DI) section of the questionnaire were compiled in order to describe certain characteristics of the respondents. This information is presented in the following tables as a profile of the respondents. Results from the tests of the hypotheses will be presented in a subsequent section of this chapter.

Profile of the Respondents

Most of the respondents were female (76.5%). The frequency distribution of male and female responses of the professional and paraprofessional employees at Denton State School are displayed in Table 1.

Table 2 displays the frequency distribution of respondents by age group. The age of respondents ranged from 17 years of age to 72 years of age. Almost two thirds (63.2%) of the respondents were less than 41 years of age. Slightly less than 50% of the respondents were below age 32.

Table 1.

Distribution of Respondents by Gender

GENDER	N	PERCENTAGE
FEMALE	283	76.5
MALE	86	23.2
NO RESPONSE	1	.3
TOTAL	370	100.0

Table 2.

Distribution of Respondents by Age

AGE	N	PERCENTAGE
Less than 27	62	19.6
27-33	97	26.2
34-40	64	17.4
41-47	29	7.8
48-54	37	10.0
Older than 54	18	5.0
No Response	53	14.0
TOTAL	370	100.0

Table 3 contains information regarding formal education of the respondents. Most of the respondents (73%) had taken some college classes. Three of the respondents held a

doctor's degree and seven (8%) of the respondents held a master's degree.

Table 4 illustrates the distribution of the respondents by position at Denton State School. Almost 45% of the respondents were employed at Denton State School as resident trainers.

Table 3.

Distribution of Respondents by Level of Education

EDUCATION	N	PERCENTAGE
Less than High School	9	2.4
High School Graduate	90	24.3
Some College	113	30.5
Associate	26	7.0
Licensed Vocational Nurse	16	4.3
Bachelor's Degree	64	17.3
Registered Nurse	11	3.0
Master's Degree	7	8.1
Doctor's Degree	3	0.8
No Response	1	0.3
TOTAL	370	100.0

Table 4.

Distribution of Respondents by Position

POSITION	N	PERCENTAGE
RESIDENCE TRAINER	164	44.3
ASSISTANT RESIDENCE SUPERVISOR	26	7.0
RESIDENT SUPERVISOR	34	9.2
THERAPIST TECHNICIAN	13	3.5
BEHAVIOR THERAPIST	4	1.1
RECREATION THERAPIST	2	0.5
LICENSED VOCATIONAL NURSE	18	4.8
REGISTERED NURSE	20	5.3
QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP)	16	4.4
UNIT DIRECTOR	4	1.1
ASSISTANT UNIT DIRECTOR	1	0.3
MEDICAL DOCTOR	8	2.2
PSYCHOLOGIST	8	2.2
SOCIAL WORKER	9	2.5
VOCATIONAL TRAINER	17	4.6
CHAPLAIN	2	0.5
QMRP ASSISTANT	13	3.5
SPEECH/PHYSICAL/OCCUPATIONAL THERAPISTS	11	3.0
TOTAL	370	100.0

Table 4a provides the frequency distribution of the respondents' position at Denton State School as classified for this study as paraprofessional and professional status. Approximately three fourths of the respondents were employed in paraprofessional positions at Denton State School.

Table 4a.

Distribution of Respondents by

Professional/ Paraprofessional Status

STATUS	N	PERCENTAGE
PARAPROFESSIONAL	273	73.7
PROFESSIONAL	97	26.3
TOTAL	370	100.0

Table 5 contains information regarding the marital status of the respondents. Slightly more than 50% were married, while 28.6% of the respondents were single.

The frequency distribution of respondents by ethnicity is displayed in table 6. Most of the respondents indicated that their ethnicity was white (almost 75%), 20% of the respondents were Black.

Table 5.

Distribution of Respondents by Marital Status

MARITAL STATUS	N	PERCENTAGE
SINGLE	106	28.6
MARRIED	189	51.1
SEPARATED	14	3.8
DIVORCED	47	12.7
WIDOWED	10	2.7
OTHER	4	1.0
TOTAL	370	100.0

Table 6.

Distribution of Respondents by Ethnicity

ETHNICITY	N	PERCENTAGE
WHITE	267	72.2
BLACK	75	20.3
HISPANIC	13	3.5
ASIAN	8	2.2
NATIVE AMERICAN	3	.8
OTHER	4	1.0
TOTAL	370	100.0

Table 7 reflects the distribution of the respondents' length of employment at Denton State School and percentages.

Approximately 70% of the respondents have been employed at Denton State School for 10 years or less. Almost 29% (107) of the respondents have been employed at DSS for two years or less and 13% (48) were employed for more than 10 years.

Table 7.

Distribution of Respondents by Tenure at Denton State School

TENURE	N	PERCENTAGE
LESS THAN 6	205	55.3
6-10 YEARS	55	14.9
11-15 YEARS	28	7.7
MORE THAN 15	20	5.3
NO RESPONSE	62	16.8
TOTAL	370	100.0

Table 8 presents the frequencies and percentages of the respondents' length of employment in their current position at Denton State School. Approximately 49% (182) of the respondents have been employed in their current positions for less than 4 years. Nearly 70% (285) were in their positions for 10 years or less.

Table 8.

Distribution of Respondents by Tenure at Denton State School in Their Current Position (CP)

TENURE (CP)	N	PERCENTAGE
LESS THAN 4	182	49.2
4-6 YEARS	59	15.9
7-10 YEARS	17	4.6
MORE THAN 10	13	3.6
NO RESPONSE	99	26.7
TOTAL	370	100.0

Table 9 contains information regarding the current work location of the respondents. Slightly less than 31% (113) of the respondents work on the Cedarfalls residential unit which represents the largest group of respondents. The next substantial sized group, 25% were located at the Westridge residential unit.

Table 10 provides the frequency distribution of the respondents based on the adaptive behavior level and the level of care required by the individuals with developmental disabilities with whom they work. Slightly more than 45% (170) of the respondents work with individuals who require extensive assistance and supervision in the completion of their daily living activities.

Table 9.

Distribution of Respondents by Work Location

LOCATION	N	PERCENTAGE
CEDARFALLS	113	30.6
EASTFIELD	62	16.7
TIMBERHILL	79	21.5
WESTRIDGE	94	25.4
INFIRMARY	7	1.9
OTHER	15	4.0
TOTAL	370	100.0

Table 11 illustrates the distribution of the respondents by their work shift at Denton State School. Thirty-one percent (116) of the respondents worked between the hours of 8AM and 5PM at Denton State School. Respondents who worked during the hours of 6AM and 2PM represented 27% of the sample, and almost 26% worked from 2PM to 10PM. The late night shift (10PM to 6AM) comprised 15% of the sample.

Table 10.

Distribution of Respondents by Level of Care Provided

LEVEL OF CARE (ABL)	N	PERCENTAGE
MEDICALLY FRAGILE (III)	56	15.2
LEVEL VI (III)	170	46.1
LEVEL V (II and III)	58	17.1
LEVEL I (I and II)	71	17.6
OTHER	15	4.0
TOTAL	370	100.0

* See Appendix E. for residential homes included in each category.

Table 11.

Distribution of Respondents by Work Shift

WORK SHIFT	N	PERCENTAGE
6AM TO 2PM	102	27.6
2PM TO 10PM	96	25.9
10PM TO 6AM	55	14.9
8AM TO 5PM	116	31.4
NO RESPONSE	1	.3
TOTAL	370	100.0

The frequency distribution of the respondents based on their prior working experience with individuals with developmental disabilities before being employed at Denton

State School is presented in table 12. Of the total response sample 38% of the respondents had worked with individuals with developmental disabilities prior to their DSS employment.

Table 12.

Distribution of Respondents by Prior Work Experience with Individuals with Developmental Disabilities

PRIOR EXPERIENCE	N	PERCENTAGE
NO	228	61.6
YES	142	38.4
TOTAL	370	100.0

In summary, the total sample was predominantly female, with one fourth being male. Seventy-five percent of the respondents were white, with 20% or one fifth being black. Almost 46% were 33 years of age or younger. Slightly less than 75% of the respondents had attended college; 127 (40%) have college degrees. Slightly more than 50% of the total sample were married, with almost 29% being single. Almost three fourth of the respondents were employed as paraprofessionals. Of the 370 subjects, 205 (55%) were employed at DSS for less than 6 years; roughly 50% were employed in their current position for 4 years or less, and 38% had prior experience working with individuals with

developmental disabilities before being employed at Denton State School.

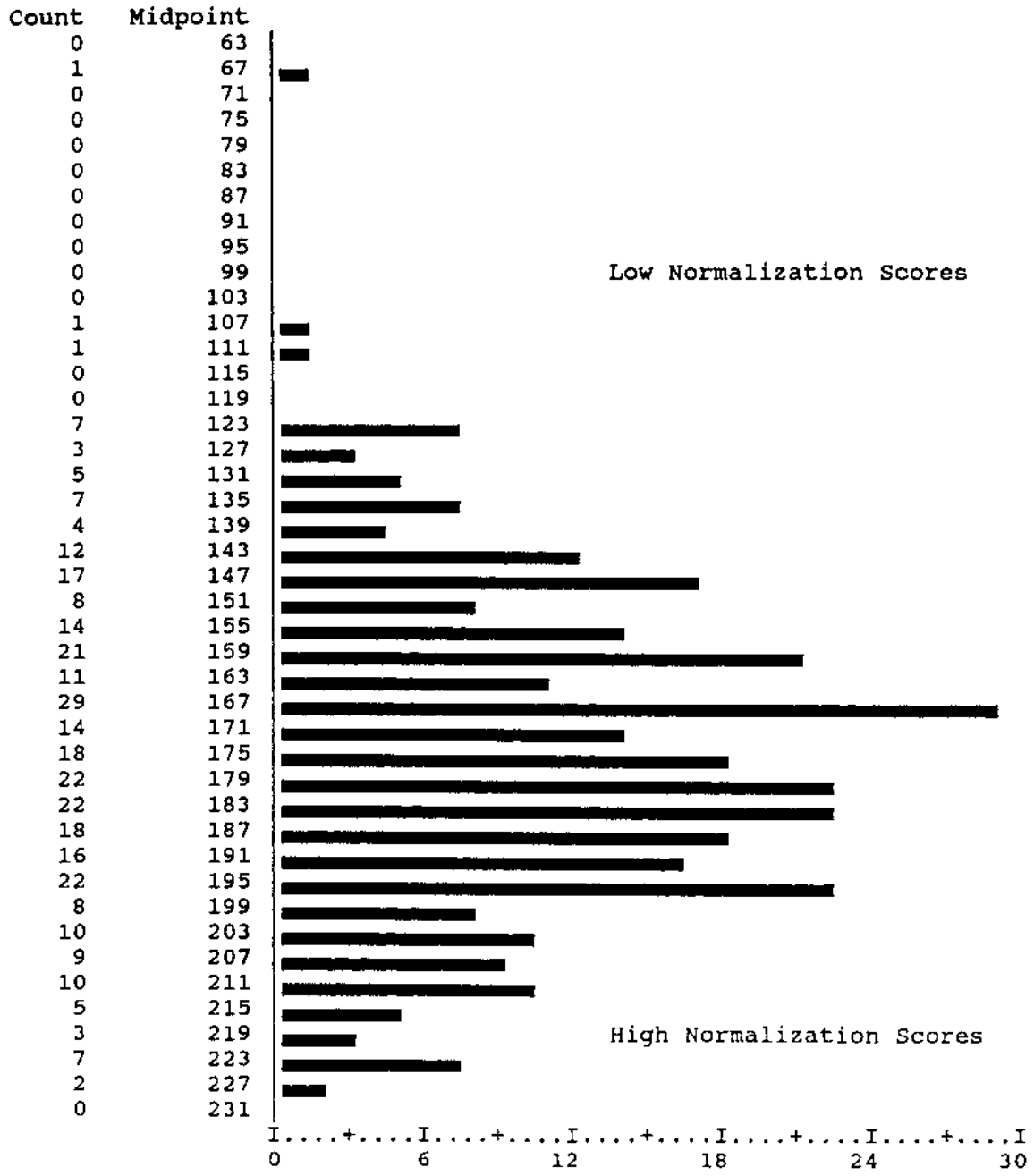
Careprovider's Service Model Orientation (Medical-Normalization/developmental Index)

Careprovider's scores from the Careprovider's Service Model Orientation Index (part I of the questionnaire) ranged from 68 to 227 (maximum number of points was 240). The mean was 173.37 and the standard deviation was 25.02. The shape of the distribution of score is presented in Figure 2. Figure 2a displays the distribution with the normal curve superimposed for comparison. Characteristics of the scorers who were located two standard deviations above and below the mean were examined (high and low scorers).

The examination of the characteristics of the careproviders who scored high revealed that the majority were white, had college degrees, worked in locations classified as level of care I, had family members with developmental disabilities, and held supervisory/management positions. Additionally, they were all female and married.

The majority of the individuals who scored low were white, worked in homes that were classified as level IV, had no prior experience working with individuals with developmental disabilities before working at DSS, and had

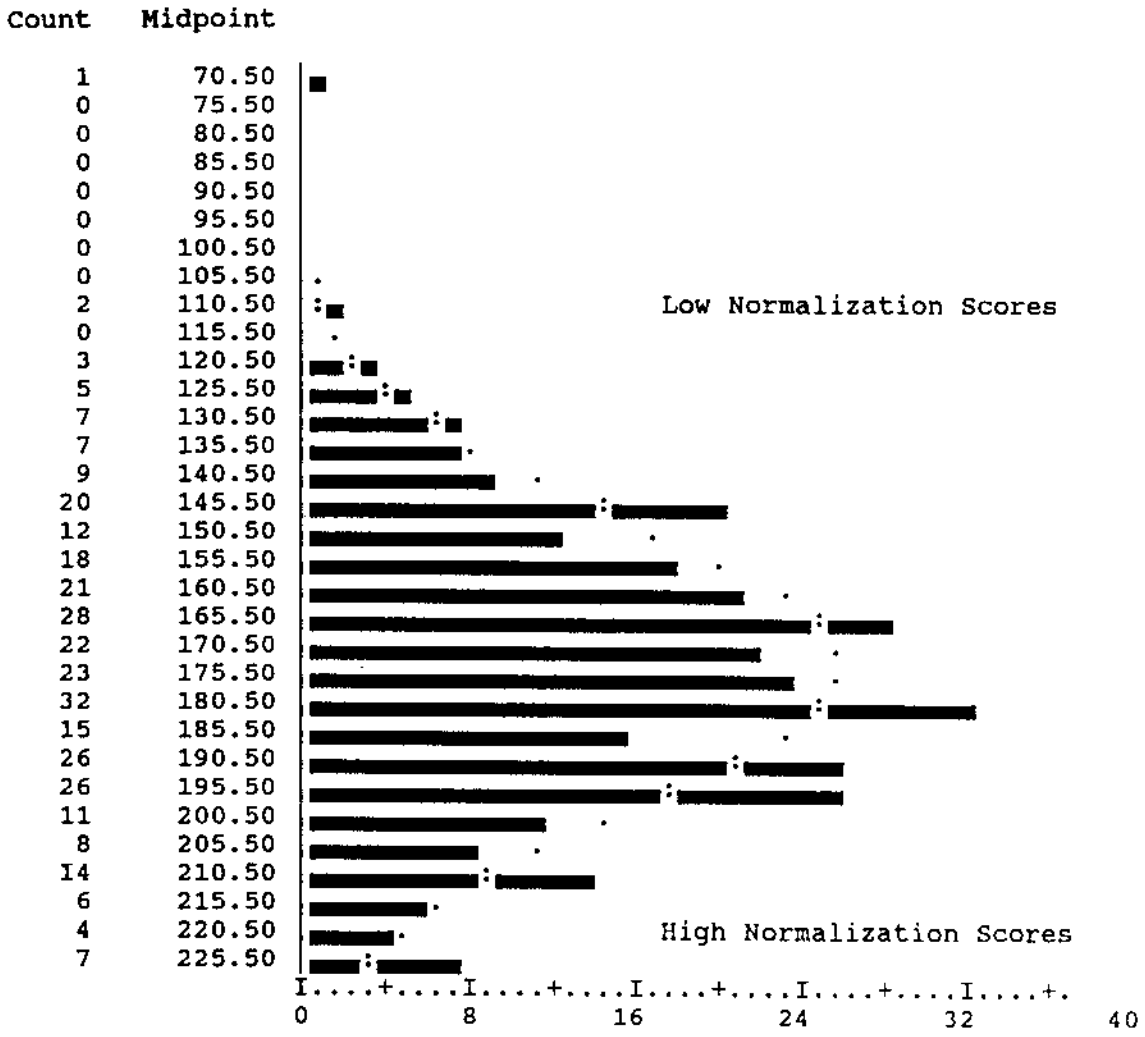
CAREPROVIDER'S SERVICE MODEL ORIENTATION (CSMO)



Histogram Frequency

Figure 2

CAREPROVIDER'S SERVICE MODEL ORIENTATION (CSMO)
(With Normal Curve)



Histogram Frequency

Figure 2a

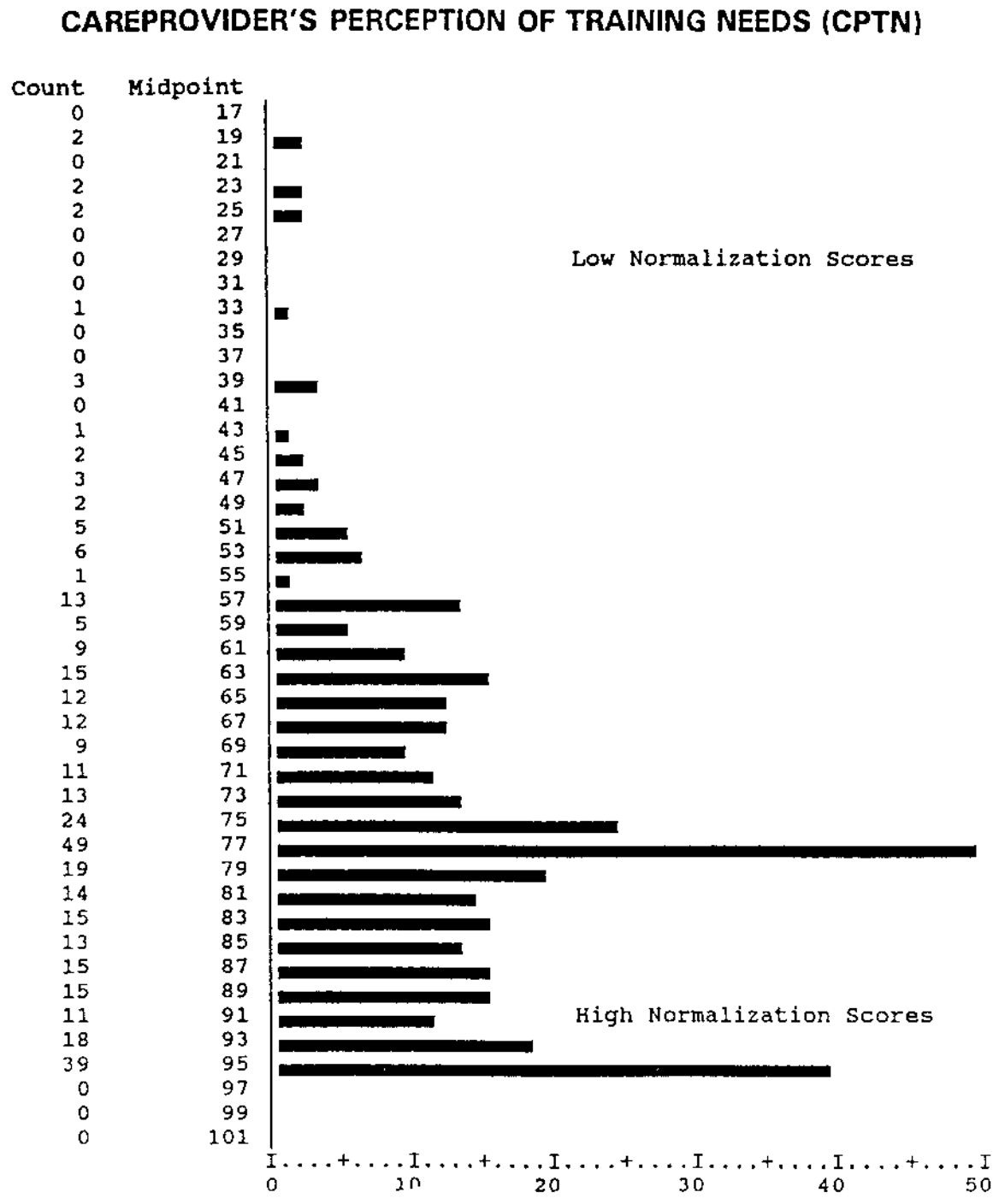
various educational backgrounds. The low scorers were all female.

The differences between the high and low scorer were in employment position, marital status, educational background, and level of care classification for their work station.

Careprovider's Perception of Training Needs (CPTN)

Careprovider's scores from the Careprovider's Perception of Training Needs Index (part II of the questionnaire) ranged from 19 to 95 (maximum number of points was 95). The mean was 75.21 and the standard deviation was 14.85. The shape of the distribution of score is presented in Figure 3. Figure 3a displays the distribution with the normal curve superimposed for comparison. The characteristics of the scorers who were located two standard deviations below the mean were examined (no one scored two standard deviations above the mean).

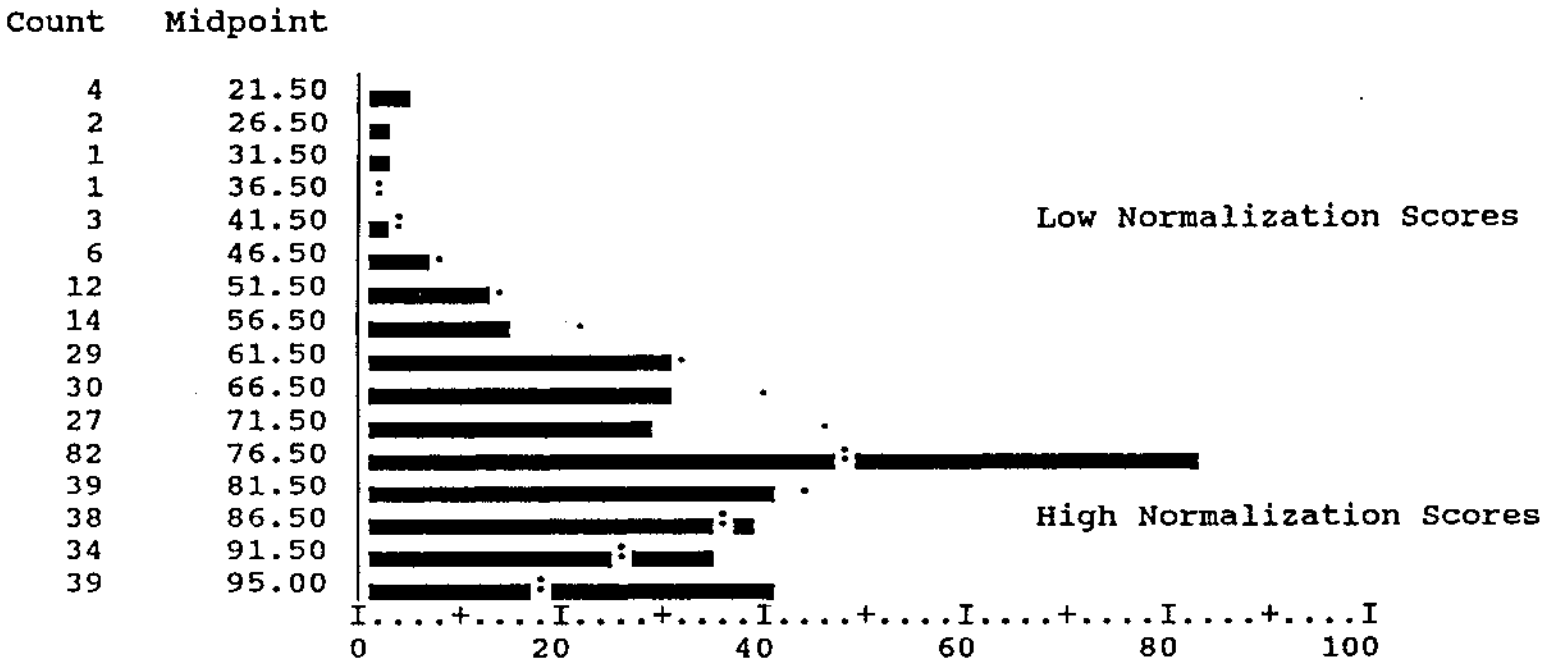
The examination of the characteristics of the careproviders who scored low revealed that the majority were white, female, and employed in the homes where level of care was classified as medically fragile. They had a wide range of education, were employed at DSS for 2.5 years or less, and had no prior experience in the field of mental retardation before being employed at DSS.



Histogram Frequency

Figure 3

CAREPROVIDER'S PERCEPTION OF TRAINING NEEDS (CPTN)
(With Normal Curve)



Histogram Frequency

Figure 3a

Findings

Statistical analyses were completed for each of six hypotheses using the total sample. Post hoc analyses were conducted to reveal the response impact associated with the level of care and adaptive behavior level of individuals with developmental disabilities.

Hypotheses and Corresponding Statistical Analyses

The hypotheses and corresponding statistical analyses which were carried out are as follows:

Hypothesis 1: The employee perceptions regarding the educational and training needs of the institutionalized adult with developmental disabilities (IADD) will differ significantly based on their length of employment at Denton State School.

This hypothesis was addressed by completing a regression analysis. For this analysis, perception of training needs (CPTN) was identified as dependent interval-level variable and tenure was treated as an interval-level independent variable. Table 13 displays the results of the regression analysis for the total sample. Tables 13a through 13d present the results from the sample when controlling for level of care provided. Multiple correlations and beta weights are shown in the tables. The significance level was set at .05 and no significant findings were found in these analyses.

Table 13.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Tenure

(n = 203)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE	-.0617	.1567	-.394	.6942	.0278	.0008	.6942

CORRELATION (r) = -.028

Table 13a.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Tenure

(n = 30)
(Level of Care = Medically Fragile)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE	.1682	.8005	.210	.8351	.0397	.0016	.8351

CORRELATION (r) = .040

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Table 13b.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Tenure

(n = 80)
(Level of Care = VI)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE	.0734	.3451	.213	.8320	.0241	.0006	.8320

CORRELATION (r) = .024

Table 13c.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Tenure

(n = 36)
(Level of Care = V)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE	-.2810	.1837	-1.530	.1353	.2538	.0644	.1353

CORRELATION (r) = -.254

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Table 13d.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Tenure

(n = 44)
(Level of Care = I)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE	.3643	.4209	.866	.3916	.1324	.0175	.3916

CORRELATION (r) = .132

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Hypothesis 2: The perceptions between paraprofessionals and professionals regarding the educational and training needs of the IADD will not differ significantly.

This hypothesis was addressed by using one-way analysis of variance to provide an indication of the variability between the groups. For this analysis, perception of training needs (CPTN) was identified as an interval-level dependent variable and the two groups (paraprofessional and professional) as the nominal independent variables. Alpha was set at .05. Table 14 summarizes the results of the one-

way ANOVA. Results indicate a significant difference between professional and paraprofessional groups in their perceptions of training needs for individuals with developmental disabilities.

Analysis of variance was also employed to measure training needs and professional status within each of the level of care categories. Tables 14a through 14d summarize the results. The .05 level of significance was not reached for any of the results.

Table 14.

Analysis of Variance of the Relationship Between Employee Perception of Training Needs and Professional Status

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	1052.9967	1	1052.9967	4.8257	.0287
Within Groups	78336.4215	359	218.2073		
Total	79389.4183	360			

n Paraprofessional = 273
n Professional = 88
ss = Sum of Squares
df = Degrees of freedom
MS = Mean Squares
F = F ratio
p = level of significance at .05 obtained

Table 14a.

Analysis of Variance of the Relationship Between Employee Perception of Training Needs and Professional Status

(Level of Care = Medically Fragile)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	1006.4064	1	1006.4064	2.5666	.1153
Within Groups	19997.7068	51	392.1119		
Total	21004.1132	52			

n Paraprofessionals = 32
n Professionals = 21
p = level of significance at .05 not obtained

Table 14b.

Analysis of Variance of the Relationship Between Employee Perception of Training Needs and Professional Status

(Level of Care = VI)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	443.5284	1	443.5284	3.1326	.0786
Within Groups	23361.5495	165	141.5851		
Total	23805.0778	166			

n Paraprofessionals = 138
n Professionals = 29
ss = Sum of Squares
df = Degrees of freedom
MS = Mean Squares
F = F ratio
p = level of significance at .05 not obtained

Table 14c.

Analysis of Variance of the Relationship Between Employee Perception of Training Needs and Professional Status

(Level of Care = V)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	273.0972	1	273.0972	1.4476	.2336
Within Groups	11507.9872	61	188.6554		
Total	11781.0794	62			

n Paraprofessionals = 56
n Professionals = 7
p = level of significance at .05 not obtained

Table 14d.

Analysis of Variance of the Relationship Between Employee Perception of Training Needs and Professional Status

(Level of Care = I)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	.6088	1	.6088	.0039	.9505
Within Groups	9556.2483	61	156.6598		
Total	9556.8571	62			

n Paraprofessionals = 41
n Professionals = 22
ss = Sum of Squares
df = Degrees of freedom
MS = Mean Squares
F = F ratio
p = level of significance at .05 not obtained

Hypothesis 3: The perceptions of employees at Denton State School regarding the educational and training needs of the IADD will be significantly related to the age of the employees.

This hypothesis was addressed by completing a regression analysis. For this analysis, perception of training needs (CPTN) was identified as an interval-level dependent variable and age as an interval-level independent variable. Table 15 presents the results for the total response sample and Tables 15a through 15d display the results disaggregated by level of care. No significant relationship was found to exist between the variables.

Table 15.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Age

(n=311)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	AGE	-.0543	.0781	-.696	.4871	.0396	.0016	.4871

CORRELATION (r) = -.040

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Table 15a.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Age

(n = 30)
(Level of Care = Medically Fragile)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	AGE	-.1417	.2519	-.563	.5766	.0845	.0071	.5766

CORRELATION (r) = -.085

Table 15b.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Age

(n = 143)
(Level of Care = VI)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	AGE	.0272	.1024	.266	.7906	.0224	.0005	.7906

CORRELATION (r) = .022

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Table 15c.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Age

(n=53)
(Level of Care = V)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	AGE	-.0646	.1336	-.483	.6309	.0675	.0046	.6309

CORRELATION (r) = -.068

Table 15d.

Regression Analysis of the Relationship Between Employee Perception of Training Needs and Employee Age

(n=54)
(Level of Care = I)

(dependent variable = Perception of Training Needs)

Step	Variable	b wt	SE	t	sig t	R	R2	SigF
1.	AGE	.0692	.1653	.419	.6773	.0580	.0034	.6773

CORRELATION (r) = .058

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Hypothesis 4: The perceptions between Denton State School employees with less than 10 years tenure and those with 10 or more years of tenure will not differ significantly in service model orientation.

This hypothesis was addressed by using one-way analysis of variance to provide an indication of the variability between the groups. For this analysis, service model orientation (medical- normalization/developmental index) was identified as an interval-level dependent variable and tenure (less than 10 years and 10 years or more) as a nominal-level independent variable. Table 16 presents the results for the total response sample and Tables 16a through 16d display the results disaggregated by level of care. Alpha was set at .05. A level of significance was not reached for any of the analyses.

Table 16.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Employee Tenure

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	671.4594	1	671.4594	1.081	.2995
Within Groups	170882.1579	275	621.3897		
Total	171553.6173	276			

n Paraprofessional = 227
n Professional = 50
p = level of significance at .05 not obtained

Table 16a.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Employee Tenure

(Level of Care = Medically Fragile)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	627.2000	1	627.2000	1.478	.2325
Within Groups	14429.8000	34	424.4059		
Total	15057.0000	35			

n Paraprofessional = 30
n Professional = 6
ss = Sum of Squares
df = Degrees of freedom
MS = Mean Squares
F = F ratio
p = level of significance at .05 not obtained.

Table 16b.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Employee Tenure

(Level of Care = VI)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	40.4861	1	40.4861	.0832	.7735
Within Groups	59835.5619	123	486.4680		
Total	59876.0480	124			

n Paraprofessionals = 105
n Professionals = 20
p = level of significance at .05 not obtained

Table 16c.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Employee Tenure

(Level of Care = V)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	.4471	1	.4471	.0006	.9804
Within Groups	37552.0058	51	736.3138		
Total	37552.4528	52			

n Paraprofessionals = 40
n Professionals = 13
ss = Sum of Squares
df = Degrees of freedom
MS = Mean Squares
F = F ratio
p = level of significance at .05 not obtained

Table 16d.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Employee Tenure

(Level of Care = I)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	583.9388	1	583.9388	1.0047	.3210
Within Groups	29061.2920	50	581.2258		
Total	29645.2308	51			

n Paraprofessionals = 43
n Professionals = 9
ss = Sum of Squares
df = Degrees of freedom
MS = Mean Squares
F = F ratio
p = level of significance at .05 not obtained

Hypothesis 5: Professionals and paraprofessionals employed at Denton State School (DSS) will not significantly differ in their service model orientation.

This hypothesis was addressed by using a one-way analysis of variance to indicate variability between professionals and paraprofessionals. Statistical analysis was completed using the total response sample and post hoc analyses were conducted to reveal the response impact associated with the level of care and adaptive behavior level of individuals with developmental disabilities. For these analyses, service model orientation (medical- normalization/

developmental index) was identified as an interval-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

Table 17 presents the results for the total response sample and Tables 17a through 17d display the results disaggregated by level of care. For the analysis of variance a probability of less than .05 was obtained for two of the analyses. The results indicate for the total sample a significant difference between the service model orientation of professional and paraprofessional employees. For individuals employed in residential units providing level I type care (Table 17d) results indicate that there was a significant difference (p = .0499) between the two groups.

Table 17.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Professional Status

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	4110.2974	1	4110.2974	6.681	.0102
Within Groups	199947.6659	325	615.2236		
Total	204057.9633	326			

n Paraprofessionals = 244
n Professionals = 83
p = level of significance at .05 was obtained

Table 17a.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Professional Status

(Level of Care = Medically Fragile)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	.0140	1	.0140	.0000	.9963
Within Groups	27931.4643	44	634.8060		
Total	27931.4783	45			

n Paraprofessionals = 28
n Professionals = 18
p = level of significance at .05 not obtained

Table 17b.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Professional Status

(Level of Care = VI)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	1104.0940	1	1104.0940	2.449	.1198
Within Groups	67186.2636	149	450.9145		
Total	68290.3576	150			

n Paraprofessionals = 123
n Professionals = 28
ss = Sum of Squares
df = Degrees of freedom
MS = Mean Squares
F = F ratio
p = level of significance at .05 not obtained

Table 17c.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Professional Status

(Level of Care = V)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	712.3236	1	712.3236	1.0121	.3186
Within Groups	40820.4097	58	703.8002		
Total	41532.7333	59			

n Paraprofessionals = 53
n Professionals = 7
p = level of significance at .05 not obtained

Table 17d.

Analysis of Variance of the Relationship Between Employee Service Model Orientation and Professional Status

(Level of Care = I)

SOURCE OF VARIANCE	ss	df	MS	F	p
Between Groups	2089.5090	1	2089.5090	4.0183	.0499
Within Groups	28600.2103	55	520.0038		
Total	30689.7193	56			

n Paraprofessionals = 36
n Professionals = 21
ss = Sum of Squares
df = Degrees of freedom
MS = Mean Squares
F = F ratio
p = level of significance at .05 obtained

Chi square analyses were utilized to test the significance of the association between employee reported

service model orientation and professional status. For these analyses, reported service model orientation (DI-16) was identified as a nominal-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

Table 18 presents the results for the total response sample and Tables 18a through 18d display the results disaggregated by level of care. The result of the Chi Square analysis for reported service model orientation and professional status indicates that there was a significant relationship for the total sample, and for individuals providing Level VI and Level I care.

Table 18.

Chi Square Test of the Relationship between Careprovider Reported Service Model Orientation and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
DEVELOPMENTAL MODEL	112	22	134
NORMALIZATION MODEL	154	38	192
MEDICAL MODEL	15	28	43
TOTALS	281	88	369

DF:	2
Total Chi Square:	46.137
p:	.0000

Table 18a.

(Level of Care = Medically Fragile)

Chi Square Test of the Relationship between Careprovider Reported Service Model Orientation and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
DEVELOPMENTAL MODEL	16	4	20
NORMALIZATION MODEL	8	4	12
MEDICAL MODEL	11	13	24
TOTALS	35	21	56

DF:	2
Total Chi Square:	5.547
p:	.0625

Table 18b.

(Level of Care = VI)

Chi Square Test of the Relationship between Careprovider Reported Service Model Orientation and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
DEVELOPMENTAL MODEL	58	9	67
NORMALIZATION MODEL	81	11	92
MEDICAL MODEL	1	9	10
TOTALS	140	29	169

DF: 2
Total Chi Square: 39.731
p: .0000

Table 18c.

(Level of Care = V)

Chi Square Test of the Relationship between Careprovider Reported Service Model Orientation and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
DEVELOPMENTAL MODEL	25	1	26
NORMALIZATION MODEL	31	5	36
MEDICAL MODEL	1	1	2
TOTALS	57	7	64

DF: 2
Total Chi Square: 4.797
p: .0909

Table 18d.

(Level of Care = I)

Chi Square Test of the Relationship between Careprovider Reported Service Model Orientation and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
DEVELOPMENTAL MODEL	11	6	17
NORMALIZATION MODEL	32	12	44
MEDICAL MODEL	0	4	4
TOTALS	43	22	65

DF: 2
Total Chi Square: 8.683
p: .0130

Chi square analyses were utilized to test the significance of the association between employee attitude towards normalization and professional status. For these analyses, attitude toward normalization (CSMO-46) was identified as a nominal-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

Table 19 presents the results for the total response sample and Tables 19a through 19d display the results disaggregated by level of care. Alpha was set to .05. A

level of significance was not reached for any of the analyses.

Table 19.

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	113	43	156
AGREE	109	36	145
UNDECIDED	30	4	34
DISAGREE	12	4	16
STRONGLY DISAGREE	15	0	15
TOTALS	279	87	366

DF:	4
Total Chi Square:	8.7238
p:	.0684

Table 19a.

(Level of Care = Medically Fragile)

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	10	6	16
AGREE	9	10	19
UNDECIDED	8	1	9
DISAGREE	5	4	9
STRONGLY DISAGREE	1	0	1
TOTALS	33	21	54

DF:	4
Total Chi Square:	5.1982
p:	.2676

Table 19b.

(Level of Care = VI)

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	58	14	72
AGREE	62	14	76
UNDECIDED	12	1	13
DISAGREE	2	0	2
STRONGLY DISAGREE	7	0	7
TOTALS	141	29	170

DF:	4
Total Chi Square:	3.0464
p:	.5501

Table 19c.

(Level of Care = V)

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	18	4	22
AGREE	25	2	27
UNDECIDED	6	1	7
DISAGREE	2	0	2
STRONGLY DISAGREE	6	0	6
TOTALS	57	7	64

DF:	4
Total Chi Square:	2.5937
p:	.6279

Table 19d.

(Level of Care = I)

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	24	12	36
AGREE	12	8	20
UNDECIDED	3	1	4
DISAGREE	3	0	3
TOTALS	42	21	63

DF: 3
Total Chi Square: 2.0250
p: .5672

* Note that no one strongly disagreed

Chi square analyses were utilized to test the significance of the association between employee attitude towards the medical model and professional status. For these analyses, attitude toward the medical model (CSMO-47) was identified as a nominal-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

Table 20 presents the results for the total response sample and Tables 20a through 20d display the results disaggregated by level of care. The result of the Chi Square analysis for employee attitude toward the medical model and professional status indicates that there was a significant relationship for the total sample, and for individuals providing Level VI care.

Table 20.

Chi Square Test of the Relationship between Careprovider Attitude Toward The Medical Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	16	2	18
AGREE	42	9	51
UNDECIDED	78	10	88
DISAGREE	88	45	133
STRONGLY DISAGREE	55	19	74
TOTALS	279	85	364

DF:	4
Total Chi Square:	17.8889
p:	.0013

Table 20a.

(Level of Care = Medically Fragile)

Chi Square Test of the Relationship between Careprovider Attitude Toward The Medical Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	2	0	2
AGREE	7	5	12
UNDECIDED	5	4	9
DISAGREE	11	10	21
STRONGLY DISAGREE	8	1	9
TOTALS	33	20	53

DF:	4
Total Chi Square:	5.0518
p:	.2820

Table 20b.

(Level of Care = VI)

Chi Square Test of the Relationship between Careprovider Attitude Toward The Medical Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	8	0	8
AGREE	22	4	26
UNDECIDED	47	3	50
DISAGREE	37	15	52
STRONGLY DISAGREE	27	6	33
TOTALS	141	28	169

DF:	4
Total Chi Square:	11.3880
p:	.0225

Table 20c.

(Level of Care = V)

Chi Square Test of the Relationship between Careprovider Attitude Toward The Medical Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	5	1	6
AGREE	6	0	6
UNDECIDED	16	0	16
DISAGREE	24	5	29
STRONGLY DISAGREE	6	1	7
TOTALS	57	7	64

DF: 4
Total Chi Square: 4.1674
p: .3838

Table 20d.

(Level of Care = I)

Chi Square Test of the Relationship between Careprovider Attitude Toward The Medical Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	1	0	1
AGREE	6	0	6
UNDECIDED	9	2	11
DISAGREE	14	12	26
STRONGLY DISAGREE	12	7	19
TOTALS	42	21	63

DF:	4
Total Chi Square:	6.6647
p:	.1547

Chi square analyses were utilized to test the significance of the association between employee attitude towards the developmental model and professional status. For these analyses, attitude toward the developmental model (CSMO-48) was identified as a nominal-level dependent variable and professional status (paraprofessional and professional) as a nominal-level independent variable.

Table 21 presents the results for the total response sample and Tables 21a through 21d display the results disaggregated by level of care. The result of the Chi square analysis for employee attitude toward the developmental model and professional status indicates that there was a significant relationship for the total sample. A level of significance was not reached for any of the disaggregated analyses.

Table 21.

Chi Square Test of the Relationship Between Careprovider Attitude Toward The Developmental Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	79	29	108
AGREE	118	44	162
UNDECIDED	60	6	66
DISAGREE	14	7	21
STRONGLY DISAGREE	6	0	6
TOTALS	277	86	363

DF:	4
Total Chi Square:	12.4002
p:	.0146

Table 21a.

(Level of Care = Medically Fragile)

Chi Square Test of the Relationship Between Careprovider Attitude Toward The Developmental Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	9	3	12
AGREE	13	11	24
UNDECIDED	6	1	7
DISAGREE	5	5	10
TOTALS	33	86	53

DF: 3
Total Chi Square: 3.7766
p: .2866

* Note no one strongly disagreed

Table 21b.

(Level of Care = VI)

Chi Square Test of the Relationship Between Careprovider Attitude Toward The Developmental Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	38	9	47
AGREE	62	18	80
UNDECIDED	35	2	37
DISAGREE	4	0	4
STRONGLY DISAGREE	1	0	1
TOTALS	140	29	169

DF:	4
Total Chi Square:	6.3677
p:	.1733

Table 21c.

(Level of Care = V)

Chi Square Test of the Relationship Between Careprovider Attitude Toward The Developmental Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	14	2	16
AGREE	25	3	28
UNDECIDED	12	1	13
DISAGREE	2	1	3
STRONGLY DISAGREE	4	0	4
TOTALS	57	7	64

DF:	4
Total Chi Square:	2.2180
p:	.6957

Table 21d.

(Level of Care = I)

Chi Square Test of the Relationship Between Careprovider Attitude Toward The Developmental Model and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
STRONGLY AGREE	16	10	26
AGREE	17	9	26
UNDECIDED	6	1	7
DISAGREE	1	1	2
STRONGLY DISAGREE	1	0	1
TOTALS	41	21	62

DF:	4
Total Chi Square:	2.1943
p:	.7001

Chi square analyses were utilized to test the significance of the association between employee attitude towards normalization (norm-scale) and professional status. For these analyses, attitude toward normalization (norm-scale) was identified as a nominal-level dependent variable

and professional status (paraprofessional and professional) as a nominal-level independent variable.

Table 22 presents the results for the total response sample and Tables 22a through 22d display the results disaggregated by level of care. Alpha was set to .05. A level of significance was not reached for any of the analyses.

Table 22.

Chi Square Test of the Relationship Between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	211	75	286
LOW NORMALIZATION	28	8	36
TOTALS	239	83	322

DF:	1
Total Chi Square:	.0993
p:	.7526

Table 22a.

(Level of Care = Medically Fragile)

Chi Square Test of the Relationship Between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	18	14	32
LOW NORMALIZATION	10	4	14
TOTALS	28	18	46

DF: 1
Total Chi Square: .4126
p: .5207

Table 22b.

(Level of Care = VI)

Chi Square Test of the Relationship Between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	109	26	135
LOW NORMALIZATION	12	2	14
TOTALS	121	28	149

DF: 1
Total Chi Square: .0089
p: .9251

Table 22c.

(Level of Care = V)

Chi Square Test of the Relationship Between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	47	6	53
LOW NORMALIZATION	5	1	6
TOTALS	52	7	59

DF: 1
Total Chi Square: .0000
p: 1.0000

Table 22d.

(Level of Care = I)

Chi Square Test of the Relationship Between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	33	21	54
LOW NORMALIZATION	1	0	1
TOTALS	34	21	55

DF: 1
Total Chi Square: .0000
p: 1.0000

Hypothesis 6: The service model orientation of DSS employees will be significantly different between groups when controlling for professional status and length of employment at Denton State School.

This hypothesis was addressed by completing two different multiple regression analyses. The regression coefficients were utilized to identify the amount of variance that is

accounted for and also not explained by the analyses. For this analysis, service model orientation (medical-normalization/developmental index) was identified as an interval-level dependent variable; professional status (paraprofessional and professional) and tenure (less than 10 years and 10 years or more) as nominal-level independent variables.

Table 23 presents the results for the total response sample and Tables 23a through 23d display the results disaggregated by level of care. No significant relationship was found to exist between the variables.

Table 23.

Multiple Regression Analysis of the Relationship Between Employee Service Model Orientation, Professional Status, and Employee Tenure

(Professional n = 40)
(Paraprofessional *n* = 144)

(dependent variable = Service Model Orientation)

Step	Variable	Control Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE								
		Professional	.8360	.9364	.893	.3776	.1433	.0206	.3776
		Paraprofessional	.0836	.4108	.481	.6312	.0403	.0016	.6312

CORRELATION (r) Professional = .143
CORRELATION (r) Paraprofessional = .040
b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Table 23a.

Multiple Regression Analysis of the Relationship Between Employee Service Model Orientation, Professional Status, and Employee Tenure

(Professional n = 8)
(Paraprofessional n = 17)
(Level of Care = Medically Fragile)

(dependent variable = Service Model Orientation)

Step	Variable	Control Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE								
		Professional	2.0414	6.7902	.301	.7738	.1218	.0148	.7738
		Paraprofessional	.1737	.8840	.197	.8468	.0507	.0026	.8468

CORRELATION (r) Professional = .122
CORRELATION (r) Paraprofessional = .051

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Table 23b.

Multiple Regression Analysis of the Relationship Between Employee Service Model Orientation, Professional Status, and Employee Tenure

(Professional n = 7)
(Paraprofessional n = 67)
(Level of Care = VI)

(dependent variable = Service Model Orientation)

Step	Variable	Control Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE								
		Professional	-.3057	1.8829	-.162	.8774	.0724	.0052	.8774
		Paraprofessional	.1649	.6483	.245	.8000	.0315	.0100	.8000

CORRELATION (r) Professional = -.072
CORRELATION (r) Paraprofessional = .032

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Table 23c.

Multiple Regression Analysis of the Relationship Between Employee Service Model Orientation, Professional Status, and Employee Tenure

(Professional n = 4)
(Paraprofessional n = 30)
(Level of Care = V)

(dependent variable = Service Model Orientation)

Step	Variable	Control Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE								
		Professional	-6.6793	5.9197	-1.128	.3763	.6237	.3890	.3763
		Paraprofessional	.1799	.8281	.217	.8296	.0410	.0017	.8296

CORRELATION (r) Professional = -.624
CORRELATION (r) Paraprofessional = .041

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Table 23d.

Multiple Regression Analysis of the Relationship Between Employee Service Model Orientation, Professional Status, and Employee Tenure

(Professional n = 14)
(Paraprofessional n = 26)
(Level of Care = I)

(dependent variable = Service Model Orientation)

Step	Variable	Control Variable	b wt	SE	t	sig t	R	R2	SigF
1.	TENURE								
		Professional	.1582	1.1830	.134	.8958	.0386	.0015	.8958
		Paraprofessional	1.0740	1.0313	1.041	.3081	.2079	.0432	.3081

CORRELATION (r) Professional = .039
CORRELATION (r) Paraprofessional = .208

b wt = beta weights
SE = Standard Error
t = t statistic
sigt - relevance of t
R = correlation coefficients
R2 = Shared Variance
SigF = significance level

Chi square analyses were utilized to test the significance of the association between employee attitude towards normalization (norm-scale) and professional status, controlling for tenure. For these analyses, attitude toward normalization (norm-scale) was identified as a nominal-level dependent variable; professional status (paraprofessional and professional) and tenure (less than 10 years and 10 years or more) as nominal-level independent variables.

Table 24 presents the results for the total response sample and Tables 24a through 24d display the results disaggregated by level of care. Alpha was set at .05. No significant relationship was found to exist between the variables.

Table 24.

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status, Controlling for Length of Tenure

1. LENGTH OF TENURE = Less than 10 Years

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	150	50	200
LOW NORMALIZATION	18	5	23
TOTALS	168	55	223

DF: 1
Total Chi Square: .0078
p: .9297

2. LENGTH OF TENURE = 10 Years or More

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	29	15	44
LOW NORMALIZATION	4	1	5
TOTALS	33	16	49

DF: 1
Total Chi Square: .0178
p: .8938

Table 24a.

(Level of Care = Medically Fragile)

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status, Controlling for Length of Tenure

1. LENGTH OF TENURE = Less than 10 Years

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	11	9	20
LOW NORMALIZATION	7	3	10
TOTALS	18	12	30

DF: 1
Total Chi Square: .0000
p: 1.0000

2. LENGTH OF TENURE = 10 Years or More

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	3	2	5
LOW NORMALIZATION	1	0	1
TOTALS	4	2	6

DF: NA
Total Chi Square: NA
p: NA

Table 24b.

(Level of Care = VI)

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status, Controlling for Length of Tenure

1. LENGTH OF TENURE = Less than 10 Years

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	79	17	96
LOW NORMALIZATION	7	1	8
TOTALS	86	18	104

DF: 1
Total Chi Square: .0000
p: .1400

2. LENGTH OF TENURE = 10 Years or More

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	11	6	17
LOW NORMALIZATION	1	1	2
TOTALS	12	7	19

DF: NA
Total Chi Square: NA
p: NA

Table 24c.

(Level of Care = V)

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status, Controlling for Length of Tenure

1. LENGTH OF TENURE = Less than 10 Years

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	30	5	35
LOW NORMALIZATION	3	1	4
TOTALS	33	6	39

DF: 1
Total Chi Square: .0000
p: 1.0000

2. LENGTH OF TENURE = 10 Years or More

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	11	0	11
LOW NORMALIZATION	2	0	2
TOTALS	13	0	13

DF: NA
Total Chi Square: NA
p: NA

Table 24d.

(Level of Care = I)

Chi Square Test of the Relationship between Careprovider Attitude Toward Normalization (Norm-Scale) and Professional Status, Controlling for Length of Tenure

1. LENGTH OF TENURE = Less than 10 Years

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	26	14	40
LOW NORMALIZATION	1	0	1
TOTALS	27	14	41

DF: 1
Total Chi Square: .0000
p: 1.0000

2. LENGTH OF TENURE = 10 Years or More

Observed Frequency Table

	PARAPROFESSIONAL	PROFESSIONAL	TOTALS
HIGH NORMALIZATION	4	5	9
LOW NORMALIZATION	0	0	0
TOTALS	4	5	9

DF: NA
Total Chi Square: NA
p: NA

Summary

Chapter IV described the sample and presented the findings related to the six hypotheses being studied. Data were discussed in regards to, perception of training needs (CPTN); service model orientation (CPSMO); attitude toward normalization (CPSMO-46); attitude toward medical model (CPSMO-47); attitude toward developmental model (CPSMO-48); reported service model orientation (DI-16); and, the careprovider's attitude toward normalization (norm-scale).

Four hypotheses were not supported (1, 3, 4, and, 6). No significant differences/relationships were found at the .05 level. Consequently, for these items, the null hypotheses were accepted. Significant differences/ relationships were found in some of the analyses that were completed for two hypotheses (2 and 5). For these cases the null hypotheses were not accepted.

Chapter V presents the summary and discussion of the findings, conclusions, and recommendations for further research.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

According to John Sumarah "conversion or transformation from deeply entrenched negative beliefs, values, and attitudes (medical model) to more positive ones (normalization/developmental model) does not take place without time, effort, and struggle" (85, p.22). The present study was designed to explore the dimensions of the careprovider's perceptions concerning the normalization/ developmental model's replacement of the medical model as the basis for providing education and training to the institutionalized adult with developmental disabilities. The variables investigated were, perception of training needs (CPTN); service model orientation (CPSMO); attitude toward medical model (CPSMO-47); attitude toward developmental model (CPSMO-48); reported service model orientation (DI-16); and, the careprovider's attitude toward normalization (CPSMO-46, and norm-scale).

Summary

Careprovider's attitudes are an important influence on the daily lives of institutionalized adults with developmental disabilities, affecting the training they receive, the scope and type of services provided, as well as

what challenging opportunities are provided them (20, 28, 29, 37, 45, 58, 88). Previous research has also indicated that the careprovider plays a crucial role in providing a more normalized and habilitative environment for the IADD (20, 82, 88). Consequently, they directly impact the degree and intensity of normalization/developmental opportunities that are provided the IADD. Attention in this study has been given to the attitudes and perceptions of careproviders concerning training needs of the IADD and service model orientation. The literature reviewed in chapter III provided an underlying assumption that if individuals with developmental disabilities are to be afforded life experiences necessary to fulfill their potential, both in daily life and in planning future endeavors, their careproviders must be receptive to the normalization/ developmental model. It is this reason why the attitudes and perceptions are considered important and why they were examined in this project.

Zigler, Hodapp, and Edison asserts that professionals in the field of mental retardation "have too often been concerned only with the physical settings of services" for individuals with mental and developmental disabilities (110, p.7). It is widely assumed that careproviders are in agreement with the normalization/developmental model and that they will, based on this agreement, provide the necessary support (including the opportunity) required by

the institutionalized adult with developmental disabilities to encounter more normalized life experiences.

The review of literature revealed that historically "societies as a whole, the courts, human service professionals," and their families have tended to view individuals with developmental disabilities "as being 'deficient' in just about every quality" (99, p.63). The medical model (as presented in chapter III) is not a viable model upon which to develop services because it does not meet the needs of the IADD, who under its guises are viewed as capable of doing very little for themselves. The aim of the normalization/developmental model is to equip the IADD with skills which will make them more functionally independent.

This study was undertaken to investigate the extent to which careproviders embrace the normalization/developmental model as bases for providing services to the IADD as compared to the medical model.

A three part questionnaire, which consisted of Careprovider's Service Model Orientation, Careprovider's Perception of Training Needs, and Demographic Information, was utilized to assess the attitudes and perceptions of 370 careproviders who are employed at Denton State School. In addition, the questionnaire was utilized to obtain information concerning the personal characteristics of the

careprovider. The questionnaire was administered during the months of July and August, 1992.

Results

The results of the statistical analyses which were completed for each of the six hypotheses are as follows:

Hypothesis 1
(Null): The employee perceptions regarding the educational and training needs of the institutionalized adult with developmental disabilities (IADD) will not differ significantly based on their length of employment at Denton State School.

Regression analyses (p= .05) are reported in Tables 13 through 13d. The results proved not significant for the total response sample. Tests results for the samples with controls for level of care were also not significant.

Hypothesis 2
(Null): The perceptions between paraprofessionals and professionals regarding the educational and training needs of the IADD will not differ significantly.

One-way analysis of variance tests (p= .05) are reported in Tables 14 through 14d. The results proved significant for the total response sample. Tests results for the samples with controls for level of care were not significant.

Hypothesis 3
(Null): The perceptions of employees at Denton State School regarding the educational and training needs of the IADD will not be significantly related to the age of the employees.

Regression analyses (p= .05) are reported in Tables 15 through 15d. The results proved not significant for the total response sample. Tests results disaggregated by level of care were also not significant.

Hypothesis 4
(Null): The perceptions between Denton State School employees with less than 10 years tenure and those with 10 or more years of tenure will not differ significantly in service model orientation.

One-way analysis of variance tests (p= .05) are reported in Tables 16 through 16d. The results proved not significant for the total response sample. Tests results disaggregated by level of care were also not significant.

Hypothesis 5
(Null): Professionals and paraprofessionals employed at Denton State School (DSS) will not significantly differ in their service model orientation.

One-way analysis of variance tests (p= .05) to investigate the variability between service model orientation and professional status are reported in Tables

17 through 17d. The results proved significant for the total response sample. Tests results disaggregated by level of care were significant only in the sample where the level of care was classified as I.

Chi square analyses (p= .05) to test the significance of the association between employee reported service model orientation and professional status are reported in Tables 18 through 18d. The results proved significant for the total response sample. Tests results disaggregated by level of care were significant only in the samples where the level of care was classified as I and VI.

Chi square analyses (p= .05) to test the significance of the association between employee attitude towards normalization and professional status are reported in Tables 19 through 19d. The results proved not significant for the total response sample. Tests results disaggregated by level of care were also not significant.

Chi square analyses (p= .05) to test the significance of the association between employee attitude towards the medical model and professional status are reported in Tables 20 through 20d. The results proved significant for the total response sample. Tests results disaggregated by level of care were significant only in the sample where the level of care was classified as VI.

Chi square analyses (p= .05) to test the significance of the association between employee attitude towards the

developmental model and professional status are reported in Tables 21 through 21d. The results proved significant for the total response sample. Tests results disaggregated by level of care were not significant.

Chi square analyses (p= .05) to test the significance of the association between employee attitude towards normalization (norm-scale) and professional status are reported in Tables 22 through 22d. The results proved not significant for the total response sample. Tests results disaggregated by level of care were also not significant.

Hypothesis 6
(Null): The service model orientation of DSS employees will not differ significantly between groups when controlling for professional status and length of employment at Denton State School.

Multiple regression analyses (p= .05) to test the relationship between service model orientation and tenure while controlling for professional status are reported in Tables 23 through 23d. The results proved not significant for the total response sample. Tests results disaggregated by level of care were also not significant.

Chi square analyses (p= .05) to test the significance of the association between employee attitude towards normalization (norm-scale) and professional status, while controlling for tenure are reported in Tables 24 through

24d. The results proved not significant for the total response sample. Tests results disaggregated by level of care were also not significant.

Conclusions

Hypothesis 1 (Null) stated that employee perceptions regarding the educational and training needs of the institutionalized adult with developmental disabilities (IADD) would not differ significantly based on their length of employment at Denton State School. The study confirmed this hypothesis. Analysis of hypothesis 1 revealed no significant difference among employee perceptions of training needs and length of employment at Denton State School for the total sample and for the disaggregated samples. The general conclusion regarding the use of tenure as an independent variable, was that acting alone it was not sufficient to produce significant differences in DSS employee's perception of education and training needs.

Hypothesis 2 (Null) states that the perceptions between paraprofessionals and professionals regarding the educational and training needs of the IADD will not differ significantly. Analysis of hypothesis 2 revealed a significant interaction between perceptions of training needs and professional status for the total response sample. Significant interactions were not found when the analysis was repeated for the samples after being disaggregated based on level of care. The general conclusion regarding the use

of professional status as an independent variable, was that acting alone it was sufficient to produce significant differences in employee perception of education and training needs for the total response sample but when the sample was disaggregated for level of care the interaction was minimized.

The interactions between the perceptions of employees at Denton State School regarding the educational and training needs of the IADD and the age of the employees were explored in Hypothesis 3. The investigation provided support for the null hypothesis. Analysis of hypothesis 3 revealed no significant difference among employee perceptions of training needs and the age of employees at Denton State School for the total sample and for the disaggregated samples. The general conclusion regarding the use of age as an independent variable, was that acting alone it was not sufficient to produce significant differences in the perception of education and training needs for these populations.

Hypothesis 4 (Null) states that the perceptions between Denton State School employees with less than 10 years tenure and those with 10 or more years of tenure will not differ significantly in service model orientation. The study confirmed this hypothesis. Analysis of hypothesis 4 revealed no significant difference among employee service model orientation and length of employment at Denton State

School (less than 10, or more than 10 years) for the total sample and for the disaggregated samples. The general conclusion regarding the use of tenure as an independent variable, was that acting alone it was not sufficient to produce significant differences in employee service model orientation for these populations.

Hypothesis 5 (Null) states that professionals and paraprofessionals employed at Denton State School (DSS) will not significantly differ in their service model orientation. The results of the one-way analysis of variance tests to investigate the variability between service model orientation and professional status indicated that significant interactions were present in the total response sample and the sample disaggregated by level of care with a classification of I. The general conclusion is that a discernable pattern exists between employee service model orientation and professional status for the total response sample and the sample with level of care I, but when disaggregated for the other levels of care that pattern is diminished.

Chi square analyses to test the significance of the association between employee reported service model orientation and professional status were conducted. The results proved significant for the total response sample. Tests results disaggregated by level of care were significant only in the samples where the level of care was

classified as I and VI. The general conclusion is that a discernable pattern exists between reported employee service model orientation and professional status for the total response sample and the samples with levels of care I and VI, but when disaggregated for the other levels of care that pattern is minimized.

Chi square analyses to test for significance in the association between employee attitude towards normalization and professional status were conducted. The study confirmed the null hypothesis. Analysis of hypothesis 5 (examining Careprovider's Service Model Orientation Questionnaire item #46) revealed no significant difference among employee attitude toward normalization and professional status for the total sample and for the disaggregated samples. The general conclusion regarding the use of professional status as an independent variable, was that acting alone it was not sufficient to produce significant differences in employee attitude toward normalization, as measured by the CSMO item #46, for these populations.

Chi square analyses were used to examine the association between employee attitude towards the medical model and professional status. The results of the analyses of the two variables indicated that significant relationships were present in the total response sample and the sample disaggregated by level of care with a classification of VI. The general conclusion is that a

discernable relationship exists between employee attitude toward the medical model and professional status for the total response sample and the sample with level of care VI, but when disaggregated for the other levels of care the intensity of that relationship is diminished.

Chi square analyses were used to explore the association between employee attitude towards the developmental model and professional status. The results proved significant for the total response sample. Tests results disaggregated by level of care were not significant. The general conclusion is that a discernable pattern exists between employee attitude toward the developmental model and professional status for the total response sample, but when disaggregated for levels of care the intensity of that relationship is diminished.

Chi square analyses were completed to test the significance of the association between employee attitude towards normalization (norm-scale) and professional status. The study confirmed the null hypothesis. Analysis of hypothesis 5 (utilizing the norm-scale) revealed no significant difference among employee attitude toward normalization and professional status for the total sample and for the disaggregated samples. The general conclusion regarding the use of professional status as an independent variable, was that acting alone it was not sufficient to produce significant differences in employee's attitude

toward normalization, as measured by the norm-scale, for these populations.

Hypothesis 6 (Null) states that the service model orientation of DSS employees will not differ significantly between groups when controlling for professional status and length of employment at Denton State School. Multiple regression analyses were utilized to test the relationship between service model orientation and professional status while controlling for tenure. The results of the regression analyses completed to investigate the relationship between service model orientation and tenure while controlling for professional status indicated that no significant relationships were present in the total response sample and in the samples disaggregated by level of care. The general conclusion, derived when comparing these results with those obtained during the previous analysis presented for hypothesis 5, is that a discernable pattern exists between employee service model orientation and professional status for the total response sample and the sample with level of care I, but when introducing the predictor variable, tenure, that pattern is diminished.

Chi square analyses were conducted to test the significance of the association between employee attitude towards normalization (norm-scale) and professional status, while controlling for tenure. The study confirmed the null hypothesis. Analysis of hypothesis 6 revealed no

significant difference among employee attitude toward normalization (norm-scale) and professional status while controlling for tenure at Denton State School for the total sample. Analyses could not be completed due to the low cell distributions for the disaggregated samples. The general conclusion regarding the use of tenure as a control variable and professional status as an independent variable, was that acting together they were not sufficient to uncover a significant relationship with employee attitudes toward normalization as measured by the norm-scale.

In conclusion, Booth's study, of attitudes of careprovider's concerning normalization within a group home setting, yielded similar finding (12). The careprovider's attitudes appeared to be highly normalized. For the present study, the distribution of scores from the Careprovider's Service Model Orientation section of the questionnaire reflect an overall acceptance of the normalization/ developmental model (see figure 2). In addition, the distribution of scores obtained from the Careprovider's Perception of Training Needs section of the questionnaire reflect an overall acceptance of the normalization/ developmental model (see figure 3). Table 22 displays a normalization/developmental orientation also. Eighty-nine percent (286) of the respondents included in the analysis were found to have normalization/developmental orientations. These results are very encouraging. Although the

careproviders' attitudes generally (on the Careprovider's Service Model Orientation instrument) reflects support of the normalization/developmental model, there was some variability in the responses obtained (11% or 36 reported low normalization/developmental orientations or a more medical model orientation). Based on the results some respondents could be characterized as high scorers and some as low scorers. Characteristics were identified for both high and low scorers: whether they had prior experience working with individuals with developmental disabilities prior to their employment at DSS, if other family members had a developmental disability, and the classification of the level of care provided. Differences were also noted if they held supervisory/management positions.

Despite the favorable findings concerning careproviders' attitudes toward the normalization/ developmental model a number of questions remain unanswered. Results presented in Table 13 indicated that for the total response sample, a low negative correlation exists between tenure and perception of training needs. This indicates that as tenure increased, the employee's orientation towards providing more normalized training decreased. Additionally, results presented in Table 15 indicated that for the total response sample that a low negative correlation was present between age and perception of training needs. This indicates that as age increased, the individual's

orientation towards providing more normalized training decreased. This would tend to support the view that younger and newer employees are more receptive to providing normalized training to the IADD, or does it reflect the fact that younger employees have been exposed to only the normalization/developmental model and not to the medical model as presented in this study? Additional analyses are require before any conclusion can be reached since the total amount of variance accounted for by the two variables in perceptions of needs was less than one percent (.003).

Another question exists concerning the lack of support of hypotheses 1, 3, and 4, (which explored the relationship between perceptions, age and the length of tenure of the careproviders). For the total response sample almost 66% of the respondents were less than 41 years of age, and 70% had been employed at DSS for 10 years or less. The lack of variability in responses may have been the result of the small sample size representing careproviders over the age of 41, and those who have worked at DSS for more than 10 years.

It is also possible that the instrument used to measure careproviders' attitudes may have affected the results. The instrument may not have been sensitive to the careprovider's attitudes. Additional methods, such as observations, or interviews may be needed to further explore the practices/ actions of careproviders and compare them with their attitude scores (attitude-behavior link).

There are no studies in the literature that have focused on careprovider's attitudes toward normalization/ developmental activities in general, service model orientations as bases for providing care and training, nor, perceptions of training need for the adults with developmental disabilities that they work with in an institutional setting. As a result of the absence of prior studies, there are no findings to support or contradict the present results which evidence the need for further investigation.

Recommendations

On the basis of the findings of this study, the following recommendations are made:

1 Some professionals and paraprofessionals who work with the IADD who live in homes which are classified as level I were found to have perceptions and attitudes which support the medical model orientation. Additional training, covering the normalization/developmental model orientation, is suggested for these individuals since they are providing services to IADDs who may be considered for community placement.

2 There should be future investigations conducted which focus on education and the amount of inservice/training professionals and paraprofessionals receive.

3. Further assessments should be conducted to obtain additional information concerning careprovider's orientation and perceptions of training needs. These efforts should utilize different approaches for collecting information, such as the use of interviews and observation of careproviders.
4. Factor analysis or some other technique should be utilized to shorten the instrument. This would allow it to be administered more readily to staff.
5. There should be future investigations conducted in residential facilities located in more and less urbanized locations to explore the effects of urbanization on employee service model orientation and perception of the training needs of adults with developmental disabilities.
6. Research should be conducted which focuses on the differences of opinion regarding the training needs of adults with developmental disabilities and service model orientation, when comparing the perceptions of careproviders with those of administrative staff employed at the same residential facility.
7. There should be future studies which utilize a larger sample of careproviders employed in a residential facility.

8. The present study was conducted three days after the facility had undergone a campus-wide recertification survey carried out by Intermediate Care Facility-Mental Retardation professionals. Additionally, an administrative effort was undertaken to obtain suggestions from every employee concerning work-place improvements and enhancements. Together these efforts may have affected the amount of responses received. A study should conducted during a period when less stress/demands are placed on the employees.
9. A survey of community residential facilities should be conducted and the results should be compared with those obtained from the state school campus to examine the affects that community integration and deinstitutionalization may have on careprovider's perception of training needs for the adult with developmental disabilities and also their service model orientation.
10. In regard to planning staff inservices and orientation training for careproviders rendering service to the IADD, information should be provided covering the history of mental retardation which should include a presentation of the medical model, developmental model and normalization principles.

11. Analyses should be conducted which utilize factors not examined during this present study such as, their family history of developmental disability, prior experience working with individuals with developmental disabilities, tenure in current position, marital status, education, gender, ethnicity, work shift, and previous careprovider experience.

Chapter Summary

Three-hundred and seventy professional and paraprofessional employees employed at Denton State School participated in this study of careprovider's perception of training needs of the institutionalized adult with developmental disabilities, and their service model orientation.

The conceptual framework upon which this study was based proposed that staff perceptions and orientation concerning service delivery to institutionalized adults with developmental disabilities can be conceptually related to five factors in a research model. These factors were identified as: personal characteristics of the careprovider; characteristics of the working environment; previous careprovider experience of staff; developmental disability history within the careprovider's family; and self-reporting of a service delivery orientation. This present study examined only a portion of this model.

Data were analyzed through the use of regression analyses, chi square tests of association, and one-way analysis of variance tests. The results of this study appear to indicate that a relationship exists between: professional status and perceptions of education and training needs of the IADD; professional status and service model orientation; professional status and reported service model orientation; professional status and attitude toward the medical model; and, professional status and attitude toward the developmental model.

Evidence from this study supports the need for further research to fully explore all of the factors present in the model. Additional geographic locations should be explored to determine if the results are consistent. This sample represents only a small number of employees from one state school, and findings cannot be generalized beyond the population being studied.

Future research is necessary not only to identify variables affecting current and common attitudes towards the normalization/developmental model, but to examine and evaluate these attitudes. If there are misconceptions and negative perceptions (medical model as presented in this study) prevalent, staff education and awareness training are indicated to provide the necessary information to promote more positive attitudes towards the normalization/ developmental model. The opportunity for institutionalized

adults with developmental disability's to achieve their potential can not be accomplished without the support of careproviders who believe in, promote, and utilize the normalization/developmental model as basis for their service delivery.

APPENDIX A

TARGET POPULATION OF STUDY

TARGET POPULATION

RESIDENTIAL SERVICES

CEDAR FALLS RESIDENCE (203)	**TIMBERHILL RESIDENCE** (89)	**WESTRIDGE RESIDENCE** (157)	**EASTFIELD RESIDENCE** (171)
UNIT DIRECTOR (1)	UNIT DIRECTOR (1)	UNIT DIRECTOR (1)	UNIT DIRECTOR (1)
ASSIST. UNIT DIRECTOR (2)	ASSIST. UNIT DIRECTOR (1)	ASSIST. UNIT DIRECTOR (1)	ASSIST. UNIT DIRECTOR (1)
QMRP's (17)	QMRP's (6)	QMRP's (10)	QMRP's (9)
RESIDENCE SUPERVISORS (16)	RESIDENCE SUPERVISORS (17)	RESIDENCE SUPERVISORS (19)	RESIDENCE SUPERVISORS (16)
ASSIST. RESIDENCE SUP. (22)	ASSIST. RESIDENCE SUP. (14)	ASSIST. RESIDENCE SUP. (16)	ASSIST. RESIDENCE SUP. (20)
RESIDENCE TRAINERS (145)	RESIDENCE TRAINERS (50)	RESIDENCE TRAINERS (110)	RESIDENCE TRAINERS (124)

ADJUNCTIVE STAFF

NURSING STAFF (RN/LVN) (130)
MEDICAL DOCTORS (9)
PSYCHOLOGISTS AND BEHAVIOR THERAPISTS (30)
HABILITATION THERAPIST (CT/OT/PT) (15)
VOCATIONAL STAFF (48)
SOCIAL WORKERS (15)
RECREATION STAFF (15)
CHAPEL AND FOSTER-GRANDPARENT STAFF (7)

TOTAL NUMBER OF PROFESSIONAL AND PARAPROFESSIONALS= 889
NUMBER OF RESPONDENTS IN PILOT GROUP= 10
PROJECTED TOTAL NUMBER OF RESPONDENTS= 879

APPENDIX B

DENTON STATE SCHOOL

DENTON STATE SCHOOL
AGENCY MISSION, VALUES AND GOALS

History

In the late 1950's, the Denton Chamber of Commerce learned that a facility for persons with mental retardation was going to be built in the Dallas-Fort Worth-North Texas area. Community leaders met with officials in Austin and asked that the facility be placed in Denton. To demonstrate the community's willingness to have the facility located in Denton, Chamber members appealed to the citizens of Denton and Denton County to donate money for the purchase of 200 acres of land on which the facility was to be placed. This land was located four (4) miles south of Denton, and thirty (30) miles north of Dallas. The State of Texas received the land with the stipulation that a facility serving persons with mental retardation be placed there.

Established in 1960 by the 55th session of the Texas Legislature, Denton State School officially opened its doors in July, 1960. Within a year, the facility had over 1,700 residents. Denton State School is currently home to 664 individuals living in 39 residential settings and 124 individuals living in 17 community-based residences in the City of Denton. The facility operates under the jurisdiction of the Texas Department of Mental Health and Mental Retardation, and employs approximately 1800 staff members with an average annual budget in excess of $34 million.

Purpose

Denton State School provides both campus-based and community-based services to persons of all ages with developmental disabilities to include information and referral; comprehensive diagnosis and evaluation; early childhood intervention; coordinated public education opportunities through the Denton Independent School District;

barrier-free residential services including campus-based residences, community-based residences and foster home placement; medical and dental services; therapy services to include Occupational Therapy, Physical Therapy, Communication Therapy, and Orthotics; a full array of work skills training beginning with pre-work skills development through supported employment; training in self-care and social skills; and case management/supported living services for individuals not residing in residential programs operated by or through the facility. The facility seeks to provide opportunities for use of generic, community-based services in all areas possible to allow for maximum exposure to and integration into the community for individuals served.

Denton State School serves a twenty-two (22) county catchment area in north central and northeast Texas. Counties included in the admission area are Wichita, Clay, Jack, Montague, Wise, Cook, Denton, Grayson, Collin, Rockwall, Kaufman, Fannin, Hunt, Lamar, Delta, Hopkins, Red River, Franklin, Titus, Morris, Bowie and Cass. The facility serves as the Mental Retardation Authority for a twelve (12) county area within the larger catchment area. Counties which are served by Denton State School as Mental Retardation Authority include Clay, Jack, Montague, Wise, Rockwall, Kaufman, Lamar, Delta, Hopkins, Franklin, Titus and Morris.

Denton State School seeks to identify and serve all individuals with developmental disabilities in its service area who are in need of residential services and habilitation. Priority for admission is given to those individuals with the most severe disabling conditions and/or needs.

Denton State School seeks to provide services in coordination with other service providers in the local area and

	other areas of the state. Interface with local and area Mental Health and Mental Retardation Centers, community-based treatment providers and other agencies providing services to individuals with developmental disabilities is continuous.
Mission	Denton State School seeks to provide a comprehensive array of quality services to meet the individual needs of persons with developmental disabilities. The agency seeks to provide these services in the most normalized manner possible affording individuals opportunities for exposure to and integration into settings and activities which allow for maximizing opportunities for personal growth and development. Structure of the services provided is determined by the individual needs identified through the use of an interdisciplinary team approach to program development. The agency seeks to preserve and protect the rights of individuals served and to assure that each individual is afforded due process of the law in the event that any right is restricted. The agency is committed to providing quality services and encourages research and study of current trends and programs to allow for improvement in service content and delivery over time.
Values: Affirming and Protecting Rights	Denton State School seeks to ensure that persons with developmental disabilities served by the facility are afforded all rights and privileges of a United States citizen set out in the United States Constitution, the Mentally Retarded Persons Act of 1977 and other related laws and that no right or privilege is abridged without due process of law. The facility also is committed to providing necessary assistance to individuals to assure that rights are understood, protected and exercised.
Values: Normalization	Denton State School seeks to utilize commonly accepted patterns and conditions of everyday life in provision

	of residential and habilitation services. These services are focused toward establishment and/or maintenance of individual behaviors, experiences and characteristics which are as culturally normative as possible. The agency seeks to structure services following the normal rhythm of the day, week and year. Services provided are focused on appropriateness to the chronological age of the individual served and significant emphasis is placed on elimination of stigmatizing language/activities in working with individuals served. Individual choice is emphasized and significant efforts are focused toward providing opportunities for individuals to exercise choice in daily activities to their level of understanding and ability. Opportunities are afforded individuals to be exposed to risk, a process which must include teaching individuals various skills to increase independent, self-directed functioning. Individuals are challenged to learn and exercise a particular skill, while acknowledging the option of failure in the execution of the task or skill. Individuals are encouraged to make choices through an ongoing process that encourages informed decision-making.
Values: Least Restriction	Denton State School seeks to provide all services in a manner which provides the least intrusion into the individual's lifestyle and activities. Residential and habilitation services are focused on providing the individual the greatest opportunity for success, self-direction and exposure to normalized and normalizing life experiences. Services are based on individual needs, interests and abilities. If limitations are necessary in the individual's life, the facility provides for due process for the proposed limitations. Structure of service delivery focuses on the principle that less restrictive alternatives are utilized prior to consideration of increasingly intrusive options being used.

Values: Inter-disciplinary Approach	Denton State School seeks to structure its services utilizing the interdisciplinary approach which ensures that assessment, planning and program implementation by professionals, clinical specialists, day and residential direct contact staff and other support personnel are integrated and coordinated. The result of this process is a common uniform program which is necessary so that staff behaviors are predictable to the individual with developmental disabilities. Active participation in the interdisciplinary team process by the individual is essential and participation of parents, family, guardian or advocate is strongly encouraged. Other team members are determined based on the strengths, needs and interests of the individual.
Values: Family Relationships	Denton State School identifies the centrality of family members in the lives of individuals and seeks to encourage active family participation in all elements of service planning with the individual. Family members are encouraged to advocate for needed services at all levels of the organization. Family members serve on standing committees (Human Rights and Quality Assurance Evaluation) and are actively involved in planning and development of services at the facility. Individuals served are assisted with maintaining family contact through social work services which include visits in the residences and program sites, telephone contact, correspondence, etc.
Facility Goals	The goals of Denton State School are focused on the following areas: effectiveness of services and benefit of services to the individuals served; staff resources and performance; efficient use of space, facilities and equipment; and relationships with other agencies in the service delivery system. Specific goals are as follows:

1. To provide a variety of campus and community residential programs that offer an array of services to an individual based on his/her strengths, needs, and preferences.

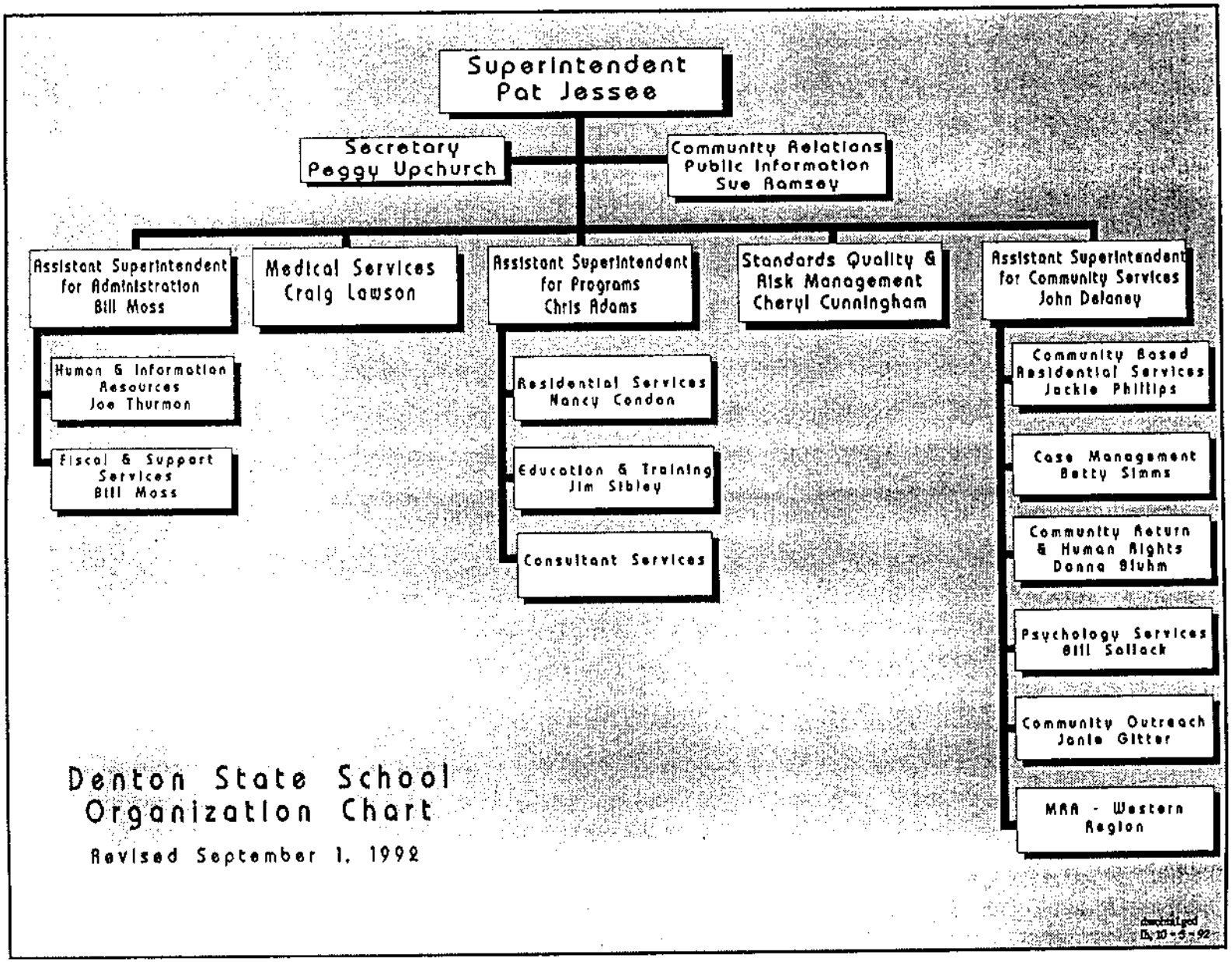
2. To provide age-appropriate training to increase living, work and leisure/relationship skills and to eliminate behavioral excesses to enhance an individual's functioning and maintenance in his/her least restrictive environment.

3. To provide and/or coordinate medical intervention, health care and habilitative services as individual need indicates and/or determined by the interdisciplinary team to enhance individuals' well being and participation in work and training programs.

4. To provide the highest quality of services that are reflective of the needs of those served and sound management in the effective and efficient use of resources.

See Attached ORGANIZATIONAL CHART

Denton State School Organizational Management Manual
Introduction - 02, October 1992, pp. 1-4.



Denton State School
Organization Chart

Revised September 1, 1992

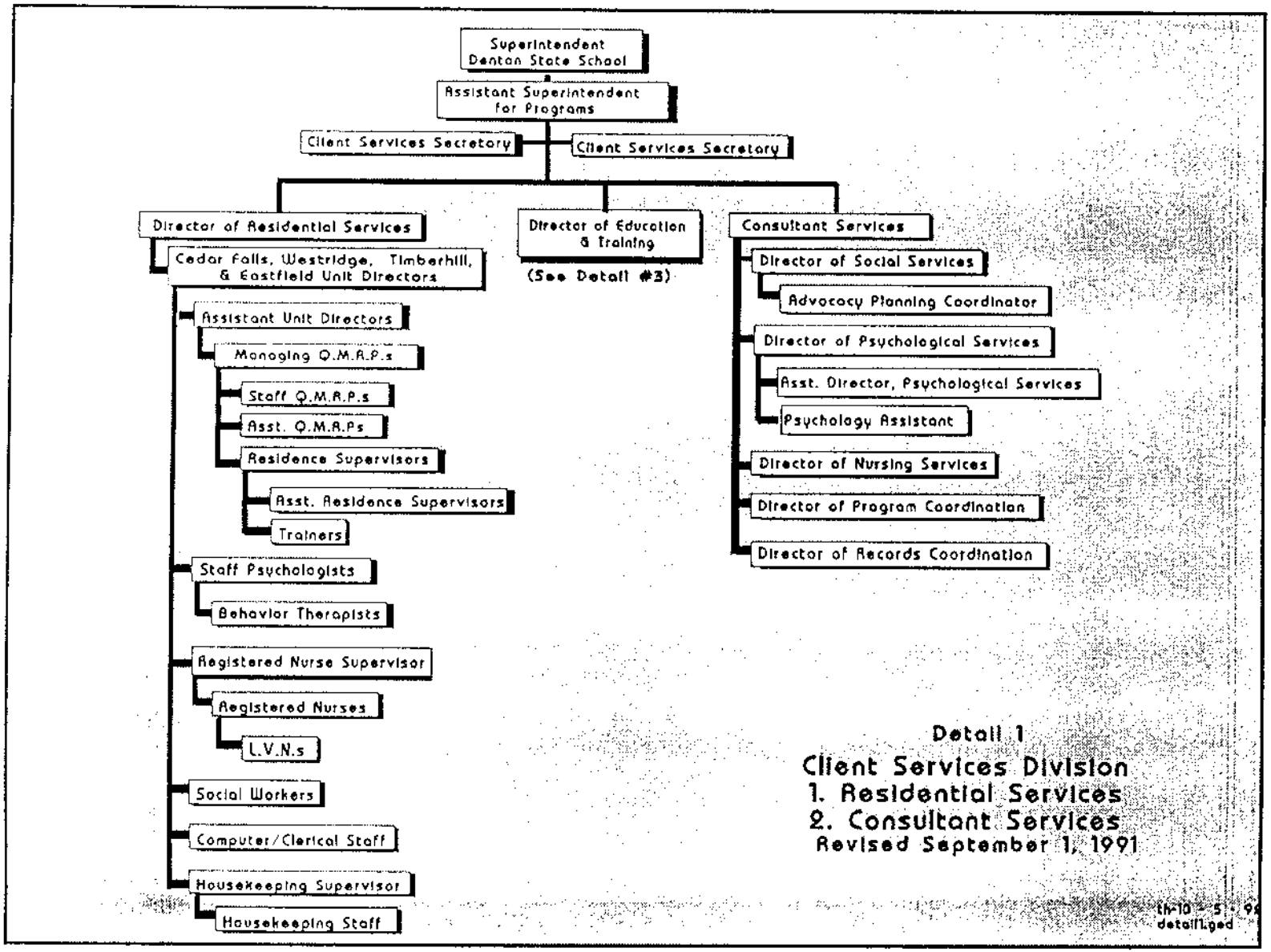
DENTON STATE SCHOOL
CLIENT SERVICES DIVISION

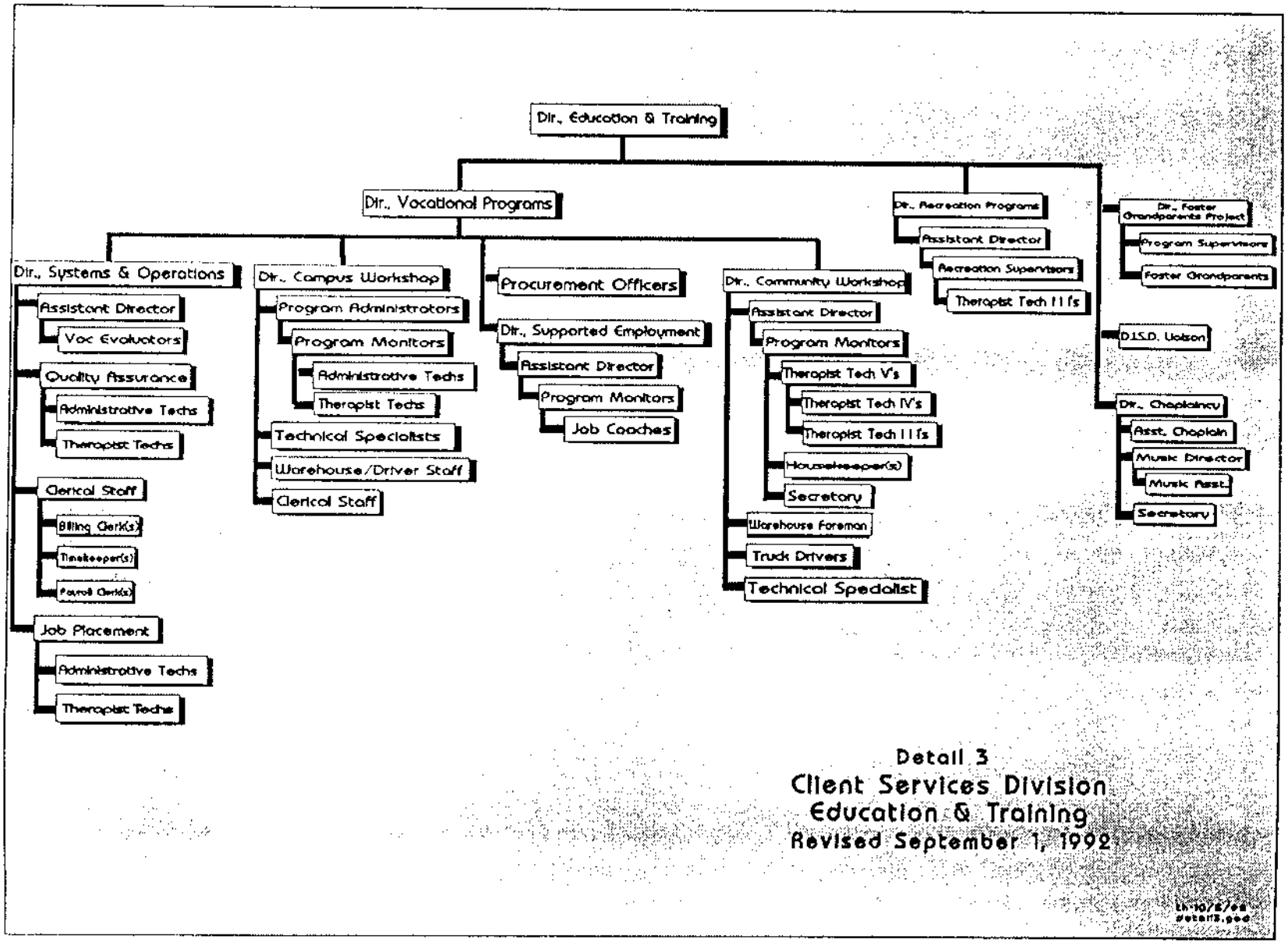
Purpose	Major responsibilities of the Client Services Division include the provision of efficient and effective care, treatment and training to all residents of Denton State School's campus-based operations.
Description of Services	The Client Services Division provides care, treatment and training services under the direction of two operational subdivisions: Residential Services and Education and Training. Professional services are coordinated through a body of professional consultants in the fields of psychology, nursing, social work and program coordination.
Residential Services	The Residential Services subdivision of the facility incorporates activities of four (4) separate living areas to include the Cedar Falls Area, Westridge Area, Timberhill Area and Eastfield Area. Each is responsible for coordination of residential and professional treatment services for assigned residents. Services are provided under the administrative direction of the Director of Residential Services.
Education and Training Services	The Education and Training subdivision of the facility incorporates training departments to include Vocational Training, Communication Therapy, Religious Services, Recreation Programs, and liaison with the Denton Independent School District in provision of educational services to school-aged residents. Services are provided under the administrative direction of the Director of Education and Training.
Professional Supervision and Consultation	Professional supervision and consultation services are provided to staff working in the areas of psychology, nursing, social work and

program coordination through the professional consultants assigned to each of these areas. Services are provided under the administrative direction of the Assistant Superintendent for Programs.

See Attached ORGANIZATIONAL CHARTS

Denton State School Organizational Management Manual
Organizational Functions - 02a, October 1992, p. 1-2


Superintendent
Denton State School
Assistant Superintendent
for Programs
Client Services Secretary
Client Services Secretary
Director of Residential Services
Cedar Falls, Westridge, Timberhill,
& Eastfield Unit Directors
Assistant Unit Directors
Managing Q.M.R.P.s
Staff Q.M.R.P.s
Asst. Q.M.R.Ps
Residence Supervisors
Asst. Residence Supervisors
Trainers
Staff Psychologists
Behavior Therapists
Registered Nurse Supervisor
Registered Nurses
L.V.N.s
Social Workers
Computer/Clerical Staff
Housekeeping Supervisor
Housekeeping Staff
Director of Education
& Training
(See Detail #3)
Consultant Services
Director of Social Services
Advocacy Planning Coordinator
Director of Psychological Services
Asst. Director, Psychological Services
Psychology Assistant
Director of Nursing Services
Director of Program Coordination
Director of Records Coordination
Detail 1
Client Services Division
1. Residential Services
2. Consultant Services
Revised September 1, 1991


Dir., Education & Training
Dir., Vocational Programs
Dir., Systems & Operations
Assistant Director
Voc Evaluators
Quality Assurance
Administrative Techs
Therapist Techs
Clerical Staff
Billing Clerk(s)
Timekeeper(s)
Payroll Clerk(s)
Job Placement
Administrative Techs
Therapist Techs
Dir., Campus Workshop
Program Administrators
Program Monitors
Administrative Techs
Therapist Techs
Technical Specialists
Warehouse/Driver Staff
Clerical Staff
Procurement Officers
Dir., Supported Employment
Assistant Director
Program Monitors
Job Coaches
Dir., Community Workshop
Assistant Director
Program Monitors
Therapist Tech V's
Therapist Tech IV's
Therapist Tech III's
Housekeeper(s)
Secretary
Warehouse Foreman
Truck Drivers
Technical Specialist
Dir., Recreation Programs
Assistant Director
Recreation Supervisors
Therapist Tech III's
Dir., Foster Grandparents Project
Program Supervisors
Foster Grandparents
D.I.S.D. Liaison
Dir., Chaplaincy
Asst. Chaplain
Music Director
Music Asst.
Secretary
Detail 3
Client Services Division
Education & Training
Revised September 1, 1992

DENTON STATE SCHOOL
RESIDENTIAL SERVICES DEPARTMENT

Purpose	Major responsibilities of the Residential Services Sub-Division includes provision of residential services and training in an environment which: 1. is safe, healthful and sanitary; 2. closely approximates life in a normal home; and, 3. provides each resident the freedom and opportunity to have normalizing life experiences.
Description of Services	Services are provided in compliance with the Accreditation Council on Services for People with Developmental Disabilities, Intermediate Care Facilities/Mental Retardation Standards and TxMHMR Rules and Directives. The department is organized geographically with four separate residential units (Cedar Falls, Westridge, Timberhill and Eastfield).
Residential Environment	Each unit is charged with the task of continually improving the living environments. These efforts are designed to provide an attractive, homelike and normal environment for those who live here. Residents are generally provided access to all areas of the homes and provided as much choice as possible in the selection of decor, clothing and possessions.
Social Environment	Families, guardians, advocates and friends are encouraged to visit and participate in the lives of residents. Social Workers are assigned to respond to the needs of significant others through timely phone calls, visits and counseling as well as to encourage participation and visits. Friendships are encouraged among people who live here and elsewhere. Dating, visiting and other normal activities

	among friends are frequent occurrences. Social activities (including off-campus and community activities) are planned by the residents or by staff who work directly with the residents. Residents are encouraged to exercise their rights unless these have been restricted by the interdisciplinary team. Such rights restrictions must be approved by the Human Rights Committee. Ongoing training is provided in ways to enhance the exercise of rights.
Training Environment	Each person is assigned a Primary Trainer. The Primary Trainer is assigned the responsibility to assist the resident toward the pursuit of his/her goals by teaching formal objectives and providing ongoing informal training. The Primary Trainer assists with training efforts provided through the Education and Training Department. Comprehensive psychological services are provided directly through personal contact and indirectly through assessment and evaluation by staff psychologists. Services include participation in detailed habilitation programs, evaluation, consultation, therapy and staff training. The Qualified Mental Retardation Professional (QMRP) coordinates the planning of each resident's goals and objectives. The QMRP is then responsible to monitor this training and facilitate any remediation activities and service provision which might be needed. The QMRP is the key person for service planning and implementation.
Health and Safety	Residents participate in their own health care through training in personal hygiene, family life, sex education and self-administration of medication. Nurses provide direct assessment of acute and chronic problems, assistance with administration of treatments and medications and communication with residents, trainers and physicians

	regarding health status. Provision of inservice training to the primary trainers and other staff is ongoing. Systems are in place to record and monitor injuries, abuse and neglect. These systems include an active reporting and initial investigating process, daily review of injuries to recommend actions for prevention, staff training and a computerized referral mechanism to the QMRP. All efforts in this area are focused on provision of a safe and secure living/training setting.
Records Maintenance	Active records are kept for each resident assigned to the living unit. The primary purpose of these records is to provide a comprehensive presentation of resident needs, program/service efforts prescribed to address these needs and the resident's response to the provision of these program/service efforts.

Denton State School Organizational Management Manual
Organizational Functions - 02b, October 1992, pp. 1-2.

APPENDIX C

QUESTIONNAIRE

COMPLETION OF THIS QUESTIONNAIRE WILL BE CONSIDERED TO BE YOUR CONSENT TO PARTICIPATE IN THIS STUDY

CAREPROVIDER'S SERVICE MODEL ORIENTATION

Instructions

This instrument contains questions which address various attitudes and beliefs concerning the education and training services provided to individuals with developmental disabilities (MR).
Circle the number for each statement which most closely reflects your attitude: (This is not a test so there are no right or wrong answers)

SCALE

1= Strongly Agree 2= Agree 3= Undecided 4= Disagree 5= Strongly Disagree

		STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
1.	The people with developmental disabilities that I work with should socialize with non-developmentally disabled adults.	1	2	3	4	5
2.	The people with developmental disabilities I work with should participate in neighborhood recreation programs.	1	2	3	4	5
3.	The people with developmental disabilities I work with are basically no different from non-developmentally disabled adults.	1	2	3	4	5
4.	The people with developmental disabilities I work with can learn to behave the same way as non-disabled adults their age.	1	2	3	4	5
5.	Medical treatment is more important than behavior therapy or independent skills training for the people with developmental disabilities.	1	2	3	4	5
6.	The people with developmental disabilities I work with should be taught how to get to and from their day programs on their own.	1	2	3	4	5
7.	The people with developmental disabilities I work with should be taught how to ride the public transportation.	1	2	3	4	5
8.	Many of the people with developmental disabilities I work with should move from a more protected residential setting to a home in the community as they achieve greater self-help skills.	1	2	3	4	5
9.	The people with developmental disabilities I work with cannot attain good independent/ self-help skills without good trainers teaching them.	1	2	3	4	5
10.	The people with developmental disabilities I work with should be treated as if they are suffering from an illness like tuberculosis, leprosy, or epilepsy.	1	2	3	4	5

SCALE 1 = Strongly Agree 2 = Agree 3 = Undecided 4 = Disagree 5 = Strongly Disagree

		STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
11.	After they are 21, the people with developmental disabilities I work with should have the same rights as non-developmentally disabled adults (equal opportunities, access, protection, etc.).	1	2	3	4	5
12.	The people with developmental disabilities I work with are capable of learning how to manage the money they earn.	1	2	3	4	5
13.	The true needs of the people with developmental disabilities I work with will never be met as long as the medical doctors are absent from their interdisciplinary teams.	1	2	3	4	5
14.	In most cases, the people with developmental disabilities that I work with should continue to live at Denton State School for their entire lives.	1	2	3	4	5
15.	The people with developmental disabilities I work with may reach their potential but will never learn to behave like non-disabled persons.	1	2	3	4	5
16.	Moderate, severe and profoundly retarded individuals have sustained major malformations or damage to the brain and are ill.	1	2	3	4	5
17.	The people with developmental disabilities I work with should dress like non-disabled adults their age.	1	2	3	4	5
18.	The people with developmental disabilities I work with have skills which can be developed by providing them rich and stimulating learning environments.	1	2	3	4	5
19.	Developmental disabilities are medical conditions.	1	2	3	4	5
20.	The people with developmental disabilities I work with should be taught how to handle being teased.	1	2	3	4	5
21.	Mental Retardation is one of the most damaging illnesses that a person can have.	1	2	3	4	5
22.	A separation should be made between the kinds of community services available for the people with developmental disabilities I work with and the kinds of services available for non-disabled adults.	1	2	3	4	5

SCALE 1 = Strongly Agree 2 = Agree 3 = Undecided 4 = Disagree 5 = Strongly Disagree

		STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
23.	The only way the people with developmental disabilities I work with are different from non-disabled adults is in how fast they learn things.	1	2	3	4	5
24.	The most important member on a person with developmental disabilities' IDT is the physician.	1	2	3	4	5
25.	The people with developmental disabilities I work with should have been trained in school for jobs.	1	2	3	4	5
26.	The people with developmental disabilities I work with should be taught how to do household chores.	1	2	3	4	5
27.	The people with developmental disabilities I work with should receive drugs such as tranquilizers and stimulants to treat their illness.	1	2	3	4	5
28.	The people with developmental disabilities I work with have physical and intellectual handicaps which will not permit them to develop social and independent living skills.	1	2	3	4	5
29.	The people with developmental disabilities I work with should receive medical services from the same persons/places as non-disabled adults do.	1	2	3	4	5
30.	Mental retardation should be classified as an illness.	1	2	3	4	5
31.	The people with developmental disabilities I work with should have the same hairstyles as non-disabled adults their age.	1	2	3	4	5
32.	Most of the people with developmental disabilities I work with have reached their highest level of educational and psychological development and will not progress much beyond the level they are at now.	1	2	3	4	5
33.	The people with developmental disabilities I work with should be treated by the technically competent expert who is the physician.	1	2	3	4	5

SCALE 1= Strongly Agree 2= Agree 3= Undecided 4= Disagree 5= Strongly Disagree

		STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
34.	The people with developmental disabilities I work with should shop in the community for their own clothing.	1	2	3	4	5
35.	The people with developmental disabilities I work with will never be found in important positions in business.	1	2	3	4	5
36.	Doctors have the most success when treating the people with developmental disabilities I work with than any other professional.	1	2	3	4	5
37.	The people with developmental disabilities I work with are able to develop skills that will allow them to live successfully in the community.	1	2	3	4	5
38.	It is a reasonable estimate that all of the population of institutionalized developmentally disabled adults have severe problems that require medical intervention.	1	2	3	4	5
39.	Most of the services needed by the people with developmental disabilities I work with are available to them in the community.	1	2	3	4	5
40.	The physician should have total authority over deciding the type of medical, education, and training services that the people with developmental disabilities I work with receive.	1	2	3	4	5
41.	The people with developmental disabilities I work with will never learn due to their disability.	1	2	3	4	5
42.	The people with developmental disabilities I work with should not be responsible for doing work around the home.	1	2	3	4	5
43.	The people with developmental disabilities I work with can develop living skills necessary to move to a group home.	1	2	3	4	5
44.	The people with developmental disabilities I work with need medical intervention/ treatment from a physician.	1	2	3	4	5
45.	The people with developmental disabilities I work with should be considered as sick and unable to complete normal social activities.	1	2	3	4	5

SCALE 1= Strongly Agree 2= Agree 3= Undecided 4= Disagree 5= Strongly Disagree

STRONGLY AGREE / AGREE / UNDECIDED / DISAGREE / STRONGLY DISAGREE

46. Normalization means that, as much as possible, people with developmental disabilities should be given normal opportunities for living, working, and training. In thinking about what the people with developmental disabilities that you work with will need in the future, how much do you agree with this?

1	2	3	4	5

47. The medical model views people with developmental disabilities as being permanently sick. There is an over emphasis on addressing the physical and health needs of the individual. Services and treatment are concentrated on curing their illness. In thinking about the needs of the people with developmental disabilities that you work with, how much do you agree with this?

1	2	3	4	5

48. The Developmental model states that the individual with developmental disabilities and the non-disabled individual passes through the same stages of development but at different rates. It also states that every individual possesses some potential for growth and development. In thinking about the future needs of the people with developmental disabilities that you work with, how much do you agree with this?

1	2	3	4	5

CAREPROVIDER'S PERCEPTION OF TRAINING NEEDS

This section contains 19 areas of training and services that you provide individuals with developmental disabilities (MR) at Denton State School. Circle the number for each training area which reflects your views of the training needs of the people with developmental disabilities that you work with (Do you feel they need this type of training?):

SCALE

1= Strongly Agree 2= Agree 3= Undecided 4= Disagree 5= Strongly Disagree

		STRONGLY AGREE	AGREE	UNDECIDED	DISAGREE	STRONGLY DISAGREE
1.	Independent living skills: eg. dressing eating, selecting clothing.	1	2	3	4	5
2.	Personal Hygiene skills: bathing, toileting, toothbrushing.	1	2	3	4	5
3.	Functional Academic skills: basic math, spelling, reading, writing, vocabulary development.	1	2	3	4	5
4.	Community Awareness/Resource Utilization: public transportation, bank, police, movies, restaurants, post office.	1	2	3	4	5
5.	Habilitation Therapy: fine and gross motor training, occupational therapy, physical therapy.	1	2	3	4	5
6.	Communication Therapy: pre-language, expressive and receptive language, following commands, answering and asking questions.	1	2	3	4	5
7.	Psycho-social Development: self esteem, self worth, self image.	1	2	3	4	5
8.	Behavior Modification: avoiding undesired behavior, behavior intervention, reducing self injurious and aggressive behaviors.	1	2	3	4	5
9.	Money Handling: banking, savings, and checking account management, calculating change, money equivalents, budgeting.	1	2	3	4	5
10.	Vocational/Prevocational skills: work related behaviors, remaining on task, completing assignments.	1	2	3	4	5
11.	Household Activities: menu planning, bed making, kitchen cleaning, comparative shopping, laundry, dusting, sweeping.	1	2	3	4	5

SCALE 1= Strongly Agree 2= Agree 3= Undecided 4= Disagree 5= Strongly Disagree

		STRONGLY AGREE		UNDECIDED		STRONGLY DISAGREE
12.	General Safety: first aid, survival signs poisons, emergency procedures, fire safety skills.	1	2	3	4	5
13.	Leisure Skills: table games, music, arts and crafts, sports participation, nature awareness, Special Olympics,socialization	1	2	3	4	5
14.	Health Awareness: Nutrition, health principles, self-administration of medications, basic food groups.	1	2	3	4	5
15.	Personal Identification: name, date of birth, telephone number, age, address.	1	2	3	4	5
16.	Telephone Usage: dialing numbers, holding conversation on phone, answering phone, using pay phone, contacting operator.	1	2	3	4	5
17.	Mobility: traveling alone, identifying traffic signs, using sidewalks, following traffic signals, crossing street safely.	1	2	3	4	5
18.	Citizenship Training: registering and voting, contacting an attorney, self advocacy, consumer information.	1	2	3	4	5
19.	Human Sexuality: identifying own gender, appropriate interactions, identify major body parts, dating.	1	2	3	4	5

DEMOGRAPHIC INFORMATION

Please circle the number (or in some cases fill in the blank) for your answer.

INFORMATION ABOUT YOURSELF:

1.) What is your current position?
1. Residence Trainer
2. Assistant Residence Supervisor
3. Residence Supervisor
4. Therapist Technician (OT, PT, CT)
5. Behavior Therapist
6. LVN
7. RN
8. QMRP
9. Unit Director
10. Assistant Unit Director
11. Medical Doctor
12. Psychologist
13. Social Worker
14. Vocational Monitor/ Supervisor
15. Other, (specify)_____

2.) How long have you worked at Denton State School? _____Years_____Months

3.) How long have you worked in your current position? _____Years _____Months

4.) What shift do you work? (Select the shift that is closest to your current work schedule)
1. 6am to 2pm
2. 2pm to 10pm
3. 10pm to 6am
4. 8am to 5pm

5.) What home do you work on, most of your time? (circle only one number)

CEDAR FALLS	EAST FIELD	TIMBERHILL	WESTRIDGE
1. CF-1	10. EF-1	20. TH-1	30. WR-1
2. CF-2	11. EF-2	21. TH-2	31. WR-4
3. CF-3	12. EF-3	22. TH-3	32. WR-5
4. CF-4	13. EF-4	23. TH-4	33. 515C
5. CF-5	14. EF-5	24. TH-5	34. 520A
6. CF-6	15. EF-6	25. TH-6	35. 520C
7. CF-7	16. EF-7	26. TH-7A	36. 522A
8. CF-8	17. EF-8	27. TH-7B	37. 522B
9. CF-9	18. EF-9	28. TH-8	38. 522C
	19. EF-10	29. TH-9	39. 522D
			40. 525A
			41. 525B
			42. 525C
			43. 525D

44. Other, (specify)_____

Vocational Staff Only- From which home does most of the individuals with developmental disabilities that you work with live on? 45. _____

6.) Did you have any prior work experience (before working at DSS) with individuals with developmental disabilities (MR) ?
1. No
2. Yes, explain_____
_____

7.) What is your sex?
1. Male
2. Female

8.) What is your race/ ethnicity?
1. White
2. Black
3. Hispanic
4. Asian
5. Other, specify_____

9.) What is your age? _____

10.) What is your education level?
1. Less than High School
2. High School graduate
3. G.E.D
4. Some College
5. Licensed Vocational Nurse
6. Associate Degree, 60 hours
7. Bachelor's Degree
8. Master's Degree
9. Other, (Specify)_____

11.) In what city did you receive most of your elementary and secondary education (grades K thru 12)? _____City _____ State

12.) What is your current Marital Status?
1. Never married (single)
2. Married
3. Separated
4. Divorced
5. Widowed
6. Other, (specify)_____

13.) Were you ever a careprovider (before working at DSS) for your parents, children, or relative?
1. No
2. Yes, from 19___ to 19___

14.) Are any members of your family developmentally disabled?
1. No
2. Yes

15.) Have any past or present members of your family been institutionalized (living in a State School or Community Facility)?
1. No
2. Yes

16.) What Service Delivery Model best describes the type of training/services you now provide the individuals with developmental disabilities (MR) that you work with?
1. Developmental Model
2. Normalization Model
3. Medical Model

APPENDIX D

FACTORS INCLUDED IN THE CAREPROVIDER'S SERVICE MODEL ORIENTATION INSTRUMENT

FACTORS INCLUDED IN THE CAREPROVIDER'S SERVICE MODEL ORIENTATION INSTRUMENT

In order to conceptualize the items included in the 'Careprovider's Service Model Orientation' instrument I have grouped the questions according to the underlying model/ principle that I am using them to measure.

ISSUES ASSOCIATED WITH NORMALIZATION:

- Age appropriateness
- Least restrictive environments and living arrangements
- Inclusion activities; aim to discourage attempts at segregation of the developmentally disabled citizens from wider society.
- Seeks to provide a lifestyle for client populations which is similar to that of the normal population using "culturally valued" means.
- Current state of the individual is considered to be of greater importance than historical factors which do not directly influence existing behavioral repertoires.

SUMMARY OF ITEMS WHICH ARE USED TO ASSESS EMPLOYEE'S ATTITUDE TOWARD NORMALIZATION

1. The people with developmental disabilities I work with should socialize with non-developmentally disabled adults.

2. The people with developmental disabilities I work with should participate in neighborhood recreation programs.

6. The people with developmental disabilities I work with should be taught how to get to and from their day programs on their own.

7. The people with developmental disabilities I work with should be taught how to ride public transportation.

8. Many of the people with developmental disabilities I work with should move from a more protected residential setting to a more open setting as they achieve greater self-help skills.

11. After they are 21, the people with developmental disabilities I work with should have the same rights as non-developmentally disabled adults (equal opportunities, access, protection, etc.).

14. In most cases, the people with developmental disabilities I work with should continue to live at Denton State School for their entire lives.

17. The people with developmental disabilities I work with should dress like non-disabled adults their age.

22. A separation should be made between the kinds of community services available for the people with developmental disabilities I work with and the kinds of services available for non-disabled adults.

26. The people with developmental disabilities I work with should be taught how to do household chores.

29. The people with developmental disabilities I work with should receive medical services from the same persons/places as do non-disabled adults do.

31. The people with developmental disabilities I work with should have the same hairstyles as non-disabled adults their age.

34. The people with developmental disabilities I work with should shop in the community for their own clothing.

39. Most of the services needed by the people with developmental disabilities I work with are available to them in the community.

42. The people with developmental disabilities I work with should not be responsible for doing work around the home.

46. Normalization means that, as much as possible, people with developmental disabilities should be given normal opportunities for living, working, and training. In thinking about what the people with developmental disabilities you work with will need in the future, how much do you agree with this?

ISSUES ASSOCIATED WITH THE DEVELOPMENTAL MODEL:

- Perceived physical and intellectual handicap.
- Orientation toward personalized services for each developmentally disabled individual.
- Consideration of individual needs.
- Progression through developmental states.
- Necessity for rich and stimulating learning environments.
- Age appropriate developmental levels.
- Realize and maximize capacity to permit independent functioning.

SUMMARY OF ITEMS WHICH ARE USED TO ASSESS EMPLOYEE'S ATTITUDE TOWARD THE DEVELOPMENTAL MODEL

3. The people with developmental disabilities I work with are basically no different from non-developmentally disabled adults.

4. The people with developmental disabilities I work with can learn to behave the same way as non-disabled adults their age.

9. The people with developmental disabilities I work with cannot attain good independent/self-help skills without good trainers teaching them.

12. The people with developmental disabilities I work with are capable of learning how to manage the money they earn.

15. The people with developmental disabilities I work with may reach their potential but will never learn to behave like non-disabled persons.

18. The people with developmental disabilities I work with have skills which can be developed by providing them rich and stimulating learning environments.

20. The people with developmental disabilities I work with should be taught how to handle being teased.

23. The only way the people with developmental disabilities I work with are different from non-disabled adults is in how fast they learn things.

25. The people with developmental disabilities I work with should have been trained in school for jobs.

28. The people with developmental disabilities I work with have physical and intellectual handicaps which will not permit them to develop social and independent living skills.

32. Most of the people with developmental disabilities I work with have reached their highest level of educational and psychological development and will not progress much beyond the level they are at now.

35. The people with developmental disabilities I work with will never be found in important positions in business.

37. The people with developmental disabilities I work with are able to develop skills that will allow them to live successfully in the community.

41. The people with developmental disabilities I work with will never learn due to their disability

43. The people with developmental disabilities I work with can develop living skills necessary to move to a group home.

48. The Developmental model states that the individual with developmental disabilities and the non-disabled individual passes through the same stages of development but at different rates. It also states that every individual possesses some potential for growth and development. In thinking about the future needs of the people with developmental disabilities you work with, how much do you agree with this?

ISSUES ASSOCIATED WITH THE MEDICAL MODEL:

- Overemphasis upon physical aspects of care.
- Conceptual framework of physical illness.
- Rationale for treatment strategies founded upon prescription of medication.
- Role and status of individuals who may become devalued by society as a result of the stigma which stems from an association of "abnormality" with "illness" and "disease".
- Conceptualization of individuals with developmental disabilities as "permanently sick".
- High priority placed upon biomedical components of service delivery.

SUMMARY OF ITEMS WHICH ARE USED TO ASSESS EMPLOYEE'S ATTITUDE TOWARD THE MEDICAL MODEL

5. Medical treatment is more important than behavior therapy or independent skills training for the individual with developmental disabilities.

10. The people with developmental disabilities I work with should be treated as if they are suffering from an illness like tuberculosis, leprosy, or epilepsy.

13. The true needs of the people with developmental disabilities I work with will never be met as long as the medical doctors are absent from their interdisciplinary teams.

16. Moderate, severe and profoundly retarded individuals have sustained major malformations or damage to the brain and are ill.

19. Developmental disabilities are medical conditions.

21. Mental Retardation is one of the most damaging illnesses that a person can have.

24. The most important member on a person with developmental disabilities' IDT is the physician.

27. The people with developmental disabilities I work with should receive drugs such as tranquilizers and stimulants to treat their illness.

30. Mental retardation should be classified as an illness.

33. The people with developmental disabilities I work with should be treated by the technically competent expert who is the physician.

36. Doctors have the most success when treating the people with developmental disabilities I work with than any other professional.

38. It is a reasonable estimate that all of the population of institutionalized developmentally disabled adults have severe problems that require medical intervention.

40. The physician should have total authority over deciding the type of medical,education, and training services that the people with developmental disabilities I work with receive.

44. The people with developmental disabilities I work with need medical intervention/treatment from a physician.

45. The people with developmental disabilities I work with should be considered as sick and unable to complete normal social activities.

47. The medical model views individuals with developmental disabilities as being permanently sick. There is an over emphasis on addressing the physical and health needs of the individual. Services and treatment are concentrated on curing their illness. In thinking about the needs of the people with developmental disabilities that you work with, how much do you agree with this?

APPENDIX E

CLASSIFICATION OF DSS RESIDENTIAL HOMES BY LEVEL OF CARE

CLASSIFICATION OF DSS RESIDENTIAL HOMES BY LEVEL OF CARE

MEDICALLY FRAGILE		LEVEL CARE = I
CEDAR FALLS 1 CEDAR FALLS 2 CEDAR FALLS 3 CEDAR FALLS 4 INFIRMARY		EASTFIELD 4 TIMBERHILL 7 TIMBERHILL 8 WESTRIDGE 519 WESTRIDGE 520A WESTRIDGE 525A WESTRIDGE 525B WESTRIDGE 526A
LEVEL OF CARE = 5		**LEVEL OF CARE = 6**
EASTFIELD 3 EASTFIELD 7 EASTFIELD 8 TIMBERHILL 2 TIMBERHILL 5 WESTRIDGE 520C WESTRIDGE 525C WESTRIDGE 525D WESTRIDGE 526B WESTRIDGE 526C		CEDAR FALLS 5 CEDAR FALLS 6 CEDAR FALLS 7 CEDAR FALLS 8 CEDAR FALLS 9 CEDAR FALLS 10 EASTFIELD 1 EASTFIELD 2 EASTFIELD 5 EASTFIELD 6 EASTFIELD 9 EASTFIELD 10 TIMBERHILL 1 TIMBERHILL 3 WESTRIDGE 522A WESTRIDGE 522B WESTRIDGE 522C WESTRIDGE 522D WESTRIDGE 523A WESTRIDGE 523B WESTRIDGE 523C WESTRIDGE 523D WESTRIDGE 524A WESTRIDGE 524B WESTRIDGE 524C WESTRIDGE 524D WESTRIDGE 526D

APPENDIX F

LETTER TO JURY PANEL

Denton, Texas 76201
April 1, 1992

Dr. Sigrid Glenn
Director of The Center
For Behavior Analysis
University of North Texas
Denton, Texas 76204.

Dear Dr. Glenn:

In partial fulfillment of the requirements for the Doctoral Degree at the University of North Texas, I am conducting a Dissertation research which attempts to examine the education and training needs of the institutionalized developmentally delayed adults as perceived by their careproviders (DSS Employees). I will also seek to determine if their perceptions are oriented towards a medicalization or developmental/ normalized view of service provision.

The data collection instrument was designed by the researcher. I am seeking validation of the data collection tool as a part of this dissertation preparation. With the approval of my Dissertation Committee's Chairperson, Dr. Ron Newsom, I am requesting that you serve as one of the judges to assist in establishing the content validity of the instrument.

Enclosed is a copy of the instrument and a brief description. Additionally, the study's problem statement, hypothesis and definition of terms are included. Please evaluate the questionnaire for clarity, comprehensiveness, and adequacy to elicit data to answer the research problem. Feel free to delete any statements that seem irrelevant and add any of those which you consider pertinent. If any wording seems unclear, please correct it or make comments (feel welcome to write on the questionnaire).

Thank you for your cooperation. Your help with my research is greatly appreciated. If you have any questions regarding the questionnaire, please call me at (817) ###-####.

Sincerely,

Sharon Coutryer, M.S.
Graduate Student
College of Higher
Education, UNT.

APPENDIX G

COVER LETTER FOR PILOT SAMPLE

May 15, 1992

Dear Denton State School Employee:

In partial fulfillment of the requirements for the Doctoral Degree at UNT, I am conducting a research which focuses on careprovider's perceptions on the normalization/ developmental model and the medical model as the basis for providing education and training services for people with developmental disabilities at DSS. The research also examines the education and training needs of these individuals as perceived by their careproviders. The questionnaire was designed by the researcher by combining items from existing tools as well as developing new items. With the approval of my Dissertation Committee, and the DSS Institutional Review Committee, I am seeking volunteers to participate in a pilot study to assess the reliability of the tool. I am asking you, as an employee of DSS, to serve as a participant by completing the attached questionnaire. Your participation in this pilot study is completely voluntary. If you agree to participate, please follow the instructions for the questionnaire and complete the questions. You may use pencil or pen.

Your help with my research is greatly appreciated. If you have any questions, please call me at xxx-xxxx or at ext. xxxx. between 8am and 5pm. I can also be reached at home at (817) xxx-xxxx.

Sincerely yours,

Sharon Coutryer
Education Specialist
Community Services
Division, Denton State
School

APPENDIX H

COVER LETTER FOR TOTAL SAMPLE

Denton, Texas 76201
July 1992

Dear Denton State School Employee:

My name is Sharon Coutryer, and I am a graduate student at the University of North Texas. I am also an employee at Denton State School. In partial fulfillment of the requirements for the Doctoral Degree, I am conducting a research which focuses on careprovider's perceptions on the normalization/ developmental model and the medical model as the basis for providing education and training services for people with developmental disabilities at DSS. The research also examines the education and training needs of these individuals as perceived by their careproviders.
Please follow the instructions for the questionnaire and complete the questions, which should require about 10 to 15 minutes. You may use pencil or pen. Do not write your name or make any other identifying marks on the questionnaire. Your identity will remain anonymous. Participation in the study is voluntary and your work status will not be affected by your participation or non-participation. Completion of the questionnaire will show your consent to participate in the study. After completing the questionnaire please return them to the set mailbox at your work station. The results of this study should be available in about 6 months. If you desire information about the results please call me at the number listed below.

Thank you for your time, interest, and participation in the study. Your help with my research is greatly appreciated. If you have any questions, please call me at (817) xxx-xxxx or between 8am and 5pm at ext. xxxx. (Community Services Division).

Sincerely yours,

Sharon Coutryer, M.S.
Graduate Student
College of Higher
Education, UNT.

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